



**Standardization And Strengthening The Functionality Of Hospital Management Boards In  
Central Hospitals Of Zimbabwe**

by

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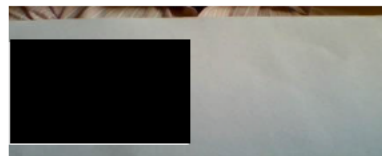
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## DECLARATION

I, Webster Funhiro, declare that **STANDARDIZATION AND STRENGTHENING THE FUNCTIONALITY OF HOSPITAL MANAGEMENT BOARDS IN CENTRAL HOSPITALS OF ZIMBABWE**, is my work and that all the sources I have used or quoted have been indicated and acknowledged by means of complete references. Thus, the following have been considered:

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## ABSTRACT

Health governance system in Zimbabwe is undergoing nationwide structural reforms. This is done through the appointment of health centre committees for rural health facilities, advisory boards for district and provincial hospitals as well as hospital management boards for central hospitals. The study was aimed at exploring standardization and strengthening performance of hospital management boards in central hospitals of Zimbabwe.

The central hospitals included in the study are Harare Central Hospital, Chitungwiza Central Hospital and Parirenyatwa Group of Hospitals in the northern region of the country. In the southern region, they were United Bulawayo Hospitals (UBH), Mpilo and Ingutsheni Central Hospitals. Questionnaires and interviews were used to collect quantitative and qualitative data respectively in the six central hospitals in Zimbabwe. The target population of the study was 66 board members and a census sampling was used whereby all were included in the study. However, 35 out of 54 (64.81%) responded to the questionnaire while 10 out of 12 (83.33%) targeted study participants were interviewed. Quantitative data was analysed using the SPSS Version 25 whereas qualitative data was transcribed, loaded and analysed through the use of NVivo Version 12 software application.

The study results revealed that 67% of hospitals had functional hospital management boards with a quorum and active term of office. There was no clear policy or guidelines to evaluate the performance of hospital management boards. Gaps revealed call for policy strengthening of the appointment and performance of HMBs in Zimbabwe.

Key words: Standardization, Strengthening, Performance, Governance, Appointment

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## TABLE OF CONTENTS

DECLARATION.....	ii
ABSTRACT.....	iii
ACKNOWLEDGEMENTS .....	iv
LIST OF TABLES .....	xiii
LIST OF FIGURES.....	xv
LIST OF ACRONYMS AND ABBREVIATIONS .....	xvi
CHAPTER ONE.....	1
INTRODUCTION AND OVERVIEW .....	1
1.1 Introduction.....	1
1.2 Background to the study .....	2
1.3 Problem statement .....	6
1.4 Purpose of the study .....	7
1.5 Research questions.....	7
1.6 Objectives .....	8
1.7 Justification and originality of the research .....	9
1.8 Scope and delimitations of the study.....	10
1.9 Limitations .....	11
1.10 Definitions of key terms .....	11
1.10.1 Standardization.....	11
1.10.2 Functionality .....	11
1.10.3 Corporate governance .....	12
1.11 Structure of the thesis.....	12
1.12 Chapter summary.....	14
CHAPTER TWO.....	15
THEORETICAL FRAMEWORK .....	15
2.1 Introduction .....	15
2.2 The agency theory.....	17
2.3 Principal-agent theory .....	17
2.4 Common pool resources theory .....	18
2.5 Institutional analysis theory .....	19
2.6 The stewardship theory .....	20
2.7 The managerialism theory .....	21
2.8 The stakeholder theory.....	21
2.9 The resource dependence theory.....	22

2.10	The new institutional economics perspective .....	23
2.11	Multi-level framework.....	23
2.11.1	Limitations of the multi-level framework .....	25
2.12	Social accountability framework.....	26
2.12.1	Voice.....	28
2.12.2	Enforceability .....	29
2.12.3	Answerability .....	30
2.12.4	Challenges of the social accountability framework .....	30
2.13	Principal-agent model of governance framework .....	31
2.13.1	Challenges with the implementation of the principal-agent model of governance framework.....	33
2.14	Framework of accountability mechanisms in health care .....	33
2.15	Governance analysis in health sector operations .....	35
2.16	The political science and public administration perspective .....	36
2.16.1	Health worker accountability framework.....	36
2.16.2	Accountability assessment framework.....	41
2.17	Framework to assess the patron-client relationship .....	43
2.18	Strategies for reforming clientelistic systems.....	44
2.18.1	Economic liberalization .....	44
2.18.2	Democratization.....	44
2.18.3	Decentralization .....	45
2.18.4	Civil service reform .....	45
2.19	International development perspective .....	46
2.19.1	Governance framework on the health system assessment.....	46
2.19.2	Health development governance framework.....	46
2.19.3	Framework to assess governance of health systems.....	47
2.20	Multidisciplinary perspective .....	48
2.20.1	Governance assessment framework.....	48
2.20.2	Framework for the identification of corruption in the health sector .....	48
2.21	The assessment of inputs-processes-outputs governance framework.....	54
2.22	Chapter summary .....	57
CHAPTER THREE.....		58
THE NATURE OF FUNTIONALITY OF CENTRAL HOSPITALS OF ZIMBABWE.....		58
3.1	Introduction .....	58
3.2	Establishment of hospital management boards in Zimbabwe .....	58
3.3	Board composition of central hospitals in Zimbabwe .....	61

3.4	Board committees in central hospitals .....	62
3.5	Autonomy of hospital management boards .....	63
3.6	Resource mobilization by hospital management boards .....	64
3.7	Health care provision by hospital management boards .....	67
3.8	National health policy implementation by the central hospitals.....	69
3.9	Formulation of institutional health policies by hospital management boards .....	70
3.10	Financial management in central hospitals.....	70
3.11	Audit assurance by hospital management boards .....	74
3.12	Chapter summary .....	75
CHAPTER FOUR .....		76
LITERATURE REVIEW .....		76
4.1	Introduction.....	76
4.2	Standard functional structures of hospital management boards .....	77
4.2.1	Health care governance .....	77
4.2.2	Good health care governance.....	79
4.2.3	Benefits of corporate governance .....	81
4.3	Components of good health care governance .....	81
4.3.1	Transparency.....	82
4.3.2	Accountability .....	82
4.3.3	Participation.....	83
4.3.4	Integrity.....	83
4.3.5	Policy capacity.....	84
4.4	Models of hospital governance .....	84
4.4.1	Philanthropic model.....	84
4.4.2	Corporate model .....	85
4.5	Health care governance structure .....	85
4.6	Health care strategic management .....	87
4.6.1	Benefits of strategic management.....	90
4.7	Governing structures and delegation .....	90
4.7.1	Roles and benefits of board committees.....	92
4.8	Board performance .....	93
4.8.1	Board performance indicators .....	93
4.9	Board evaluation .....	93
4.10	CEO evaluation.....	94
4.11	The process of appointing hospital management boards .....	94
4.11.1	The appointing authority for hospital management boards .....	95

4.11.2	Selection criteria for hospital board members .....	95
4.11.3	Board diversity .....	96
4.11.4	CEO appointment in public hospitals.....	96
4.12	Challenges encountered by hospital management boards.....	97
4.12.1	Financial challenges in hospitals .....	97
4.12.2	Staff shortage in hospitals.....	98
4.12.3	Organizational viability .....	99
4.12.4	Adherence to regulations .....	100
4.12.5	Workforce capability in hospitals.....	101
4.12.6	Patient safety .....	102
4.12.7	Patient experience .....	103
4.12.8	Staff engagement.....	104
4.13	Strategies to enhance the functionality of hospital management boards.....	105
4.13.1	Strategies that enhance transparency by hospital management boards.....	106
4.14	Strategies that enhance accountability by hospital management boards .....	110
4.14.1	Standards and codes of conduct.....	110
4.14.2	Conflict of interest policies .....	110
4.14.3	Competitive bidding.....	111
4.14.4	Contracts.....	112
4.14.5	Privatization or corporatization of hospital services .....	113
4.14.6	Performance-based financing mechanism .....	114
4.14.7	Organizational separation.....	115
4.15	Strategies that enhance stakeholder participation .....	116
4.15.1	Client or patient satisfaction surveys by hospital management boards.....	116
4.15.2	Stakeholder forums.....	117
4.15.3	Advisory committees .....	118
4.15.4	Partnering with other organizations.....	119
4.16	Strategies that enhance the integrity of hospital management boards .....	120
4.16.1	Internal audits .....	120
4.16.2	Budgeting .....	121
4.16.3	Financial audits .....	123
4.16.4	Hospital board operating procedures.....	124
4.17	Strategies that enhance policy capacity for hospital management boards .....	124
4.17.1	Forecasting.....	124

4.17.2	Staff recruitment and retention in health care systems.....	125
4.17.3	Research and analysis capacity .....	126
4.17.4	Decentralization and autonomous capacity of hospital boards .....	127
4.17.5	Transformational leadership by hospital boards .....	128
4.18	Chapter summary .....	129
CHAPTER FIVE.....		131
RESEARCH DESIGN AND RESEARCH METHODS .....		131
5.1	Introduction.....	131
5.2	Philosophical paradigms.....	131
5.3	Research design .....	132
5.3.1	Qualitative research method .....	133
5.3.2	Quantitative research method.....	135
5.4	Study population and data source .....	138
5.5	Sampling and sampling technique .....	138
5.6	Data collection technique .....	139
5.7	Procedure for data collection.....	139
5.7.1	Ministry of Health and Child Care permission to conduct a study .....	139
5.7.2	The pilot study .....	140
5.8	Reliability and validity .....	141
5.8.1	Cronbach’s alpha test.....	141
5.9	Data analysis .....	143
5.10	Ethical considerations.....	143
5.11	Chapter summary .....	144
CHAPTER SIX .....		145
DATA ANALYSIS AND PRESENTATION OF FINDINGS.....		145
6.1	Introduction .....	145
6.2	Response rate .....	145
6.3	Characteristic descriptive analysis.....	145
6.4	DATA ANALYSIS .....	148
6.4.1	Introduction .....	148
6.4.2	Standard functional structures of hospital management boards in central hospitals of Zimbabwe.....	148
6.4.3	Process of appointing hospital board members in central hospitals.....	164
6.4.4	Challenges faced by hospital management boards in carrying out their mandate .....	171
6.4.5	Study participants’ suggestions for enhancing the functionality of hospital management boards	177

6.4.6	Functionality of hospital boards .....	182
6.5	Chapter summary .....	204
CHAPTER SEVEN .....		205
INTERPRETATION AND PRESENTATION OF RESEARCH FINDINGS .....		205
7.1	Introduction .....	205
7.2	DETERMINATION OF STANDARD FUNCTIONAL STRUCTURES OF HOSPITAL MANAGEMENT BOARDS IN CENTRAL HOSPITALS OF ZIMBABWE .....	
7.2.1	Functional hospital management board .....	206
7.2.2	Number of board members in hospital management boards .....	206
7.2.3	Board committees .....	207
7.2.4	Board's term of office and duration as a board member .....	207
7.2.5	Policy to evaluate performance of the CEO .....	208
7.2.6	Frequency of board meetings and setting of agendas .....	209
7.2.7	Policy to evaluate performance of the hospital management board .....	210
7.2.8	Board remuneration .....	211
7.2.9	Succession planning .....	211
7.2.10	Involvement of external or independent non-executive directors .....	212
7.2.11	Existence of an internal audit department .....	213
7.2.12	Contribution of hospital boards to governance in hospitals .....	214
7.2.13	Alignment of organizational goals with interest of stakeholders .....	218
7.2.14	Formulating and implementing business and corporate strategies .....	219
7.2.15	Major successes in achieving good corporate governance mandate .....	220
7.3	EXAMINATION OF THE PROCESS OF APPOINTING HOSPITAL MANAGEMENT BOARD MEMBERS IN CENTRAL HOSPITALS OF ZIMBABWE .....	
7.3.1	Appointing Authority for board members .....	221
7.3.2	Selection criteria for board members .....	222
7.3.3	Gender balance of the board .....	223
7.3.4	Board composition and educational requirements .....	224
7.3.5	Board involvement on the appointment of the CEO .....	224
7.4	ESTABLISHMENT OF CHALLENGES FACED BY HOSPITAL MANAGEMENT BOARDS IN DISCHARGING THEIR MANDATE .....	
7.4.1	Major challenges in achieving good corporate governance mandate .....	225
7.5	RECOMMENDATION OF STRATEGIES FOR ENHANCING THE FUNCTIONALITY OF H	

OSPITAL MANAGEMENT BOARDS IN ZIMBABWE .....	226
7.5.1 Strategies that can strengthen the performance of hospital management boards .....	227
7.5.2 Hospital management boards governance models .....	229
7.6 Chapter summary .....	231
CHAPTER EIGHT .....	232
CONCLUSIONS AND RECOMMENDATIONS .....	232
8.1 Introduction .....	232
8.2 Summary of research findings .....	232
8.2.1 Determination of standard functional structures of hospital management boards in central hospitals of Zimbabwe .....	233
8.2.2 Examination of the process of appointing hospital management board members in central hospitals of Zimbabwe .....	234
8.2.3 Establishment of challenges faced by hospital management boards in discharging their mandate .....	235
8.2.4 Recommendation of strategies for enhancing the functionality of hospital management boards in central hospitals of Zimbabwe .....	235
8.3 Conclusions .....	236
8.3.1 Determination of standard functional structures of hospital management boards in central hospitals of Zimbabwe .....	236
8.3.2 Examination of the process of appointing hospital management board members in central hospital of Zimbabwe .....	237
8.3.3 Establishment of the challenges faced by hospital management boards in discharging their mandate .....	237
8.3.4 Recommendation of strategies for enhancing the functionality of hospital management boards in central hospitals of Zimbabwe .....	238
8.4 Recommendations .....	238
8.4.1 Recommendations to strengthen the functionality of hospital management boards in discharging the good corporate governance mandate .....	238
8.4.2 Recommendations on the process for appointing hospital management board members in central hospitals of Zimbabwe .....	239
8.5 Contributions to theory, policy and practice .....	240
8.5.1 Theoretical contributions .....	240
8.5.2 Policy contributions .....	241
8.5.3 Contribution to practice .....	241
8.5.4 Limitations .....	241
8.6 Areas for future research .....	242
8.7 Conclusion .....	242

Appendix 1: Questionnaire .....	260
Appendix 2: Interview Schedule .....	268
Appendix 3 : Multivariate Analysis Tables.....	272
Appendix 4: Thesis editing confirmation letter.....	290
Appendix 5: MOHCC Approval.....	292
Appendix 6 : Ethical Clearance Approval Letter.....	293
Appendix 7 : Turnitin Report.....	294

## LIST OF TABLES

Table 1: Correlation between research objectives and questions.....	8
Table 2 : Conceptual Framework.....	56
Table 3 : Benefits of establishing hospital management boards.....	59
Table 4 : Patients' Rights .....	68
Table 5 : Claims and Expectations of Stakeholders .....	118
Table 6 : Hospital budgeting process .....	123
Table 7 : Recruitment strategies in public hospitals .....	126
Table 8 : Respondent's identification.....	135
Table 9: Interpretation of Cronbach's Alpha Model .....	142
Table 10 : Cronbach's Alpha Test .....	146
Table 11: Number of respondents by hospital .....	146
Table 12 : Number of years as board member .....	147
Table 13 : Board Members' Profession .....	148
Table 14: Number of board committees per institution.....	149
Table 15: Names of board committees by institution .....	151
Table 16 : Rating of board committees mentioned by respondents .....	152
Table 17 : Duration as board member and board's term of office.....	153
Table 18 : Years of experience as board member.....	153
Table 19: Alignment of organizational goals with stakeholder expectations by institution .....	155
Table 20 : Important stakeholders versus organizational goals .....	157
Table 21: Formulation and implementation of business and corporate strategies by institution .....	159
Table 22 : Best practices in achieving good corporate governance mandate .....	161
Table 23: Major best practices by institution .....	163
Table 24 : Appointing authority at respective institutions .....	166
Table 25: Identification and engagement of board members as revealed by CEOs .....	167
Table 26: Identification and engagement of board members as revealed by board chairs.....	168
Table 27: Board member selection criteria.....	169
Table 28: Major limitations as highlighted by CEOs.....	172
Table 29: Major limitations as highlighted by board chairs .....	174
Table 30: Strategies to strengthen the performance of hospital management boards.....	178
Table 31 : Functional hospital board .....	183
Table 32 : Reasons for non-functionality of hospital boards.....	184
Table 33: CEO also chairperson of the board .....	184
Table 34: Board meetings based on prepared agendas.....	185
Table 35: Setting of agenda for meetings .....	186
Table 36 : Board Remuneration .....	188
Table 37: Set annual fee.....	189
Table 38 : Per meeting fee.....	189
Table 39 : Travel and other reimbursements .....	189
Table 40 : Other payment methods.....	190
Table 41 : Policy to evaluate board performance.....	191
Table 42 : Board evaluation criteria and frequency .....	191
Table 43 : Board involvement on the appointment of the CEO.....	192
Table 44 : Policy to evaluate performance of the CEO.....	193
Table 45 : Evaluation criteria of the CEO and frequency .....	193
Table 46 : Policy on succession planning.....	195
Table 47 : Existence of internal audit department .....	196
Table 48 : Other board sub-committees .....	197
Table 49: Relationship between policy to evaluate performance of the board and the CEO.....	198

Table 50 : Contribution of the board of directors.....	202
Table 51 : Principal component analysis of hospital board contribution.....	203
Table 52 : Contribution of board of directors to hospital governance .....	203

## LIST OF FIGURES

Figure 1: Philosophical Paradigms.....	132
Figure 2: Board committees identified .....	150
Figure 3 : Board of directors aligning goals with those of its stakeholders .....	156
Figure 4: Formulation and implementation of business and corporate strategies.....	160
Figure 5 : Appointing authority for board members .....	165
Figure 6 : Limitations experienced on achieving good corporate governance mandate .....	171
Figure 7 : Level of involvement of external directors.....	187

## LIST OF ACRONYMS AND ABBREVIATIONS

BOD	Board of Directors
CEO	Chief Executive Officer
CSR	Corporate Social Responsibility
DIPA	Departmental Integrated Performance Agreement
EC	European Commission
EVA	Economic Value Added
HMB	Hospital Management Board
HSB	Health Service Board
IODSA	Institute of Directors in Southern Africa
MOHCC	Ministry of Health and Child Care
MOU	Memorandum of Understanding
NFP	Not-for-profit
NGOs	Non-Governmental Organizations
NHS	National Health Services
NHS	National Health Strategy
OPC	Office of the President and Cabinet
PPPs	Public-Private-Partnerships
REC	Research Ethics Committee
ROA	Return on Assets
SDGs	Sustainable Development Goals
TAPIC	Transparency, Accountability, Participation, Integrity, Policy
UBH	United Bulawayo Hospitals
UNDP	United Nations Development Programme
USAID	United Nations Agency for International Development
WHO	World Health Organization
ZIMASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation

# CHAPTER ONE

## INTRODUCTION AND OVERVIEW

### 1.1 Introduction

With the exception of some, there is a general awareness among the boards of trustees and management boards on health system efficiency in most countries worldwide (Botje et al., 2013). The hospital financial management and performance are enhanced through the involvement of board of directors (Afriyie et al., 2020). Hospital boards are responsible for maintaining good corporate image, good governance and public trust. Reforms in the health sector might not be sufficient to remedy all the problems facing public hospitals, although the milestones are highly commendable (Allen et al., 2014). The hospital boards play an oversight role in the management of these ‘life saving’ institutions, hence their performance should be sustainably strengthened for hospitals to deliver as expected by the citizens and multiple stakeholders in a country. Against this backdrop, the exploration of the effectiveness of hospital management boards in central hospitals is necessary.

In Australia and USA, the notion of governance has retained its original meaning, which is, to steer rather than row (Osborne and Gaebler, 1992). The governance of hospitals can be defined as processes and tools that steer the totality of institutional activity, influencing organizational behaviour and take into consideration the needs of multiple stakeholders (Saltman and Duran, 2016). Governing public organizations involves tax payers’ funds as compared to private enterprises where shareholders equity is injected. The healthcare system stability should be a top government priority, due to the hospitals’ fragility in the face of challenges and crises like the current Covid-19 pandemic (Schneider, 2020). Health sector governance is very critical in the improvement of health, hence the need for robust platforms for effective intersectoral activities and the capacity to conduct policy research and evaluation (Fryatt et al., 2017).

The hospital board performance is vital in ensuring organizational efficiency, effectiveness, sustainability and competence in the sector of service. In hospital management, healthcare service quality is achieved through robust performance indicators (Jiang et al., 2020). The hospital performance on quality is strongly related to hospital board and management

practices. In order to deliver responsive health services, the possession of distinct qualities and performance of required duties or functions is highly desirable (Zimbabwe, 2014).

This introductory chapter provides background of the study, description of hospital boards, governance in health delivery systems and its link to the general corporate governance principles. The presentation encompasses problem statement, research objectives, research questions, motivation for the study, justification and originality of the study. Additionally, conceptual framework, scope and delimitations, limitations, definitions of key terms and the thesis structure are highlighted. Also, a brief discussion of the methodology followed to provide a solution and the setting for the study is outlined. Lastly the synopsis on content of the thesis.

## **1.2 Background to the study**

According to Cristian et al. (2017), governance in health systems take into consideration the stakeholder involvement in the decision making process, variations in rules or processes that have an effect on the authority and accountability for health policies, organizations and service provision. Decision makers in the decentralized models of governance have greater decision space, hence selection of priorities at local level ensure efficiency and effectiveness in the utilization of available resources (Sreeramareddy and Sathyanarayana, 2019). The reforms that might have an effect on health service delivery and governance activities include parameters such as authority, accountability, openness, participation and coherence.

At global and national contexts, stakeholder involvement is of paramount importance on board resolutions and greatly influences accountability by the entity. In the case of Flemish hospitals in Belgium, the decision making process differed among hospitals. Specifically, the hospitals with active stakeholder committee involvement showed meaningful impact on operational level in all hospitals. However, the results from the study entails that there is need for more research on the connection between stakeholder involvement and hospital governance (Malfait et al., 2017). In the case of Romania over the past three decades (1990-2019), efforts have been made in order to standardize hospital classification, hospital governance structures, management, modern reimbursements mechanisms and regulatory requirements (Duran et al., 2019). The application of governance structures or instruments in

Romania faced a number of impediments which include misalignment by responsible authorities in decision making capacity of hospitals, policy inconsistencies, limited managerial autonomy, outdated and inconsistent regulatory frameworks. The study conducted in Romania proffered that some of the challenges are due to internal forces like limited operational, strategic and financial capacity in hospitals for them to exhibit better financial and good governance systems. Globally healthcare reforms are typically achieved through policy change which is generally attained through interventions like operational efficiency, effective financial utilization, transparent processes, procedures and practices. There is no doubt that policy changes or reforms are very critical because of the undeniable politically challenging, complex and worrying environment in the globalized world today (Braithwaite et al., 2017b).

The decolonizing of the global health sector involves a shift of systems of dominance and power to improve the health of population (Khan et al., 2021). The study of health leadership in the African context or settings was conducted through a careful consideration of experiences in public hospitals and health leadership development of different countries (Gilson and Agyepong, 2018). As the study results will show, the current leadership practices in the central hospitals largely impact negatively on staff incentives, expertise and patient treatment. This situation indicates that the status quo of health leadership should be transformed in order to make the central hospitals more responsive to the health needs of the citizens. The results on leadership development showed that it is not enough to train individuals but rather focus should be on developing an organizational context or structure that sustains contemporary leadership practices. The study suggested that given the interdisciplinary set up of health care which is broadly categorized into curative and preventive services, hence integrated effort to improve health care performance and governance.

In Southern African countries, health care systems are undergoing different stages of realignment in term of governance structures, effectiveness and efficiency. The governance structures and processes was conducted in South Africa through a study of public hospitals with a view to determine the effect of hospitals and hospital governance for the determination of health service delivery (Fusheini et al., 2016). The study results revealed that apart from good governance being a key element in service provision, there is also need for stakeholder assessment and the design of appropriate interventions. In the practice of

good hospital governance, leadership political will, provincial influence, good hospital structures and processes are important facets in hospital management. These factors inherently render freedom in execution of policies and plans that lead to the achievement of health strategic goals or outcomes. In an effort meant to improve public sector delivery and democracy, Botswana has embarked on reforms to address governance issues. The decentralization of service provision as a governance strategy for encouraging participatory development was adopted in Botswana, however the government retained the centralization of the coordination of state administration. It is further noted that governance of public hospitals in Botswana has remained embedded in a hierarchical organizational structure with highly centralized tendencies. In practice, all public or government hospitals in Botswana report to the Ministry of Health head office, a situation that provides limited management and operational autonomy (Mooketsane et al., 2017).

In Zimbabwe, the health governance system is undergoing structural reforms. The implementation of the reforms are based on the appointed health centre committees for rural health facilities, advisory boards for district and provincial hospitals and hospital management boards for central hospitals. It is noted that in order to achieve the sustainable services in health systems, respective countries, health institutions and health managers should embrace good governance principles, processes and practices. However, in carrying out board work, the hospital boards in the middle and low income countries often encounter various problems which include, among others, inadequate authority to govern, failure to engage competent individuals to serve in boards, inadequate information which compromises decision making, lack of board evaluation mechanisms and that some board members are not even knowledgeable about their duties and responsibilities (Sikipa et al., 2019).

Central hospitals in Zimbabwe have a structure which was designed to meet the good governance principles. In China, the hospital administrators, local leadership and hospital commissions concurred that power over the management of public hospitals should be given to administrators (Nong and Yao, 2019). The Zimbabwean structure comprises the hospital independent board members, the CEO and three executive directors who include the clinical director, operations director and finance director. The hospital board has the overall function of policy making and oversight role of the hospital operations (Health Services Act : Chapter 15:16). The hospital governance concept adopted different models in European countries. The

micro-level hospital governance is most ideal for routine operational management of staff and services, whilst the meso-level involves policy making where decisions are made at institutional level free from government interference (Rechel et al., 2018). Nevertheless, the hospital management boards are not answerable for the daily functions of the health institutions. The hospital management board is mandated to monitor the performance of the executive management. The CEO of the central hospitals, among other leadership functions, is responsible for development, administration and giving direction to the institution. Furthermore, the CEO continuously monitors and evaluates effectiveness, efficiency, appropriateness and quality of planning, monitoring and evaluation methods in place. The CEOs and boards are obliged to deliver government policy, hence the central government routinely scrutinizes performance against targets. The CEO is expected to meet the set targets, failure of which dismissal is proffered (Janke et al., 2019). In other words, this means that it is the duty of the CEO to ensure that service delivery methods, standards and operational procedures, identification of risks and opportunities for improvement, design and enforce appropriate actions is put in place to achieve the required health care services. Thus, the CEO assures that both clinical and administrative activities are in compliance with Health Professions Authority standards and MOHCC policy guidelines. From the governance perspective, a CEO contributes to decision making and participates in board meetings through presentations of the hospital performance and issues for the board's consideration. The CEO is held accountable by the board in pursuance of the hospital's mission, through implementation of annual budgets and operational plans (Friedman and Rabkin, 2018). In this regard, the CEO has the overall responsibility in the implementation and enforcement of board's resolutions.

In the Zimbabwean context, a lot has been reported on health systems concerning corruption, mismanagement and malpractices in procurement processes and practice. This is despite the fact that there are functional hospital boards in all central hospitals, hence the need to explore the boards' functionality or performance. Literature extant and qualitative studies have put more emphasis on the views and experience of management staff and clinicians and not the boards for good health governance system in health facilities (Bismark and Studdert, 2013). The public hospitals reforms in Zimbabwe have mainly focused on leadership and management. Leadership and culture changes are the facets which can open decision space in terms of human, technical and financial resources (Witter et al., 2021). At the time of this

study, it was now mandatory that all central hospitals to have functional hospital boards to ensure good governance in health care delivery. It is stressed that every central hospital should have an effective board that is mandated to develop an ethical code that is applicable to employees, executive management and the hospital management board itself. In addition, the central hospital management board should comprise seven non-executive and four executive directors (Health Service Act, Chapter 15:16). However, the selection process and responsibility of the appointment of hospital board members is not well articulated in the Health Service Act. This is a concern since central hospitals provide a public service which serves the interests or needs of citizens and various stakeholders for the societal common good.

It is often said that the ‘fish rots from the head’ and in this regard, this means that if the hospital board is ineffective, then ultimately less might be expected from the followers and this being management at all levels. When adopting boards of directors, a stakeholder approach with larger and more independent board members is not harmful to organizational performance, hence desirable (Garcia-Lacalle et al., 2021). This suggests that hospital boards ensure the success of the entity. Despite numerous researches on hospital good governance, significant gaps still remain on the area of senior leadership positions and hospital performance (Sarto and Veronesi, 2016). Against this background, this research is an attempt to contribute towards strengthening transparency on the appointment of hospital boards.

### **1.3 Problem statement**

Governments in developing countries have pursued techniques and strategies to strengthen the performance of their public hospitals. One key strategy adopted by some governments is through granting autonomy to public hospitals. The hospital autonomization is aimed at strengthening public hospitals to generate revenues, whilst reducing subsidy from the central government. In achieving hospital autonomy, the government moves away from welfare state, thus withholding state financing of all public hospitals from taxes and state enterprises’ remittances (Puspita et al., 2020). Public hospitals are afforded the opportunity and incentive to generate revenues (Võ and Löfgren, 2019). However, despite boards of directors being created in those public hospitals, limited success have been realized on policies that grant autonomy had (De Geyndt, 2017).

Governance practice of autonomized hospitals is often obstructed by resistance from regulatory authorities who fear their power would be reduced. Autonomization which is also referred to as corporatization is structurally well characterized in central hospitals, thus achieving strategic reforms in the management of resources (Lipunga et al., 2021). Stakeholders at the highest level more often devise strategies to uphold their power even if it is at the detriment to societal response to health needs and challenges. The MOHCC attempts to keep its authority through a combination of direct and indirect appointment of hospitals staff and board members, as well as the procurement of medical supplies and equipment. The central government is obliged to review governance institutional frameworks to enhance greater autonomy aimed at bolstering control in the management of procurement and human resource activities. Hospital managers are motivated in the discharge of their duties through flexibility and opportunities for decision making (Barasa et al., 2017b). The extant literature is not quite clear on the governance procedures to be followed in human resources management policies and procurement of supplies to ensure the autonomy of public hospitals.

#### **1.4 Purpose of the study**

The main aim was to explore governance aspects towards standardization and strengthening of the performance of hospital management boards in central hospitals in Zimbabwe.

#### **1.5 Research questions**

The study sought to answer the following research questions:

- What are the standard functional structures of hospital management boards in central hospitals of Zimbabwe?
- How are hospital management boards appointed in central hospitals of Zimbabwe?
- What are the challenges faced by hospital management boards in carrying out their mandate?
- How can the functionality of hospital management boards be enhanced in central hospitals of Zimbabwe?

## 1.6 Objectives

- To determine standard functional structures of hospital management boards in central hospitals of Zimbabwe
- To examine the processes for appointing hospital management board members in central hospitals of Zimbabwe
- To establish the challenges faced by hospital management boards in carrying out their mandate
- To recommend strategies for enhancing functionality of hospital management boards in central hospitals of Zimbabwe

The research objectives pertaining to the study, as reflected in Table 1 were derived from the research questions.

Table 1: Correlation between research objectives and questions

Research Questions	Research Objectives	Related Source
What are the standard functional structures of hospital management boards in central hospitals of Zimbabwe?	To determine standard functional structures of hospital management boards in central hospitals of Zimbabwe	Research Questionnaires
How are hospital management boards appointed in central hospitals of Zimbabwe?	To examine the processes for appointing hospital management board members in central hospitals of Zimbabwe	Research Questionnaires
What challenges are faced by hospital management boards in carrying out their mandate?	To establish the challenges faced by hospital management boards in carrying out their mandate	Research Questionnaires
How can the functionality of hospital management boards be enhanced in central hospitals of Zimbabwe?	To recommend strategies for enhancing functionality of hospital management boards in central hospitals of Zimbabwe	Research Questionnaires

Source: Researcher (2018)

## **1.7 Justification and originality of the research**

The decline in good corporate governance in Zimbabwe resulted in business failures and the eventual collapse of a number of corporations with net effect of significant economic and social costs to the country. Poor enforcement of rules and regulations influence corrupt tendencies in the public sector, hence weak governance has negative effects on health service provision (Rispel et al., 2016). Central hospitals in Zimbabwe were not an exception as numerous cases of corrupt practices were reported. The Anti-Corruption Trust of Southern Africa Report (2019) established that there is epidemic conflict of interest and various malpractices bedeviling the health system of Zimbabwe. Furthermore, the Transparency International Corruption Perceptions Index (2016) revealed that in terms of ranking Zimbabwe was positioned at 160<sup>th</sup> out of 180 most corrupt countries. The accessing of Universal Health Coverage can be achieved through concerted efforts by national governments and international partners in fighting corruption. In most African countries bribery was discovered to be strongly associated with increased challenges in accessing medical care (Hsiao et al., 2019).

The study is aimed at reinforcing the need for board members to be effective in protecting the stakeholders' interests through participation or involvement and models or strategies that foster good corporate governance practices.

The study further contributed to strengthening effective use and safeguarding of hospital resources within the context of organizational resources stewardship principle. Hence, hospital management and decision makers will have an insight into good corporate governance practices and an understanding of the strengthening of health policies to achieve the desired goals in health care service provision.

The research brings valuable contribution towards leadership and good governance literature for Zimbabwean public hospitals and beyond. Models developed contribute tremendously to the way public hospitals are managed and controlled. The poor implementation of good health policies will ultimately produce unintended effects or fail due to corruption (Greer et al., 2016).

This inclusion of all board members in the research meaningfully contributes to the body of knowledge due to their involvement in leading the organization. In the healthcare sector, the government authorities and public agents are very instrumental in the planning, implementation, development and dissemination of policies for the best interests of all stakeholders. It can be argued that the authoritarian style of leadership should be controlled in order to soften and abandon the structures that limit health professionals' autonomy. (Eriksson, 2017).

The research further contributes to the body of knowledge in Zimbabwe and abroad through standardizing and strengthening the functionality of hospital management boards in the public sector. These attempts to bridge the gap in policy development through identifying strengths and weaknesses in the current system, then come up with approaches that assist on the achievement of objectives. The leadership in the healthcare sector can pursue the objective by formulating long term policies, providing adequate funding, promoting professionalism and related competency, through experience and vision (Dickson, Tholl and Phsi, 2013).

The results of this particular research assist decision makers in the state enterprises to consider attracting and retaining competent board members, management and employees for the sustainability of public entities. Furthermore, findings may assist political leaders, consultants and auditors during their scope of work. In terms of legislation contribution, the results bridge the knowledge gap through aligning the Health Service Act (Chapter 15:16) in tandem with the good corporate governance practices.

### **1.8 Scope and delimitations of the study**

The study is limited to hospital board practices in Central Hospitals of Zimbabwe. The central hospitals involved include Harare, Chitungwiza and Parirenyatwa Group of Hospitals in the northern region of the country and United Bulawayo Hospitals, Mpilo and Ingutsheni Central Hospitals in the southern region. The researcher specifically considered the effectiveness of hospital board practices with emphasis on mission, strategy, board composition, board structure, board meetings, funding, public image, the degree of operational independence and financial management.

## **1.9 Limitations**

The researcher faced some constraints in terms of financial resources and family commitments. Generally, qualitative research requires more time in data collection, data management, and data analysis phases. Creswell (2014) stressed that, the researcher has to develop themes and categories that take into consideration personal experiences, theories, patterns and generalizations on the topic. Therefore, the researcher was highly committed and had to forego certain commitments to achieve the level of rigor in the qualitative data analysis that was commensurate with the objectives of the study.

The health governance practice is a complex undertaking which involves the board members, top-level management, middle level management and clinical managers. However, this study focused only on hospital board members of central hospitals and their influence on other levels of management. The study could have wholesomely focused on healthcare governance practice and the overall quality of management but this was not possible given the limited time the university allocated to complete the study.

## **1.10 Definitions of key terms**

The study considered certain key terms in this research that have operational definitions and these are briefly discussed below.

### **1.10.1 Standardization**

Standardization is defined as the development and implementation of technical standards that are generally based on agreed terms from different stakeholders that inclusive of firms, users, interest groups, standards organizations and governments (Xie et al., 2016). Standardization is important to maximize compatibility, interoperability, safety, quality, repeatability and equity in the delivery of services.

### **1.10.2 Functionality**

Functionality is the quality of being useful, practical and fit for the purpose for which

something was made (Cambridge Business English Dictionary, 2018). Accordingly, Minichilli et al. (2009) suggest that boards have two main functions which are:

- *Controlling perspective*: The board has a control or oversight role over the organization which considers the desired interest of the owners, stakeholders or principals.
- *Service perspective*: This entails that the board should assist the organizational leadership and staff in various ways, such as resource acquisition, strategy and policy development as well as contact with external stakeholders.

### **1.10.3 Corporate governance**

Corporate governance is the manner in which power is applied over corporate entities. It takes into consideration such activities like the operations of the board, relationship with shareholders or members and the executive management of the enterprise, as well as external auditors, regulators and other legitimate stakeholders (Tricker and Tricker, 2015). Accordingly, Tricker and Tricker (2015) highlight the distinction between corporate governance and management in that the executive management has the mandate for the daily operations of the entity, whilst the governing board guarantees proper running of the entity in the desired way.

## **1.11 Structure of the thesis**

This section provides an outline of the study as detailed below.

The first chapter provides the background, problem statement, research objectives, research questions, study justification and originality, scope and delimitations, limitations, definitions of key terms and the structure of the thesis. The research philosophy, tactics and significance of the study are highlighted.

The second chapter provides hospital governance models and frameworks. The governance models that were considered for the study include, the principal-agent, common pool resources, institutional analysis, agency, stewardship, managerialism, stakeholder and resource dependency. Furthermore, there are several frameworks which fall under three broad

governance frameworks for health systems, namely the new institutional economics, public administration, political science and the multidisciplinary perspectives.

The third chapter provides an overview of the nature of functionality of central hospitals in Zimbabwe. Also presented in the chapter are the background of the establishment of hospital management boards, the structure, financial management aspects, and the resource mobilization, the mandate of hospital management boards in terms of policy formulation, implementation and compliance with statutory requirements

The fourth chapter provides review of the health care governance literature extant in the confines of corporate governance. Specific focus is on the health care governance, good healthcare governance, components of health care governance and its benefits, models of hospital governance practice, healthcare governance structure, healthcare strategic management and its benefits, governing structures, delegation and strategies that strengthen hospital board performance.

The fifth chapter provides a discussion and presentation of the research methodology employed and research protocols implemented in the study. Among the key methodological aspects presented are the research programme, procedural framework and the research framework. The sequential phases of the research methods are also discussed and the use of both qualitative and quantitative methods is clearly discussed. Furthermore, descriptions of data analysis techniques, documenting and reporting protocols are discussed. The research ethics implemented to guide the professional and socio-moral procedures to conduct the study are also discussed.

The sixth chapter provides the analysis of data and presentation of findings.

The seventh chapter provides the discussion and interpretations of research findings.

The eighth chapter provides a summary of findings, conclusions and recommendations. Also presented in the chapter are critical implication of theory, policy and best practice, possible limitations and a summary of the research contributions.

## 1.12 Chapter summary

This chapter provided a detailed overview of the study. It covered the introduction, background of the study, problem statement, purpose and objectives of the study, conceptual framework, scope, delimitation and limitations of the study. The chapter also highlighted the structure of the thesis. To gain insights with regard to standardization and strengthening the functionality of central hospital management boards, relevant literature in healthcare governance practice was reviewed. The research is intended to develop models and make recommendations to strengthen the functionality of hospital management boards. The next chapter is dedicated to the theories and frameworks that are vital in health care governance practice.

## CHAPTER TWO

### THEORETICAL FRAMEWORK

#### 2.1 Introduction

The general assumption is that good governance leads to improved services in society and this is why there is a growing interest in health care governance (van Olmen et al, 2012). Theories present situations or events in an organized way in life. Generally, theories can be defined as a set of definitions, concepts and proportions that make clarifications or predict events by illustrating the relationship between variables (Babbie, 2003). Thus, theories enable prediction, description and explanation of both natural and human behaviour phenomena. Corporations operate based on governance theories, hence impacting on social well-being (Till and Yount, 2019). Often, strategic planners and renowned researchers use theories to identify the most appropriate audience and means of bringing about change and outcomes in a given situation. The derived interventions from a complete planning process guided by relevant theories are considerably effective (Sahay et al., 2006).

The strengthening of health sector governance systems is considered a complex endeavour. The conflicting interests and expectations of patients, staff, citizens, politicians and other stakeholders have to be balanced without losing focus on an ultimate need to improvement in health services access, quality, safety and system performance (Saltman and Duran, 2016). The stakeholder-oriented approach is associated with low levels of power, greater involvement of stakeholders, greater consultation and integration of development on social and sustainability initiatives (Vitolla et al., 2019). Strategic decision makers have to design governance models that are suitable in balancing the competing interests of the various public players including civil society organizations (CSO) and the private sector. In recent years (2010-2019), most governments have changed their focus from direct command and control approach to mere supervisory and regulatory role (Saltman and Duran, 2016). It has been noted that this kind of arrangement tends to limit state interference and it provides public sector institutions the autonomy to manage their affairs. The management structures in the public sector are now market driven in order to maximize service provision efficiency and overall effective institutional performance.

The concept of governance in health systems was first proffered indirectly through the WHO's World Health Report that was issued in 2000. The World Health Report (2000) tendered that governance is the fundamental responsibility of the national governments to direct their health systems in accordance with WHO's standards, guidelines and expectations on health service provision. The WHO's expectations on health governance actually propelled academics to proffer governance models which covered stewardship responsibilities of both national, regional, local government levels and even the private sector organizations. Duran and others (2016) defined health sector governance as a combination of the three levels which are macro, meso and micro. The macro level consist of national level policy making functions while meso is concerned with institutional decision making and micro is governance at operational level such as at clinics and doctors' cubicles or wards.

The models for consideration are based on the meso level mainly because of their focus on steering the totality of institutional activities within a context of complex relationships among multiple stakeholders. Saltman and Duran (2016) stressed that since 1990 the meso level provider governance system in European countries considered three models in an endeavour to encourage high standard, more responsive, accessible and efficient service provision. The models were considered in order to address the rationalities or expectation of competing stakeholders. The most prominent and interested power groups in the health sector include politicians, patients, physicians and employees.

For this study, eight theories relevant to the focus of the study are presented and discussed. They are the agency theory, principal-agent theory, common pool resources theory, institutional analysis theory, stewardship theory, managerialism theory, stakeholder theory and resource dependency theory (Ansell and Torfing, 2016, Mohammed and Muhammed, 2017, Biermann and Harsch, 2017, Keay, 2017, Shepherd, 2018, Burton-Jones et al., 2020). These were selected because, to a great extent, they provide a better explanation on the hospital management boards' effectiveness in central hospitals. The theories are linked to several governance frameworks which fall into three categories, thus the new institutional economics, political science and public administration, international development and multidisciplinary.

## 2.2 The agency theory

The hospital management board is viewed as a monitoring mechanism that ensures employees' accountability for their actions and work performance. The agency theory has got some challenges that are encountered in its application and it's referred to as the agency problem. There are scenarios where the agency problem manifest, for example when the controlling or majority shareholders tend to be part of the executive management, resulting in the awarding of huge perks that compromise the minority shareholders (Lim and Yen, 2017). Agency theory posits that the agents or the executive may act opportunistically, which may undermine principals, that is the ministry. In a bid to counter the opportunistic actions, the political principals use performance management to monitor and control the executive and be accountable (Bjurstrøm, 2020). It is in the interests of management and stakeholders that the agency problem should be resolved through alignment with the ultimate goals of the entity. In fact, this can be minimized through controlling performance appraisal of the board of directors and monitoring of costs. In this current study the board chair and other board members are representatives of the interests of various stakeholders like patients, community care groups and others. The CEO is responsible and accountable to the interests of internal stakeholders who include the hospital administrative management, medical and non-medical staff.

## 2.3 Principal-agent theory

Thus the relationship focused on agency connection between two interested parties that give rise to an agreement where the principal delegate work to the agent who is supposed to conduct duties and responsibilities based on an agreed contract (Eisenhardt, 1989). Fundamentally, the principal-agent theory is premised on the notion that the principal is responsible for hiring the services of the agent who would then undertake the assigned or particular service (Chhotray and Stoker, 2009). The assigned agents should render services to meet the interests of the principal, hence the objectives may be different but the ultimate goal of the organization should be achieved. In practice, agents usually have vast information about how the organization is run as compared to the principals since they are the implementers with a "hands-on" approach, but there should not be conflict of interest in their dealings. Rather, the agent should not take advantage of the vast information gathered or

obtained with the aim of pursuing personal interests to the detriment of the principal. Chhotray and Stoker (2009) proffered that, in hospital governance the agent can be either board members or management, whilst the principal is the government or state, from which the agent is paid for services rendered. The agent should enjoy some independence. However, on another dimension Stoker (1998) postulates that, when there is gross interference in the operations of the agent, various challenges may be encountered for instance on the appointment of proxies and information systems. Fundamentally, health systems that make use of the principal-agent theory rely on the assumption that there is close interaction between the principal and the agent's diverse interests.

It should be pointed out that the principal-agent theory is anchored on two assumptions which are the performance based incentives and sanctions to the health workers. These are implemented and enforced in order to ensure accountability, management and control of information flow and power differences or dynamics among the diverse stakeholders (Stoker, 1998). Essentially, it can be noted that the governance of health care system is very key in ensuring that high quality health service is delivered. This point resonates with Abor (2016) who asserts that hospitals which have hospital boards offer better quality of health care than those without. Hence, the duty of management boards is primarily to ensure that hospitals perform to the expectations of its various stakeholders, that is, to be responsive to the health needs and challenges for the common societal good. In an endeavour to achieve and access high quality service, qualified and competent board members should be appointed and that should not be underrated (Millar et al, 2015).

#### **2.4 Common pool resources theory**

The theory of common pool resources was developed by Ostrom (2010) and it refers to the creation of institutional arrangement with a goal to manage the open resources as predetermined. Ostrom (2015) suggested that the self-governing systems results in individuals or groups to cope better with challenges since they are used to repetitive problem-solving as a strategy. Stoker (1998) argued that the common pool resources theory opined that governance is an autonomous system with self-governing systems or networks of performers. In fact, the common pool resource theory assumes that individuals can maximize own profits when resources are utilized mutually by many actors. Furthermore, some

problems which individuals cannot solve alone can be solved collectively (Osmundsen et al., 2021).

In this regard, it can be noted that common pool resource theory is a self-organized network with an underlining assumption that it is more effective than to the regulations enacted by the government. This is because of the notion that a self-organized institutional management is bound to facilitate availability of information and reduced transaction costs often associated with the enactment of such regulations (Stoker, 1998). Furthermore, in situations where governments are not well managed or under-governed, then social norms are bound to become a natural remedy to the anomaly of effective management (Olivier de Sardan, 2015). Dixit (2009) further opines that when governments are poorly managed, then the civil society and non-government organizations would fill in the governance gap to ensure continuous delivery of public services. The common pool resources is concerned with organizations adopting strategies that ensure collective resource utilization of the scarce resources to the best interest of service users or the general public (Sanderson et al., 2020). Since the common pool resource theory means that the resources are owned by everyone in the community and not by an individual entity, the major drawback is that this can lead to potential of overuse and degradation of assets (Hardin, 1968). In an attempt to avoid the tragedy of communal ownership of resources, people can come up with coalitions to manage resources and minimize overuse and degradation. It should be pointed out though that in the common pool resources theoretical discourse, institutional operations can still be managed through regulation by the government or privatization.

According to Ostrom (1990), the common pool resources theory is composed of three levels, which are the operational level, collective level and constitutional level. In support of the three levels under the common pool resources Abimbola's framework (2014) suggested that, the three levels of health care system structure can be described as operational being referring to the citizenry and healthcare workers, collective being community groups and constitutional governance level as governments as well as the various regulatory authorities.

## **2.5 Institutional analysis theory**

The institutional approach is a governance system which focuses on rules which are both

formal and informal, hence more emphasis is on informal rules such as norms and values that affect public governance practices in many low-income countries (Carmago and Jacobs, 2011). The Douglas North's Theory (1990) of institutional analysis refers to the phenomenon where the creation and maintenance of markets is done by respective institutions. North (1990) further suggests that institutions consist of formal rules and informal constraints whilst organizations consist of groups of individuals who have common objectives. The institutional analysis theory provides advanced and critical views that might have an influence on progressive policy making (Lounsbury and Wang, 2020). In relation to the current study the institutional approach is focused on exploring the informal and formal rules governing the demand and supply of services, taking into consideration the effect on functions, individuals, government and other stakeholders, monitoring and enforcement of rules. Furthermore, the authorities can also be affected and influenced by the set rules (Baez-Carmago and Jacobs, 2011).

## **2.6 The stewardship theory**

Stewardship is described by the WHO's World Health Report (2000) as the effective trusteeship of national health system. The stewardship theory propounds that staff motivation, safeguarding of organizational resources and achievement of broad and specific organizational objectives are instrumental for the success of the entity. Furthermore, the theory advocates for management in taking a proactive function in the control and evaluation of strategic policies and actions (Liff and Andersson, 2021). Stewardship offers reinvigorating sense of ownership and purpose among public sector managers. In addition, the theory promotes restoration of the notion of trusteeship and legitimacy to the functions of the state (Saltman and Ferroussier-Davis, 2000). It is also noted that the theory suggests involvement of executive management in the board as a way of strengthening the board effectiveness since management is considered as institutional stewards, who are in a better position to grasp and appreciate the hospital's operations due their high acumen. The aim of the theory is to accomplish collective goals by the executive management, hence not solely focus on individual interests (Schillemans and Bjurström, 2019).

In certain scenarios, it is noted that the CEO could actually have extended powers especially if he or she is also the chair of the board. Significant decisions are made by the CEO, for

instance project approval, partnerships, acquisitions and even modifications on the organizational structure. The theory recognizes individual effort through proposition of a fair return or remuneration (Martin and Butler, 2017). This theory is quite relevant because proper remuneration of employees, effective and efficient use of human, material and financial resources is pivotal to health care service provision in a country. If a board and management are not stewards, they would tend to abuse resources through corruption or other actions. For this reason, I really think that the theory is quite relevant for this study.

## **2.7 The managerialism theory**

The top management is very instrumental in the day-to-day activities of any entity. Managerialism can be perceived when top management encourage public servants to act without regard for consequences, thus giving managerial discretion (Karlsson, 2019). For instance, it is a crucial institutional structure to provide information and guidance to the board on the on-going operations of the entity. This is emphasized in Molinari and others (1995) stressed that in an organization, executive management renders professional advice to the board members. The theory supports the inclusion of senior management in the hospital management boards. Managerialism recognize management's special contribution, rights and powers hence managers have the responsibility to promote managerialism regularly (Klikauer, 2015). However, the possibility of collusion between board members and management is quite possible and can be mitigated through application of the agency theory that is aimed at protecting the stakeholders' interests. Generally, it might be argued that hospitals with insider or medical staff participating on the boards are expected to be perform better than those with more external or non-medical staff because they are current with the various operations of the health facility. Thus this study explored the merits and demerits of involvement of management or medical staff in the boards of central hospitals in Zimbabwe.

## **2.8 The stakeholder theory**

This theory proposes the involvement or participation of different stakeholders in the affairs of an organization. The stakeholder theory is used to guide both public policy and business decision making. However, there are circumstances when management might be willing to fulfil the expectations of the broader group of stakeholders, but may be constrained from achieving that due to the demands of powerful stakeholders (Barney and Harrison, 2020).

For the health sector, it would mean that the hospital management board should consider integration, balancing and addressing different stakeholder interests in tandem with the goals and expectations of the organization (Eeckloo et al., 2004 : Christopher, 2010). The theory is also referred to as the “Pluralist Approach” in institutional management or governance practice. The stakeholder theory resonates well with the evolution of corporate governance in the sense that the concept does not consider only shareholders but rather the involvement of all stakeholders of the organization to ensure representation and consensus in decision or policymaking. The health systems governance is fostering the engagement of patient and family advisory councils to improve care delivery. Furthermore, the involvement of patient representatives is considered a noble gesture to boost service delivery (DeCamp et al., 2019). There ought to be mutual understanding between the entity and the citizenry, thus creation of value and trade with one another. Management is obliged to foster strategies that precipitate stakeholder prospects (Freeman et al., 2018). It provides a basis for management to intentionally seek to understand the needs of various stakeholders and integrate them for appropriate responsive action in line with the organizational objectives. It is noted that in a stakeholder theory guided institutional governance, board members’ backgrounds and the communities or populations they represent would likely entice them to support strategic activities that are compatible with the diverse stakeholder expectations. For this study, the stakeholder theory is quite relevant since hospital board members are viewed as community advocates for the various stakeholders.

## **2.9 The resource dependence theory**

The involvement of board members with various set of relevant skills, knowledge, expertise and social capital are considered as important ingredients under the resource dependency theory which are all vital for the enhancement of organization’s capacity to achieve the desired goals and objectives. Strategies should be devised in a bid to harness and manage resources from the external environment (Sherer et al., 2019). The assumption embedded in the theory is that the diversity in board members’ backgrounds bring to the entity positive networking and even a diverse of resources from themselves and other stakeholders. This can be in the form of expertise, financial or material resources and other necessities. Generally, the organization is deemed to be a fountain of various capabilities, in both human capital and material (Hillman and Dalziel, 2003) . Furthermore, proponents of the resource dependence

theory supports the view that external board members strengthen the capacity of the entity to shield it against various risks or possible threats that are exerted from the external environment (Pfeffer, 1972): (Pfeffer and Salancik, 1978): (Middleton, 1987). Health is part of social development; hence resources should be channelled towards provision of quality and affordable health services for all citizens for the societal common good of physical wellbeing.

The increased diversity and strong strong leadership is a noticeable issue in health care governance. There are many gaps in understanding the concepts of health systems and process of conducting the assessment, since the health system governance is relatively a new concept (Pyone et al., 2017).

The health governance models were classified based on four different theoretical perspectives, thus the new institutional economics perspective, political science and public management perspective, development literature perspective and others through use of multi-disciplinary approaches (Pyone et al., 2017).

## **2.10 The new institutional economics perspective**

Five frameworks in healthcare governance were established basing on the new institutional perspective theories (Chhotray and Stoker, 2009 :(Klepczarek, 2017). The frameworks which fall under this category are the multi-level framework, social responsibility, principal-agent model of governance framework, accountability mechanisms framework in health care and the governance analysis framework in health sector operations.

## **2.11 Multi-level framework**

The framework combines three levels of the health governance, thus the operational, collective and constitutional (Abimbola et al., 2014). The operational level is a stratum which is concerned with the citizenry and the various healthcare providers. The collective stratum involves the various community groups or stakeholders. The third level is the constitutional stratum which is focused on the governments or states at different levels. This level is believed to protect the national interests. The government in any hospital system is an important player in that it is the regulatory body or overall monitoring arm in health service

provision. The multi-level framework is inclined to the concept of ‘governing without a government’.

Under the multi-level framework arrangement of health governance, the resources are managed through consideration of the interests of various stakeholders. The community or stakeholders are consulted on the development of rules and guidelines on how the pooled resources are managed. This is often done without the involvement of the government or arms of the state.

The multi-level framework is focused on managing the pooled resources. The health system actors or stakeholders include the government, various interested establishments, groups and persons at diverse levels of authority have the mandate to conduct different functions in the affairs of the health facility. For example, generation of resources, service delivery, monitoring or oversight responsibility and to influence decision making. In order for health systems to be considered people-centered, the roles and responsibilities of various stakeholders that include service users, health workers, health management and the community should be recognized and genuinely involved in the several health system operational levels (Abimbola et al., 2014). This implies that roles and relations of all actors should be incorporated for to attain and sustain a people-centered health system in a country. The three levels of multi-level framework have been classified as operational governance and collective governance which are elaborated below.

#### *a) Operational governance*

The operational governance refers to individual local health system players spearheading service provision in their community or locality. Informed decisions by individual health system actors should be based on the market forces of services. Fundamentally, operational governance in the health sector involves individuals and health providers in the local community who make and implement practical decisions at operational level. The key tenet of operational governance meets the individual choices and market forces of supply and demand. Practical decisions may also be based on community governance and constitutional governance spearheaded by the government (McGinnis, 2011).

### ***b) Collective governance***

Collective governance pertains to the collective actions through which community groups or representatives enter into partnerships to provide a service like health care services as is the case in this study. The interested groups may be the users, appointees from community leaders or the government. The community groups internally come together on their own to support health care operations through various interventions such as setting, changing, influencing, monitoring and enforcing the rules that should guide the supply and demand decisions of individual health system players in the community. The decisions and activities of the community groups should be regulated through constitutional government processes. The relevant branches or departments of government act as the regulatory authority to allow or authorize the activities (McGinnis, 2011).

### ***c) Constitutional governance***

This is concerned with the involvement of governments and its branches or statutory bodies to regulate functions of an entity through setting, dictating or influencing the rules to govern collective and operational actions or decisions. The entities or institutions, both at operational and collective governance levels, are defined and legitimized through the constitutional provisions. Thus, the constitutional governance level is there to enforce rules contained in the constitution or policy documents. In this regard, health system players are externally involved in the making, changing, influencing and monitoring of service providers (McGinnis, 2011).

As can be seen, the health system governance involves many players or actors which normally make it difficult to manage the interests and relations among the various actors. In other words, the decentralization of health systems has brought some challenges due to multiple actors with different political, socioeconomic, cultural contexts and viewpoints (Barbazza and Tello, 2014).

#### **2.11.1 Limitations of the multi-level framework**

- Some non-governmental players usually mobilize external support in the form of finances, equipment, medicines, human and other essential requirements in order to

fulfil the unsatisfied demands of the various stakeholders they serve (Golooba-Mutebi, 2005).

- The need for external support to acquire information to meet the unsatisfied demand and in facilitating the responses to the unsatisfied demand for healthcare provision (Bjorkman and Svensson, 2009). Health care providers should possess power and advantage in health care transactions, hence the importance of quality information.
- Challenges might be encountered in the case of individual or collective decisions and actions by non-governmental players which are skewed in favour of the elite or high income earners or exclude the minority or vulnerable groups (McCoy et al., 2012).

## **2.12 Social accountability framework**

The framework was developed by Baez-Camargo and Jacobs in 2013. Social accountability employs strategies that are aimed at improving institutional performance through citizen engagement and public responsiveness (Fox, 2015). In practice, the social accountability initiatives are useful in a number of ways which include: (a) revealing development outcomes in local government; (b) exposing government shortfalls or failures; (c) detect corruption or administration malpractices in the public sector; (d) empowering the underprivileged groups; and (d) ensuring that national and local government structures are responsible and responsive to the poor (Camargo and Jacobs, 2013). Furthermore, in order to strengthen governance interventions in health a system, accountability is very key (Baez-Camargo in 2011). Baez-Camargo (2011) opined that if accountability is strengthened and improved, then the corrupt tendencies would be minimized and such outcomes like equity and efficient utilization of resources will respond positively. This framework is largely influenced by the principal-agent theory which is evident in its utilization of direct and indirect links or routes. The citizenry echo their concerns or preferences, hence the direct accountability notion. The indirect accountability dimension utilizes the existing institutional capacity and the functional public health systems.

Social accountability ensures that government officials or service providers are answerable to the citizens and civil society organizations through formal or informal mechanisms. Hence, in practice the principal-agent relationship encompass the concept of accountability (Baez Camargo and Jacobs, 2013). The social accountability is distinguished from other

conventional mechanisms of accountability through engagement or direct participation of citizens (Malena, Forster and Singh, 2004). In terms of public administration, the social accountability activities are associated with the provision of public goods or services through decentralization to local or community levels. In public governance, the principal, which is the government or state, is mandated with the provision of public goods and services. Examples of services offered under the public administration arrangement are health, education, policing, national security, registration of births and deaths and many other such services.

As for public accountability, five components characterize it which are mandate, resources, performance, information on performance and the enforceability (World Bank Report, 2004). The matrix of accountability is that there should be a clear mandate of what the agent is expected to do. In addition, the agent should not be hindered in accessing the resources necessary to implement the assigned tasks or mandate. After performance of the mandate, the principal should monitor the performance of the agent and provide the necessary feedback.

The World Bank's 2004 model posits that citizens should hold governments answerable through mechanisms of political representation and in return the government ensures that service providers are accountable for delivering public goods or services to the population. The World Bank's 2004 model suggested that the provision of public services to the population ought to be conducted in an accountable manner facilitated through the relevant state legislation and policies. From this analysis, it can be seen that the link between citizens and providers of goods and services is indirect and requires monitoring and control mechanisms. However, when there are resource constraints or bottlenecks in the service value chain, the short route is desirable. This direct link can be achieved through gathering information about performance of certain activities through direct community involvement. The communities are directly involved in monitoring of service providers, hence, the bureaucratic system is avoided or eliminated altogether.

An example of social accountability which involves various stakeholders is participatory budgeting. This kind of accountability can improve local governance performance through making resource allocations that are in line with the needs and expectations of the citizenry. In terms of participatory budgeting, citizens deliberate among themselves and then with government officials in order to reach a consensus and then efficiently allocate funds. The

concept of participatory budgeting is increasingly being used in many countries including worldwide. This came as a recommendation for good governance practice by the World Bank and the United Nations in an effort to improve health efficiency (Campbell et al., 2018). In the case of Albania, participatory budgeting is highly and successfully used amongst the civil society organizations, coincidentally, it is the country that has the highest level of corruption in Europe which shows that good governance practice is a complex phenomenon (Eliasson, 2016). The community scorecards, reports that emanate from citizens, stakeholder involvement in the budgeting process and participatory public expenditure tracking are some of the monitoring mechanisms that can assist to achieve public accountability. There is great need for participatory evaluation of local service provision, transparent and participatory procurement processes and monitoring of local government contracts (World Bank Report, 2004).

It has been noted that social accountability is achieved through three core elements, namely the voice, enforceability and answerability. In order for social accountability to be effective, it should be based on the assumption that voice is unproductive lest it can elicit answerability and enforceability (Goetz and Jenkins, 2005, United Nations Development Programme Report, 2010). The matrix to achieve social accountability encompasses an informed citizenry that exercises voice which is transmitted to those with enforcement capabilities and authority.

### **2.12.1 Voice**

The concept of voice in social accountability can be referred to as the capacity of a person to express his or her rightful opinions (Jackson et al., 2018). According to the UNDP Report (2010), citizens express their tastes, preferences, opinions, views and demands accountability from decision makers or power holders. This is enabled through various of modalities which can either be formal or informal. Participatory, aggregation and articulation as well as transmission mechanisms can be used to distinguish the concept of voice from mere collection of complaints or comments.

#### **2.12.1.1 Participatory**

In participatory governance, the government ensures more accountability to the needs of the

governed (Sou, 2019). To ensure maximum citizen participation in aspects of public sector performance, the citizens have to be very clear on the mandate to be achieved. Hence, for monitoring and evaluation to be effective, citizens should be conscientised on their rights, entitlements and the mandate that the public officers should fulfil or deliver. Capacity building should also be made on the goals to be achieved as a prerequisite for the voice to be effective (UNDP Report, 2010).

#### **2.12.1.2      *Aggregation and articulation***

Due to conflicting interests and ideal views, information aggregation and articulation is collectively valuable in the decision-making process. This approach helps to defuse conflicts among the various stakeholders (Squintani, 2019). Therefore, it is key that the information process need to be aggregated and articulated should entail the citizen's assessments, opinions and complaints as well as to give highlights on the shortcomings, unfulfilled targets and grievances into actionable demands (UNDP Report, 2010).

#### **2.12.1.3      *Transmission***

The use of modern technology can facilitate effective interaction and transmission of vital information anywhere and anytime. In the health sector, the technology driven services provide patients or clients, health workers and health care organizations to immediately access health information which is often critical for decision-making and better treatment and care (Negash et al., 2018). There is great need for effective communication and this is why the aggregated and articulated information should be channelled in such a way that it would reach the intended recipients within the time required. The relevant recipients can be the actors or decision makers who can then work on the available information to formulate well-informed decisions. In the case of health care governance, the recipients can be the legislature, civil society organizations, government officials, politicians and health care management (UNDP Report, 2010).

### **2.12.2      *Enforceability***

Enforceability can be defined as some form of sanction or reward (positive or negative) that

is based on certain action (Schedler et al., 1999). The limited financial resources have a negative impact on the health team's monitoring, supervising and planning of planned activities. Due to lack of electoral process for key positions and authoritarian leadership in some countries, there is often limitation in citizens' participation and voice in decision-making (Jacobs and Camargo, 2020). When the desired results or mandate is not appropriately achieved, then consequences are expected to exist and be executed. This enforceability can be achieved through incentives which can be positive or rewards for good performance. This can be in the form of commensurate remuneration or scope in career progression opportunities. On the other hand, enforceability can be done through disciplinary procedures to force compliance on achieving the unsatisfactory performance (UNDP Report, 2010).

### **2.12.3 Answerability**

Answerability can be defined as the obligation to inform and explain, or simply the justification of one's action (Schedler et al., 1999). According to the UNDP Report (2010) answerability is the commitment to provide an account of what transpired and the right to obtain a feedback. In social accountability, answerability can be a two-way process, thus feedback can be bottom up or top down. For any mandate undertaken the service providers require feedback and at the same time citizens should be appraised on actions to be taken or achieved considering the information they might have provided.

### **2.12.4 Challenges of the social accountability framework**

The social accountability framework is quite popular among non-governmental organizations or donor agencies and policy makers. However, there are some practical challenges on the applicability of the model, which include lack of skills and competence, political interference, corruption, poverty and unemployment (Shava and Mubangizi, 2019). The World Bank Report (2011) argued that the demand for social accountability is based on a favourable political-socio environment, enabling legal frameworks, state support, institutional capacity and the strength of civil society. There is a mixture of both successes and failures of social accountability on its application (Gaventa and Barrett, 2010; McGee and Gaventa, 2010).

The social accountability framework cannot be applied effectively where there is inadequacy of formal structures of governance. Actually, the low levels of security and direct violence discourages the mobilization of citizens to participate in social accountability (Schouten, 2011). The disorderly conduct and precarious statehood might have a negative impact on the application of the social accountability model. Social accountability can be affected by high factionalism or conflict of interests among certain individuals. The powerful minority or the elite might capture certain projects for their benefit hence threatening the participatory dimension of social accountability. The success of social accountability can be limited due to administrative incapacitation, community mistrust and the effects of poverty.

In the majority of developing countries, the general service delivery culminates due to efforts by the central government through state enterprises or parastatals, charitable or other NGOs, the private entities and citizens (Josh and Moore, 2004). In a situation when there is a country experiences co-production of goods and services, the social accountability framework's application would definitely suffer due to competing interests by multiple stakeholders. The unorthodox arrangement of co-production will make it difficult to meet the interests of the various stakeholders who include regulators, producers, users, professionals, clients and recipients. Hence, the co-production arrangement poses a challenge in the enforcement of a straightforward type of social accountability (Joshi and Moore, 2004).

### **2.13 Principal-agent model of governance framework**

Brinkerhoff and Bossert (2013), posits that the governance framework rely on the interactions among the principals and agents considering their diversified interest. The framework depicts three diversified principal-agent interactions which are the government and healthcare workers, healthcare workers and citizens and the government and citizens. Therefore, agents in hospital governance can be considered to be either board members or the hospital management who offer services to the interest of the principals in return for some form of incentives or remuneration. Board members and management usually have vital information since they are at governance and operational level respectively as compared to the principal, which in this case is the government. Hence, principals rely more on the agents to make informed decisions.

In the WHO's Report of 2000 as cited in Roberts et al, (2004), there are three accepted health systems goals which are: (i) the improved health status through equitable offering of quality health services; (ii) preventive; and (iii) promotional programmes. The second goal is the rate of response to legitimate patient or client and the public expectations. The third goal is the fair financing mechanism which in the long run protects against financial risks for those who need health care. Frenk (1994) also specified three categories of actors who are key in health system governance. The first category is the state actors, who include the politicians, policymakers and government officials. These actors spearhead the provision of health care services at national level and they include the ministry of health, insurance agencies, pharmaceutical procurement and distribution entities. The parliamentary portfolio committee of health, regulatory bodies and various entities are some arms of the state which play an oversight and accountability roles in smooth operation of healthcare system.

The second category of health actors is that of health service providers. This category is a composition of private, public and voluntary providers. The mix of actors can include clinics, hospitals, laboratories, teaching or educational institutions and counselling facilities which represent all the three sectors of service providers (Bennett et al., 2005, Lagomarsino et al., 2009). Furthermore, Bennet et al., (2005) and Lagomarsino et al., (2009) stressed that there is a third category of actors composed of clients. These include the citizens who access the service, the general public and CSOs. These actors may be categorized further into various strata in view of level of income, location, type of service, type of disease or condition, sex, age, just to make a few.

In most countries with democratic governments, the clients are considered to be the principals whilst state regulators are the agents. In autonomous systems of governance, health service provision is deemed to be of interest to politicians and public officials alike since it affects almost every geo-political constituency in a country. It is in the best interest of clients to exercise their right through the expression of their expectations to politicians, policymakers and public officials. In return the policymakers and public officials are held accountable to meet the demands of citizens (Brinkerhoff and Bossert, 2013). In the management of central hospitals, the hospital management boards are considered as agents to the clients since they are supposed to offer services to the expectations of the clients or citizens. Brinkerhoff and Bossert (2013) echoed that, in authoritarian governments politicians and health workers may

view themselves as principals rather than agents.

### **2.13.1 Challenges with the implementation of the principal-agent model of governance framework**

According to Berry and Igboemeka (2004), in many countries there is incompatibility on the available versus the desired capacities on the implementation of good governance. In order for health care systems authorities to plan, design and implement health policies, they require adequate government support in doing so. The Brazilian case is a good example where decentralization brought efficiency and effectiveness in service delivery (Bossert, 2008). On another dimension, operational capacity is required in public sector institutions to efficiently provide public goods and services in response to the expectations of citizens (Grindle, 1997). Governance, to a great extent, is concerned with power, hence, the neglect of power and the political economy negatively affects governance processes (Gonzalez-Rossetti, 2000, Fox and Reich, 2011). In most scenarios, the state and the health service providers are more powerful than the clients or citizens. In the case of China, state actors and providers wield more power than client or citizens. Furthermore, a power distribution has an influence on the governance of public institutions. In a political system with more democratic governance, the clients and citizens are more powerful as compared to an authoritarian system. In an authoritarian system, there is too much restriction where advocacy is very much controlled in terms of health policy and management (Gomez, 2006).

### **2.14 Framework of accountability mechanisms in health care**

The model was designed to assess accountability mechanisms in healthcare systems between the principal and the agent. Three critical factors are considered under the accountability framework mechanisms, thus the resources in use, attitudes and values (Cleary et al., 2013). Hence, the framework applies the principal agent theory.

The accountability mechanisms were crafted with the intention to achieve health care system goals like the promotion of accessibility to high quality care. However, the various accountability modalities might be applied differently and accorded higher priority comparable to others (Hupe and Hill, 2007). The accountability mechanisms can be designed to cater for both internal and external needs. External or community accountability can be

utilized through non-governmental players in a bid to enforce public sector answerability for their actions. Organizational accountability encompass institutional supervision, authorizations and balances that are compatible to the public sector (Brinkerhoff, 2004b). The human resource management and supervision processes falls under the bureaucratic accountability mechanisms (Brinkerhoff and Bossert, 2008). However, in the recent years external accountability has been gaining more attention while the internal accountability mechanisms have been unfortunately neglected (Molyneux et al., 2012).

The study was conducted covering 10 African countries, 3 Asian countries and 4 South American countries to review the internal and external accountability mechanisms. The bureaucratic accountability mechanisms focused on the human resources management processes which include, among others, supervision, disciplinary action and monitoring of activities. The budgeting, planning and target setting was also part of the internal accountability processes. In the Kenyan case study, although there is clarity of roles in hospital board committees, low education level is a major barrier. The results revealed that some older board committee members faced challenges in engaging with the committees as evidenced through failure to grasp financial management issues (Goodman et al., 2011).

On the external mechanisms, various activities constituted the accountability aspects. These include patient right charters, complaints mechanisms, the provider report cards and the involvement of the community and clinic committee in the overall monitoring of health workers and the planning of health service delivery. The results from the study conducted in Tanzania revealed that quite a number of citizens could not participate in the community accountability mechanism mainly because the concept was new and generally members of the public were not aware of their rights. As a result, it was found that they were unwilling to reveal their views about health service priorities (Maluka et al., 2011).

In this regard, it has been noted that the low and middle income countries have developed an increased interest in adopting the robust answerability mechanisms aimed at reinforcing performance of health care systems. In practice accountability mechanisms should be used taking into account different contexts with a focus to address the overall health system, resource, attitudes and perceptions of health workers.

## 2.15 Governance analysis in health sector operations

The governance analysis in health sector operations was developed through the input from the European Commission (EC). The European Commission Report (2009) proffered a model which focused on answerability involving various stakeholders. The EC (2009) framework is aimed at assessing governance practices under the developmental and donor assistance. The EC considers principles of participation, inclusion, transparency and accountability. Other core governance issues that are included in the EC framework are the stakeholder power, interactions and their functions.

The interest groups are now considered on implementation of policies, hence need for important partners in public authorities. Generally, there is now a shift from interest groups being the main actor, but rather focus is on the EC being the moderator and focal point for interactions with third parties (Tanasescu, 2009). The EC has addressed the democratic deficit through the involvement of stakeholders in a clear and structured way in policy making process.

The EC has considered some yardstick principles to be critical in governance and these are openness for stakeholder and participation of interests, transparency and publicity, argumentative communication and the binding nature of decisions.

### *a) Openness for stakeholder and equal participation of interests*

All stakeholders who have an interest or stake in a particular issue should be represented both for normative and functional reasons. The interested stakeholders are mandated to ensure involvement in the decision making process, thus strengthening the buy-in concept.

### *b) Transparency and publicity*

The commission recognizes the transparency and publicity concerns, so that the individuals who are not part of the process can have an appreciation of the deliberations and take positions on the debates. The EC ensures balanced participation of all the affected stakeholders.

*c) Argumentative communication*

The EC ensures that there is reason-based communication and participants are transparent. Argumentative mode of communication is encouraged through communicative interactions among stakeholders.

*d) Binding nature of decisions*

In an endeavour to ensure stakeholder buy-in, the EC ensure that interactions are not just mere talks but rather, the decisions made are binding to all participants and all the bodies of the Commission who include the Council of Ministers and the European Parliament. This process allows the commission to engage into meaningful consultative process with all interested stakeholders.

## **2.16 The political science and public administration perspective**

Three frameworks are considered under the political science and public administration perspective, thus the health worker accountability framework (Berlan and Shiffman, 2012), accountability assessment framework (Brinkerhoff, 2004) and the patron-client relationship assessment framework (Brinkerhoff and Goldsmith, 2004).

### **2.16.1 Health worker accountability framework**

Research has shown that clients are not being treated with respect rather they are treated poorly by healthcare workers in low income countries (Berlan and Shiffman, 2012). Consumer preferences, access to care with detailed information and treating consumers with respect should be the responsibility of health care providers. When there is lack of provider accountability, consumers usually face adverse effects of health care service provision. The health system and social factors influence effectiveness of the health provider accountability. The health system factors which shape provider accountability include oversight mechanisms, sources of funding and competition in the health sector. The consumer power and provider beliefs or norms constitute the social factors surrounding provider accountability.

Haddad et al, (1998) and supported by Blendon et al (2001) postulated that in the low income countries, preferences for health care providers and consumers frequently diverge.

In essence, health workers or providers offer services to meet the demands of the powerful actors such as the government officials, donor agencies and funders, whilst not satisfactorily meeting the needs of individuals or consumers who seek the services. In practice, the health workers who are answerable to the clients, usually treat them with respect, provide necessary information and facilitate access to care required.

### **2.16.1.1 Health system structure**

This refers to the way health service provision is organized, financed and governed (Berlan and Shiffman, 2012). The features which are considered under the health system structure include the oversight functions, the health financing system and competition.

#### **2.16.1.1.1 Oversight mechanisms or functions**

The overall responsibility of government officials and donors or partners to supervise the health system determines the level of accountability of providers to consumers. The actors have the responsibility to formulate responsive policies, supervision guidelines and the evaluation criteria in health systems. In light of this, the provider accountability to other actors might limit or hinder their responsiveness to consumer preferences and needs.

To overcome challenges associated with the reporting or accountability structure, certain reforms can be implemented. Decentralization and community participation can be implemented in order to shift oversight functions from central to lower levels, thus, encouraging consumer responsiveness and community interactions. For instance, in the case of Brazil, the decentralization model managed to partially move the health care funding control towards municipalities. Furthermore, in the Philippines, the establishment of community health boards enhanced the empowerment and satisfaction of consumers resulting in health services functioning effectively (Collins et al, 2000). In the case of Peru, the government embarked on the health care reform initiative, through the establishment of grassroots committees with the mandate to decentralize the accountability of health systems (Iwami and Petchey, 2002).

#### 2.16.1.1.2 Sources of funding

The sources of health care financing might have an influence on providers who might shift their focus to the funder rather than the patient or client needs and preferences. Usually, the funders of the health care are the government, donors, partners, insurers and others who might have divergent goals to those of the consumers. Both the government and private sector are obliged to honour their commitments, hence accomplishing the desired access to health (Gbadeyan et al., 2016). Sometimes, such a financing mechanism results in the abandonment of consumer expectations. In the case of Papua New Guinea's Western Highlands Province, the decentralization model resulted in lowering of competencies at district level, reduced funding and support for oversight, also in problems with co-ordination and favouritism in hiring decision (Campos-Outcalt et al., 1995). Furthermore, in the case of the then Zaire, the introduction of user fees over a period of 5 years resulted in the quality of service improving but the utilization of service decreased by 40%, with 18-32% of the decrease caused by the rise in health service costs (Basset et al., 1997). However, during the period 1995 to 2014, several countries are significantly relying on government spending instead of over-reliance on the out-of-pocket and development financing (Dieleman et al., 2017).

#### 2.16.1.1.3 Nature of competition

It is quite debatable that private sector has the capacity to provide health care services in a country (Hanson et al., 2008). However, proponents of private sector role in health care provision (Birugi, 1998, Akin and Hutchinso, 1999, Kruk et al., 2009) argued that the practice of competition between the public and private sector provides citizens with a wider spectrum of choice. In addition, the idea of private sector players in health service delivery actually enables competition between the public and private sector, an aspect that can lower cost and increase quality.

In a study that was undertaken in South Africa it was revealed that private clinics outperformed public clinics on the 12 of the 16 performance indicators on outpatients (Peltzer, 2009). Most studies revealed that provider accountability to consumers is quite positive especially on services provided by NGO health care facilities. In the studies

conducted to compare NGO to public sector provision of primary care, Bangladesh, Bolivia, Cambodia, Guatemala, Haiti, India, Madagascar, Pakistan and Senegal, revealed that NGOs performed far much better both in terms of quality and expansion of coverage.

#### *2.16.1.1.3.1 Social factors*

Health systems structures are not the only factor that can influence provider behaviour, but social factors might also influence accountability though they are deemed to be indirectly linked to health system.

#### *2.16.1.1.3.2 Consumer power*

The inadequacy of power and information amongst consumers in most instances is influencing provider behaviour. Several studies revealed that provider accountability was strengthened or enhanced due to consumers' access to information. Pandey et al. (2007) undertook a study and the results unearthed that community meetings, dissemination of posters and handouts empowered citizens to know their rights to access health services and to convey their grievances. Additionally, the study results showed that those communities that received information had their health seeking behaviour improved as compared to controlled communities as nurses reported a surge in patients treated per visit in the communities. Similarly, a study that was conducted with a focus on community involvement in malaria prevention in Kenya indicates that enhanced accessibility to information enabled communities to embrace preventive behaviour (Opiy et al., 2007).

#### *2.16.1.1.3.3 Provider norms*

Extant literature reveals that many providers of goods and services belittle the poor. In the case of Uganda and the then Zaire, providers disobeyed the policy to reduce or set aside hospital fees for underprivileged clients despite government stipulated policies (McPake et al., 1999, Haddad and Fournier, 1995). Buzuzi and others (2016) conducted a study in Zimbabwe focusing on the effect of user charges on health seeking behaviour and financial protection during financial crisis. The results from the study revealed that,

patients without health insurance endured the payment of costs on consultation services, medicines and transport. The health seeking behaviour was adversely affected, resulting in delayed treatment and poor patients opting for a reduction in treatment medicine doses (Buzuzi et al., 2016). Furthermore, several studies demonstrate that some providers are gender biased in favour of males. Studies conducted in Ghana and South Africa revealed that the low income earning patients were being abused by female nurses (Jewkes et al., 1998, Abrahams et al., 2001, D'Ambruoso et al., 2005).

### **Interventions to solve health provider accountability challenges**

- i. Community involvement in the decentralization process of health care provision proved to be quite positive when it is facilitated through government structures. The results from community involvement in decentralization yielded positive reaction of provider behaviour in in low-income countries like Peru, Ghana and Philippines (Ramiro et al., 2001, Iwami and Petchey, 2002, Nyonator et al., 2005).
- ii. The NGOs or partners facilitation of community collective action contributed to good health seeking behaviour by local citizens and subsequently positive response by the health providers. NGOs and partners projects on community collective action were initiated in Bangladesh, Papua New Guinea, Thailand and Nepal, which indicated positive results on behaviour change (Desmet at al., 1999, Manandhar et al., 2004, Fitzpatrick and Ako, 2007, Geounupakul et al., 2007).
- iii. The results from the studies conducted in India and Kenya and other countries revealed that the behaviour of service providers can be influenced by consumers who are well informed (Sangl and Wolf, 1996, Bhandari et al., 2003, Mozunder and Marathe, 2007, Opiyo et al., 2007, Pandey et al., 2007).
- iv. The designing of memorandum of agreement or contracts with NGOs for the provision of health service might influence health care provision and this was revealed in studies that were conducted in Africa, Asia and Latin America. The positive effects would be witnessed on the quality and equity services offered to the underprivileged, specifically comparable with the performance of both the profit-making and public hospitals (Loevinsohn and Harding, 2005, Liu et al., 2007, Anwar et al., 2008). However, the major concern on the

operations of NGO institutions is the issue of capacity to cover all the desired customers.

## **2.16.2 Accountability assessment framework**

Health systems accountability is focused on control, oversight, cooperation and reporting, hence all players have connections and relationships of different types. Accountability can be referred to as the commitment by individual or agencies to supply vital information and justify certain actions to other players with a view to take corrective actions where necessary (Brinkerhoff, 2004a). The various actors with the accountability interests are the health ministries, ministries of finance, insurance companies, legislatures, regulatory agencies and hospital management boards. Hutchinson et al. (1999) argued that in the case of Uganda before the decentralization of health centre boards, the citizenry was disgruntled with the health workers' performance and even the decision making by policy makers.

Accountability can be categorized into three, namely the financial accountability, performance accountability and political or democratic accountability. The financial accountability in health systems is concerned with cost control measures and budgeting, contract oversight, detection of fraud and corruption. Performance accountability is concerned with provision of assurances that enhance quality of care, efficient and effective allocation of resources, service provider behaviour, adherence to regulatory and contractual obligations. The political or democratic accountability is for the purpose of ensuring transparency in resource utilization, equity and fairness in service delivery, conflict and dispute resolutions and responsiveness to citizens' needs or expectations (Brinkerhoff, 2004).

### **2.16.2.1 *Financial accountability***

The financial accountability is concerned with the internal control systems that deal with revenue collection systems, tracking and reporting of funds allocated, disbursement and utilization of funds in accordance with budget outlines, as well as compliance with tools of auditing. It is quite apparent that financial accountability is for the purpose of compliance with internal control systems, policy guidelines and statutory requirements.

The legislature passes the budget law through relevant statutes, detailing the expenditure allocations to the health ministry. For this reason, the health ministry officials are held accountable for the appropriated funds (Brinkerhoff, 2004).

#### **2.16.2.2**      *Performance accountability*

The performance accountability is for the purpose of health providers' performance in accordance with the agreed performance indicators. The individual, departmental or ministerial performance agreements and targets should be aligned to the financial allocations, hence the close relationship between the financial accountability and performance accountability. The financial resources to be accounted for by institutions should be for the production of intended services and goods to the citizens (Brinkerhoff, 2004). The satisfactory performance accountability should produce outputs, outcomes and the impact to citizens and by implication, the nation at large.

#### **2.16.2.3**      *Political or democratic accountability*

The building of trust among the citizenry is anchored on governments abiding by the agreed moral standards, ethics, integrity and professional obligation (Gilson, 2003). In any democratic system of governance, the political or democratic accountability is concerned with the government fulfilling the electoral promises, delivering public trust, meeting the needs and concerns of the citizens. This scenario allows for enhancement of the legitimacy of the government to the citizenry (Brinkerhoff, 2004). In order to generate political support, politicians usually make promises during their campaigns, building of health facilities and provision of affordable medicines and these actions are obviously attractive to the electorate since health care affects almost everyone in society.

#### **Challenges for the implementation of the accountability framework**

- i. The health system function is a complex notion, hence the flow of information among health workers, clients and regulatory authorities is also difficult in terms of information, expertise and access to services. The monitoring, evaluation and control of information on provider performance is also difficulty, due to interference on information flow by health workers (Millar and McKevitt, 2000).

On the issue of expertise, service users or consumers may not be knowledgeable of the treatments and medicines to be administered and thus need some protection (Shaw, 1999). A review of literature suggested that most clinicians training under the existing curriculum achieve a level of knowledge that is routine or classic, hence this has proved to be insufficient (Croskerry, 2018).

- ii. The motivational factors and the public and private divergent interests might hinder efforts to increase accountability (Bennett et al., 1997). When policy makers come up with policies, they target both minority and the majority service users despite divergent interests on their health needs. The divergence in needs and expectations naturally might lead to conflict in demands for accountability.
- iii. In all three purposes, the gaps in capacity can limit efforts to increase accountability (Brinkerhoff, 2004). Due to failure by health facilities to put control measures in the financial accountability, the result is weak control and assurance accountability. The wastage of resources or lack of accountability leads to corruption or other malpractices in the health sector.

## **2.17 Framework to assess the patron-client relationship**

The donor agencies have found clientism and patrimonialism systems very difficult to contain especially in aid receiving countries (Brinkerhoff and Goldsmith, 2004). However, to a greater extent various interventions have been used to fight clientelism and patrimonialism, through such reforms like economic liberalization, democratization, decentralization and other civil service reforms. According to Lasswell (1950) politics is defined as the system that determines who gets what in society. Politics is concerned with the determination of resource allocations within and between groups (Bøggild and Petersen, 2016).

The concept of clientelism is defined as an informal exchange between the patron and the client, which is based on the mutual benefits derived (Horak and Bader, 2017). The patron wields power, hence can easily influence the distribution of assets or resources under his or her control in return for their support and co-operation (Brinkerhoff and Goldsmith, 2004). However, it should be noted that under the clientelism arrangement, the friendship is unevenly balanced and this explains why the patrons often aimed at the

underprivileged and take advantage of their restricted information and autonomy.

In the case of the Mexican study, it was revealed that voters were lured through incentives like cash, caps, tee-shirts, pencils, foodstuffs, sheep and other rewards (Schedler, 2002). The clientelistic system of governance is very common in countries with low productivity and high inequality.

## **2.18 Strategies for reforming clientelistic systems**

Economic liberalization, democratization, decentralization and civil service reforms are some of the major strategies that might enhance governance in the modern world.

### **2.18.1 Economic liberalization**

In an effort to destroy the patron-client system of governance, economic reform is usually implemented to address the challenges of monopoly and discretionary power of government officials. The state can achieve this through the implementation of favourable economic policies to get rid of protectionist policies which favour the powerful minority or cartel. Greater opportunities should be opened for the majority, hence the state would become less vulnerable to be captured by the elite (Frischtak, 1994). In the case of Argentina, Mexico and Venezuela, voters abandoned established political parties and that gave rise to new ones (Benton, 2001). In practice, liberalization of the economy disrupts the clientelistic governance system which leads to levelling of the economic playing field to new businesses, competition, entrants and reduction in politicians' patronage.

### **2.18.2 Democratization**

The democratic theory is premised on the view that if ordinary people are given an opportunity to have a voice in the affairs of the government, then the government will work to meet the interests of the majority and not only for those who have the right connections (Brinkerhoff and Goldsmith, 2004). The resources are distributed among ordinary people, thus creating a source of opportunities and avoiding threats. The emancipative approach entails a conducive environment for tolerance, empathy, engagement, inspiration and trust (Welzel et al., 2018). It should be noted that in the

process of democratization, governments should not fall into the trap or pitfall of state capture. The powerful groups would use their vast resources to ‘buy’ influence and skew the laws for their individual benefit (Kaufmann et al., 2002). Furthermore, some democracies are prone to vote buying. This is a scenario where politicians use their influence over state resources to manipulate the governance system, through payment of supporters and manipulation of elections. However, vote buying threatens the tenets of democracy (Parkes et al., 2017).

### **2.18.3 Decentralization**

This governance arrangement or system where command and accountability for function is allocated or distributed from central level to the periphery (Brinkerhoff and Goldsmith, 2004). In the case of Mar del Plata, Argentina, many residents opted for participatory civic governance (Stokes, 2003). The results from interviews conducted revealed that residents no longer want inducements of clientelism, which tend to compromise the provision of public goods. Furthermore, results from the 26 countries that adopted the concept of decentralization revealed positive impact on the health system especially in terms of governance, financing and delivery of services (Muñoz et al., 2017).

### **2.18.4 Civil service reform**

The civil service reform can be achieved through reorganization and reorientation in order to get rid of patrimonial or undemocratic rule. The professionalization of government ministries or agencies is done by way of transparency in recruitment and career progression, a trajectory which is positively associated with economic growth and modernization (Brinkerhoff and Goldsmith, 2004). The main purpose of the public service reform should be to depoliticize and professionalize the bureaucracy. The civil service agencies should be apolitical in their operations. In the USA, the Progressive Era reformers enacted laws earmarked to reduce positions available for political appointments or patronage.

Developing and reforming continents like Africa embraced reforms to control administrative costs and increase staff performance. A good example implemented in Africa is when customs and income tax departments were merged to form revenue

authorities like the Zimbabwe Revenue Authority (ZIMRA) in Zimbabwe. The World Bank and other donors echoed their support for these reforms which are targeted at cost-cutting and performance enhancement. A study conducted in Brazil revealed that government employees proved to be very efficient if they are given the mandate to exercise autonomy in decision making, hence feel comfortable to render services in their communities (Tendler, 1997).

## **2.19 International development perspective**

There are three frameworks that fall under this category designed to deal with governance in aid assistance. The identified frameworks are those developed by Islam et al. (2007), Kirigia and Kirigia (2011) and Mikkelsen-Lopez et al. (2011). They are concerned with the facilitation of effective aid policy and how governance can be measured.

### **2.19.1 Governance framework on the health system assessment**

There are two broad mechanisms that are utilized on assessing health system governance. The first component is the World Governance Indicators (WGI), which was developed by the World Bank to measure the country's governance system based on six dimensions (Kaufmann et al., 2011) (Kaufmann et al., 2009). The governance of a country in terms of development is rated based on voice and accountability, political stability, governance effectiveness, rule of law, regulatory quality and the control of corruption.

However, the second component is specifically for health system governance, the rating is based on the six dimensions which include the quality of service delivery, health workforce, information systems in health, accessibility to essential medicines, health financing and leadership and governance (Health Systems 20/20 Project, USAID).

### **2.19.2 Health development governance framework**

The framework is envisioned for usage in Africa. The two broad objectives of the framework are concerned with governance and leadership which are critical factors for the attainment of the Sustainable Development Goals (SDGs) and related national goals. Failure to implement robust leadership and good governance principles to promote health

progression might have resulted in most African countries' failure to be on track in the attainment of SDGs by 2030.

### **2.19.3 Framework to assess governance of health systems**

The use of governance frameworks in the health sector takes into consideration certain key variables. These include identification of the governance issues, identification of the major governance drivers of being either weak or strong and the provision of a logical way to assess the governance complexities (Mikkelsen-Lopez et al., 2011). The framework to assess governance was adopted from the WHO (2007) model on health system in collaboration with contributions from Savigny and Adam (2009).

The six components which are, governance, human resources for health, health service delivery, information systems, health financing, medicine supplies and technologies were suggested for health system strengthening (Savigny and Adam, 2009). However, it should be noted that all these components are achieved through people or human effort which suggests that health facility personnel remain central to quality health service delivery.

In addition to the six components proffered by Savigny and Adam (2009), the assessment of governance across a health system should consider the strategic vision and policy design, transparency in operations, accountability, addressing corruption and participation and consensus orientation (Mikkelsen-Lopez et al., 2011). The components are interconnected with the ultimate objective of satisfying the needs and expectations of the numerous stakeholders or actors.

The application of the framework in health system governance has certain limitations. The first limitation of the framework is, due to its broad nature and different contexts, hence it does not provide the approved performance pointers. A comparison among different contexts is compromised, though it is flexible and includes all aspects that matter most as compared to other approaches. The second is that, for the approach to be applied successful, there is need to identify possible weaknesses in governance. However, this can be solved through the application of other frameworks such as the Siddiqi et al (2009), Lewis and Petterson (2009) and the Islam (2007). The third limitation is that the

framework can expose the barriers in the governance system, but does not proffer appropriate interventions (Mikkelsen-Lopez et al., 2011).

## **2.20 Multidisciplinary perspective**

### **2.20.1 Governance assessment framework**

The assessment of governance framework by Siddiqi et al, (2009) was designed on the basis of the UNDP principles of governance. The framework is aimed at assessing health governance at national level, which is the level responsible for policy formulation. Hence, there is the other level which is sub-national or operational level, with the responsibility for policy implementation. It considers entire levels of health system governance from national down to health facility level, hence its uniqueness from other frameworks.

The Siddiqi et al. (2011) framework, put into consideration 10 governance performance indicators, which include strategic vision, participation and consensus orientation, rule of law, transparency, responsiveness of institutions, equity and inclusiveness, effectiveness and efficiency, accountability, intelligence and information and ethics. It is considered as the most comprehensive mechanism on the assessment of health systems governance (Siddiqi et al., 2009).

### **2.20.2 Framework for the identification of corruption in the health sector**

The Transparency International (2006) proffered that corruption is the misuse of entrusted power for personal or private gain. The framework allows for the analysis of corruption or malpractices in the public sector institutions. There is growing interest by relevant stakeholders like policymakers, donors, planners, and the citizenry on how corruption can be eradicated in state enterprises and parastatals, to enhance good quality of healthcare and outcomes. Corruption negatively affects health and welfare of citizens, hence is felt by both individuals and households (McPake et al., 1999 : Gupta et al., 2002 : Azfa, 2005 : Lewis, 2006 and Rose, 2006). Hence, civil society organization, development partners and national governments have focused their attention on efforts to combat corruption (World Bank 2000, Transparency International, 2006).

### 2.20.2.1 *Forms of corruption in the health sector*

- i. *Malpractices in the awarding of contracts for the construction and rehabilitation of health facilities:* This involves the awarding of contracts to carry out construction works at health facilities based on political influence, kickbacks and bribery (Vian, 2005). The unethical tendencies are prevalent among government officials and contractors during tender evaluation and implementation of projects (Ameyaw et al., 2017). The malpractice result in failure to perform to the expected standard, hence facilities incur high costs but low quality service. Corruption in the construction of health facilities might threaten the safety and health of clients (Shan et al., 2020).
- ii. *Malpractices in the awarding of tenders for the procurement of medical equipment, medicines and surgicals:* The influence on the awarding of tenders might be as a result of kickbacks, bribes, political interference, collusion or bid rigging during the procurement process and unethical promotion. Furthermore, winning suppliers might fail to deliver but not held accountable (Kohler and Dimancesco, 2020). This type of corruption results in high costs to the facilities, sub-standard equipment being procured, inappropriate equipment and medicines which may not meet the needs or expectation of the clients. In the health care systems the consequences for such malpractices result in increased rates of morbidity and mortality (Schipperges et al., 2017).
- iii. *Distribution of facility medicines for personal or private gain:* This type of corruption involves theft or diverting medicines from institutional storage facilities to private distribution points for personal gain (Vian, 2020a). Some health workers even end up selling medicines that were meant for clients free of charge. This type of corruption creates artificial shortages in the health institutions. The malpractice results in low utilization of medicines, failure by patients to get proper treatment and high default rate by patients due to shortage of medicines.
- iv. *Non-compliance with regulatory requirements on quality of products, services, facilities and professional ethics:* Some regulatory authority officers might ask for

bribes to facilitate procedure or gain endorsement for the registration of medicines, quality of medicines, inspections and certification manufacturing procedures. The results of inspections or findings by relevant authorities can be influenced through bribes or political considerations, leading to weak or poorly managed regulatory system (Vian, 2020b).

Furthermore, during inspection of food outlets or restaurants, food production and other manufacturing entities, can be influenced through bribes. Hence, the certification, accreditation or licencing would be compromised to non-adherence to procedures and standards. Non-compliance to regulations or set standards might result in incomplete or fake products, incompetent suppliers of goods and services, poor quality of services and increase in incidences of food poisoning and the spread of infectious diseases.

- v. *Education for health professionals:* Corrupt practices by authorities or delegated officials can be initiated through bribes, political interference or influence and nepotism for the selection of applicants for training opportunities. The autonomy given to hospital managers on recruitment and promotion of health workers, incentivise them to accept bribes to initiate trainings, transfers and promotions (Naher et al., 2018). In some instances bribes can be used to facilitate entrance to medical schools or other training institutions. Furthermore, bribes can be used to obtain passing or better grades to undeserving cadres. The malpractices would result in the churning out of incompetent professionals. Hence, clients would lose faith or trust in service provision from the health facilities.
  
- vi. *Health workers' ethics:* Corruption can manifest in terms of theft, pilferage and misallocation of funds for personal gain. Some health professionals might use facilities and equipment on private patients or clients. Clients who pay bribes in hospitals to seek medical care is estimated at 17% worldwide (Mackey et al., 2016). Moreover, such clients are unnecessarily referred to private practices or privately owned ancillary services. In other incidences, clients or patients can be informally made to pay for services resulting in facilities' loss of revenue generation. All these corrupt malpractices would result in loss of faith or trust by clients, reduced utilization of

services and reduction in quality of care.

### **2.20.2.2 Interventions to minimize corruption**

Savedoff (2006) tendered that the uncertainty surrounding the demand for services, various distributed actors including regulatory authorities, financiers, health workers, clients and suppliers interact in multifaceted ways, disproportionate information among various actors, make it tough to identify and regulate diverging interests, actually leave the health sector vulnerable to corruption. Therefore, various strategies or interventions should be instituted to minimize corruption in the health system.

- i. *Avoid monopoly in service provision:* If there is limitation in terms of the choice for service providers, the result is vulnerability of citizens to corruption. Patients or clients would be compelled to pay bribes in order to get the required services. This suggests that the government should come up with strategies through health reforms that open the market to other players in the sector. For instance, privatization or contracting of services, separate the provider and the player and increase in numerous agents who provide specific services (Klitgaard et al., 2000). The results of the study that was conducted in Bolivia which revealed that alternatives to government services created competition in the sector and this was associated with lesser informal payments (Gray-Malina et al., 2001).
- ii. *Discretion:* This is the autonomy by government officials and its agents to make decisions for instance on hiring staff, procurement of medicines and equipment and other independent decisions. However, it should be noted that high discretion without proper monitoring of processes might create chances for corruption. The anti-corruption strategies or interventions should leave room for discretion. The strategies might include separation of duties and responsibilities in order to create checks and balances, ensure decision-making which should be clarified through regular operating procedures and policies and enhancing information systems. In the case of Africa, the distribution agency ensure adherence to segregation of duties for example the separation of tasks in ordering, order checking and transportation, thus the control measures minimize chances for collusion and

medicines diversion (Vian, 2006).

- iii. *Accountability*: When there is lack of accountability, the ultimate result is corruption in the system. Three mechanisms of accountability include, measurement of goals and outcomes, clarification and validation to both internal and external stakeholders and penalty and punishment for either poor-performance or malpractices (Brinkerhoff, 2004).

Approaches to improve answerability encompass the strengthening of information systems, allowing the existence of watchdog agencies, hospital boards, civil society organizations, performance incentives for best performers and punishment for poor performers. In an effort to strengthen answerability in the health sector, Vian and Collins (2006) revealed that in South Africa, the government was held accountable through the introduction of the district planning and reporting system.

- iv. *Citizen voice*: Thomson (2005), Lewis (2006) and Milewa (2006) concurred that the citizens' voice are the protocols and ways to ensure effective involvement by stakeholders in planning and service provision. The citizen voice is meant to upsurge government accountability. Approaches to improve citizens' voice encompass the establishment of local health boards, client satisfaction surveys, suggestion boxes at health facilities and complaint offices to record and mediate reports on unethical or corrupt conduct. The research conducted by the Center for Civic Education (<http://www.civiced.org>) revealed that countries like Russia, Latvia and Indonesia experienced effectiveness in civic education, which resulted in increased citizens' participation in explaining their needs and problems.
- v. *Transparency*: The transparency concept is premised on the notion of active disclosure of information pertaining to how decisions are made, improve public participation and inform citizens. Furthermore, transparency assists in the documentation and dissemination of information on anti-corruption programmes and how to minimize or eliminate corruption. A very good example where transparency achieved the intended results was in Croatia. In particular, regulations were proposed and implemented through coming up with lists for

patients requiring certain procedures or treatment in hospitals. The intention of the intervention was to reduce bribery where some health personnel may ask for bribes to get priority (Transparency International, 2006). Some of the approaches to improve transparency include public service reports, price monitoring mechanisms, public meetings and the dissemination of information through websites or other platforms (World Bank, 2003). Fung et al. (2007) argued that for transparency to be effective, disclosure of information should be done through government agencies and other external representatives for example the civil society organizations (CSOs) or the media.

- vi. *Detection and Enforcement*: These are the steps or procedures that are used in gathering information and evidence on corruption and then take corrective action like punish or sanction perpetrators. The enforcement in the Ministry of health can be done through the use of internal and external auditors, policing and through the courts or criminal justice system. Enforcement activities include whistleblowing, surveillance, internal security, fraud control, risk management, investigation and punishment of perpetrators. Deterrent measures can be taken through effective disciplinary systems, to ensure modifications in organizational culture. A hospital in Cambodia, enforced change in organizational culture through withholding of bonus incentives for poor performance (Barber et al., 2004).
  
- vii. *Rationalization*: Corruption can be influenced by individual beliefs, attitudes and social norms. The erosion of civil service values have created void in which corruption is unfortunately justified (Miller et al., 2001). Medical professionals and public officials are expected to have a sense of moral responsibility and empathy for others for good wellbeing (Randall and Gibson 1991, Kurland 1995, Raats et al., 1995). Professionalism can be defined judgements and actions by professionals that are derived from the specific set of principles and commitments that offer guidance and orientation (Egener et al., 2017). In general, people with medical needs bestow their trust in medical professionals and medical institutions due to their professional status in society. The two fundamental duties of medical professionals is trust as well as be astute to deserve respect and professionally apply medical knowledge, skills, powers and privileges for the ultimate benefit of

patients and society (Rhodes, 2019).

In the case of Haitian communities, there was a sudden increase of donor-funded health programmes, hence local leadership utilized those resources to develop their economic position and status. Unfortunately, they justified their actions to be logical, sensible and effective (Brodwin, 1997) for community development. In the case of corruption among African countries, de Sardan opined that negotiation, gift-giving, predatory authority and distributive authority allow corruption to be socially embedded (de Sardan 1999).

- viii. *Pressure to abuse*: Due to low salaries, some employees are tempted to get involved in corruption in order to settle their financial debts and make a living. One of the strategies or interventions to deal with this challenge is to carry out background checks before hiring of employees. Also, it is important to periodically check on the status of the workforce during their employment (Vian 2006). Senior public officials should declare their assets before being engaged for employment to public offices.

Furthermore, attractive or increase in salaries can be used to suppress financial pressure that might lead to corrupt tendencies (Van Lerberghe et al., 2002, Ferrinho et al., 2004). In the case of Haiti, the Philippines and Cambodia, performance based incentives were used to reduce financial pressure (Eichler et al., 2000, Management Sciences for Health 2001, Soeters and Griffiths 2003, Dugger 2006).

## **2.21 The assessment of inputs-processes-outputs governance framework**

The model proposed the need to carry out health sector governance assessment, through an approach of analysing the governance inputs, processes and outcomes (Baez Camargo and Jacobs, 2011). All stakeholders or actors in the governance system are categorized into three components.

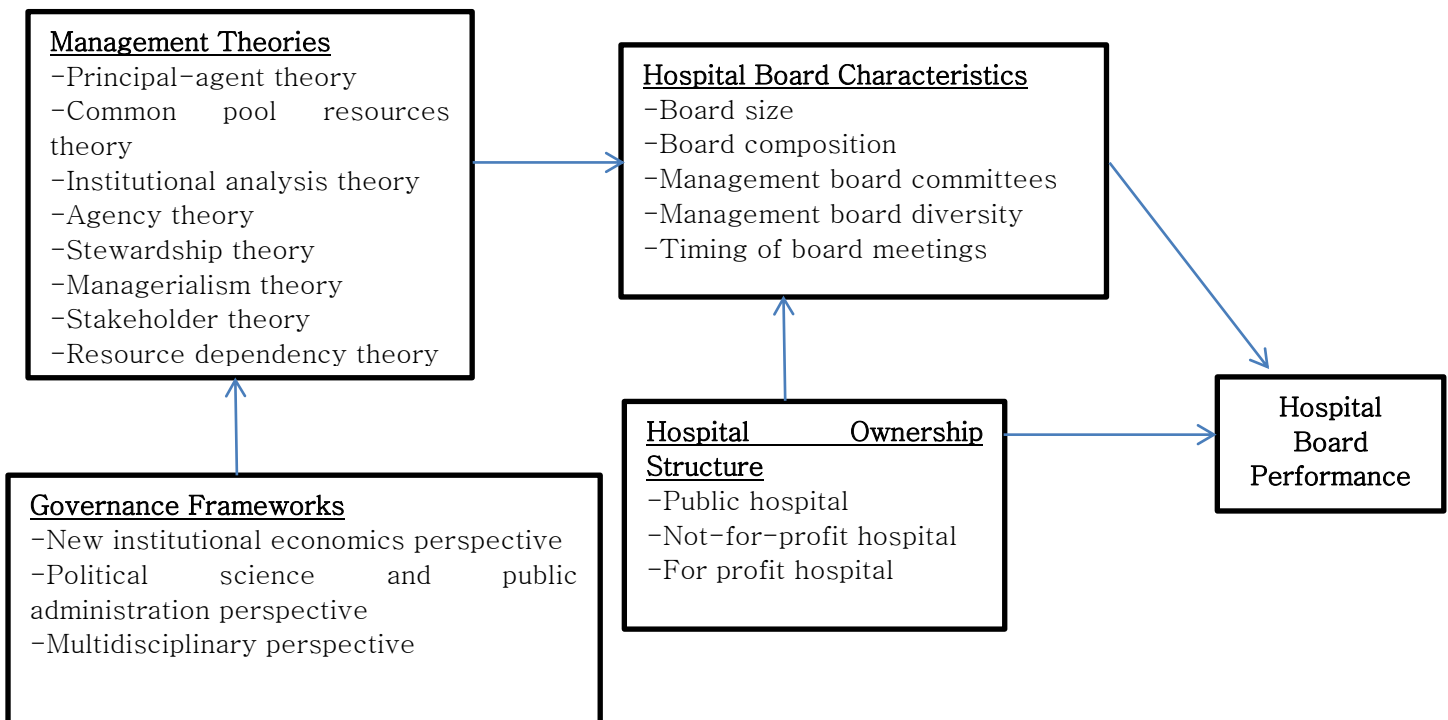
- I. *Governance inputs*: This is concerned with the responsibility of designing of relevant rules and policies which are used in governing particular institutions. The

stakeholders involved in the process of health policies, strategic vision and the setting of goals in health governance should be identified. Failure to come up with best inputs in the health system would result in failure to bring adequate benefits to the citizens. Hence, the need for coherence through the mix of medical supplies, technical expertise, political will and organizational requirements and skills.

- II. *Governance processes*: These are the rules and administrative procedures implemented in the governing of the health sector. The regulations and operations should be executed transparently and productively, in order to bring the intended quality results. The production of quality results or outcomes is dependent on the implementation of processes in an accountable, transparent and corrupt free environment.
- III. *Governance outcomes*: The designing and implementation of rules and processes, would ultimately produce positive and quality results or outcomes. The positive outcomes would definitely generate the social benefits or desirable health service to the citizens. Examples of governance associated health outcomes include equitable access of health for all citizens, to the expectation of the general populace through utilization of available resources. The positive impact of health service is a vital factor for broad economic development of a country.

The study is centred on the mission, strategy, board composition, board structure, board meetings, funding and public image and financial oversight and degree of independence. The framework provides the relevant theories in explaining the governance of public hospitals. The multi-theoretical framework is adopted in this study with the aim of highlighting issues that might impact directly on the overall hospital governance and performance in the Zimbabwean context. The conceptual framework hinges on hospital boards, corporate governance and board performance.

Table 2 : Conceptual Framework



Source: Constructed by author (2019)

The management theories and frameworks adopted by an organization have a positive impact on the hospital board characteristics, whether it is a not-for-profit, for profit or public hospital. A study conducted in Indonesia suggested board independence and corporate governance working simultaneously (Tulung and Ramdani, 2018). The board characteristics and organizational expectations ultimately have a bearing on the hospital board performance either good or bad. The accounting or financial expertise and size of the board influence performance of an entity, whilst the performance of the firm is not affected by board independence (Johl et al., 2015).

Literature has indicated that, to a great extent, the performance of hospital boards is enhanced through board characteristics, which include mission, strategy, board composition, board structure, board meetings, funding and public image and degree of independence. All these factors of board performance fall under the three broad theories or approaches as illustrated in Table 2.

## 2.22 Chapter summary

This chapter provided an overview of hospital governance theories and frameworks that have an effect on hospital management and performance. The theories covered include, the principal-agent, common pool resources, institutional analysis, agency, stewardship, managerialism, stakeholder and resource dependency. The governance frameworks for health care systems are classified into three broad categories. These are the new institutional economics, political science and public administration and the multidisciplinary perspectives. Thus, the study is guided by various frameworks under these broad categories.

The nature of functionality of hospital management boards in the Zimbabwean context should be understood. The next chapter provides an overview of the functionality of the hospital management boards.

## **CHAPTER THREE**

### **THE NATURE OF FUNCTIONALITY OF CENTRAL HOSPITALS OF ZIMBABWE**

#### **3.1 Introduction**

In Zimbabwe, there are six central hospitals which are Parirenyatwa Hospital, United Bulawayo Hospital, Harare Hospital, Mpilo Hospital, Ingutsheni Hospital and Chitungwiza Hospital (Health Service Act : Chapter 15:16 as read with First Schedule). The functionality of hospital management boards in Zimbabwe are governed by the Health Service Act (Chapter 15:16) as read with Second and Third Schedules. Fundamentally, there is no formal standard operating manual for the operation of central hospitals in Zimbabwe. Hospital boards have to satisfy the needs of its numerous stakeholders inclusive of both internal and external. Examples of hospital stakeholders include patients, staff, healthcare professions, regulators, funders and government. Hence, the complexities of healthcare setting do constrain the influence of the hospital management board in terms of strategy formulation, implementation, monitoring and improving its performance. The ultimate responsibility of the board is to assure safety and high quality patient care (Chambers et al., 2019). Essentially, it is within the scope of the board of directors to provide direction to management of the enterprise (Nkundabanyanga, 2016).

#### **3.2 Establishment of hospital management boards in Zimbabwe**

The hospital management boards in Zimbabwe are established in terms of the Health Service Act (Chapter 15:16). In terms of the Health Services Act: Chapter 15:16 (Section 19, subsection 1), the instituting of HMBs for central hospitals is the prerogative of the Minister of Health and Child Care. The hospital management board is the accountable authority for the central hospital concerned. Public sector boards are established with a mandate to enhance social performance and create public value to citizens (Chambers et al., 2013). Currently, health systems are holding hospital management boards answerable for the provision of quality of care in their respective institutions. Hence, quality improvement is encouraged, which should include the balancing of external priorities with internal investment, quality assurance, engagement of staff at all levels and engagement of patients (Jones et al., 2017).

In an effort to improve hospital governance, many countries are exploring organizational models to change the day to day governance of health institutions. Central hospitals in Zimbabwe underwent reform aimed at embracing the tenets of good governance, hence the establishment of hospital management boards. The establishment of supervisory boards in hospitals is key in terms of solving management problems. This can be achieved through the strengthening of decision making on service provision and investments by the non-executive board (Petersone et al., 2019).

Sikipa et al. (2019) postulated that the hospital management boards bring in various benefits to the institutions that they manage. They proffered ten benefits associated with the establishment of hospital management boards as outlined in Table 3 below,

**Table 3 : Benefits of establishing hospital management boards**

<b>Benefits Associated</b>	<b>Desired Outcome</b>
Community engagement	-The hospital management board has the responsibility of interfacing/engaging with the community at various forums
Link with leadership	-Networking with leadership of various sectors both community, local or regional with a view to enhance the institutional operations
Expansion of equitable access to health	-Board members should be appointed from various sectors with diverse backgrounds, hence bring leverage in terms of experience, ideas and expertise
Strengthening of accountability and performance	-Enhanced accountability and improved performance for the benefit of diverse stakeholders
Enhancement of oversight, accountability and professional growth of the executive management	-Enhance monitoring and evaluation of the performance of hospital executive management
Assist and support the CEO	-Render support and shield the CEO from pressures exerted by various forces (both internal and external) for example politicians, health staff, worker's unions and others
Problem solving	-Bring new and objective solutions to challenges affecting hospitals
Support philanthropic initiatives	-Support resource mobilization and corporate social responsibility initiatives to raise grants, external financing and government support -Initiate Public-Private-Partnerships
Plan, strategize and prioritize investments	-Application of models to plan and prioritize investment opportunities for example use of techniques such as the Cost-Benefit-Analysis (CBA) and Return on Investment (ROI)

Source: Sikipa et al., (2019, p.2)

As can be seen, hospital management boards contribute immensely in giving direction and leadership support to hospital management in their endeavor to fulfill the mandate of service provision. Performance of the executive management is highly energized through the strategic initiatives by the hospital management boards.

It should be pointed out that the management of central hospitals in Zimbabwe was designed in such a way to allow segregation or split of the day to day management of hospitals and strategic management from management of service provision. Many developing countries face the challenge of inadequacy and inefficiency in the utilization of resources, hence failure to meet the national and global targets for health outcomes (Linnander et al., 2017). The board structures adopted by countries vary, including non-executive trustee style boards, unitary boards, two-tier boards and four-part governance arrangements (Chambers et al., 2019). In the case of Zimbabwe, hospital management boards have been modeled around the unitary or corporate board system. The CEO is considered as an active member of the hospital management board at a central hospital. However, the majority are appointed as independent non-executive board members with a collective responsibility for hospital performance.

In the Zimbabwean context, public health facilities comprise central, provincial, district hospitals and clinics, municipal hospitals and clinics. Hence, there is a de facto principal-agent relationship where the government enter into contractual agreement with the hospital management board members or directors to provide a service (Hart, 1995). In the good governance matrix of central hospitals, hospital management boards are mandated to ensure fulfillment of both the government and the various stakeholders' interests. The structured dynamic network of stakeholders are crucial in building healthcare systems which are aimed at devising strategies of moving from local to international level, with a focus on innovation, information and collaboration among stakeholders (Pereno and Eriksson, 2020). In a hospital set up, the patient is the most important stakeholder since the actions or decisions of a hospital management board and executive management have a direct effect to the health wellbeing of individuals.

### 3.3 Board composition of central hospitals in Zimbabwe

In accordance with provisions of the Health Service Act: Chapter 15:16 (2), the composition of the hospital management board for a central hospital should be constituted with membership of not more than seven members including the CEO. The board governance is a combination of the board independence, board composition and board structure (Bakalikwira et al., 2017).

Accountability and board structure are closely associated as was revealed in a study that was conducted in Ghana. It is the duty of the government to facilitate the incorporation of non-executive board members in proportion to board size (Bakalikwira et al., 2017). The results on board composition were buttressed by Sartawi and others (2014) who exposed that there is a positive correlation between voluntary disclosure of the firm's operations and board size.

The directoral independence need to be achieved through diversity of board membership. The board composition should recognize diversity in terms of appointments for locating various skill sets into the boards (Tomasic, 2016). The independent directors provide important information either for monitoring or advisory function (Brown, 2015). Hospital management boards of central hospitals in Zimbabwe are appointed based on the mix of six non-executive members and one executive member. The promulgations in the Health Service Act (Chapter 15:16), Section 19 (c), echoed that the Minister of Health and Child Care is mandated to appoint the other six board members based on their professional or managerial skills.

The board composition encompass, the board size, independence of board members, gender balance in the boards, convening of board meetings and CEO duality (Arulvel and Pratheepkanth, 2019). The Health Service Act (Chapter 15:16) recognizes and limits the size of the board to seven members and the CEO duality. In practice, the duality situation means automatically the CEO becomes the board chairperson of the hospital management board and concurrently plays. However, the good corporate governance best practices, prohibits the CEO as the senior executive should to be the chairperson of the board as this violates the principle of independence and accountability. The executive management including the CEO should be accountable to the board. The sentiments of enhancing independence during the

execution of fiduciary functions and the application of legitimate power by the board are highly dependent on the board composition (Nuhu and Ahmad, 2016). On the independence of the board and gender balance in its composition, the Health Service Act (Chapter 15:16) is silent on the selection criteria.

The management board with a blend of both internal and external directors, with various expertise is most likely to bring positive board performance, due to high degree of external contacts (Nuhu, 2017). Generally, advocates of strategic management have emphasized that the attention of the boards should be focused on active participation in strategic thinking (Lawal, 2016). The Health Services Act (Chapter 15:16), Section 19 (c) recognizes the importance of appointing board members with relevant professional or managerial skills. In the case of Ethiopia, hospital governing boards have between 5 to 7 members, of which the board composition ought to be tailor-made to cater for gender and community representation when appointing new members. The board composition of Ethiopia was initiated with the aim of enhancing the mobilization of resources, community participation and improvement in hospital performance (McNatt et al., 2014). Hence, the six external board members or non-executive directors appointed in central hospital management boards in Zimbabwe are drawn from different professional backgrounds. This strategic board composition is believed to bring in an assorted and relevant set of experiences, expertise, knowledge and networks for the sustained performance of a central hospital.

### **3.4 Board committees in central hospitals**

In accordance with dictates of the Health Service Act (Chapter 15:16), Second Schedule, Paragraph 8, the hospital management board may institute one or more sub-committees, which may be considered appropriate for the function of the main board. The board committee names are not specified by the Health Service Act, hence the board committees should be constituted with a focus on addressing the laid down functions of hospital management boards as stated in the Act. The governance reforms of 2003 suggested the setting up of various board committees as a requirement in all corporate boards (Lee, 2020). The board committees provide a significant task in the accounting, finance and management functions. Furthermore, board committees deal with the complexity associated with the legal requirements and the operating environment (Kolev et al., 2019).

There are various benefits derived from board committees, which include knowledge specialization through monitoring and advising, task-division efficiency and the strengthening of accountability by way of separation of executive management functions and the engagement of external directors (Chen and Wu, 2016). In central hospitals of Zimbabwe, the chairing of board committees is done by a member of the hospital management board. The hospital management board would vest its functions to the board committees, but they remain accountable to the main board. In other words, the board committees have additional delegation and specialization which is achieved through such committees like the audit, compensation and nomination board committees (Kaczmarek and Nyuur, 2016).

Members of the board committees may include other members who are not among the seven core board member. However, the co-opted members of the sub-committees cannot be chairpersons of the board committees, hence they have their terms and conditions determined by the hospital management board. In central hospitals, co-opted members can be other members of the hospital executive, who would contribute in terms of their expertise or experiences. The setting of executive compensation, identification of potential board members and financial reporting are some of the functions of the board committees, which require expertise or specific skill sets (Kolev et al., 2019).

In accordance with provisions of the Health Service Act (Chapter 15:16), all meetings held by board committees should be subject to a quorum, such that decisions would be binding. However, in the absence of the chairperson of the board committee, the members present may appoint another member to preside at such a convened meeting.

### **3.5 Autonomy of hospital management boards**

The reforms undertaken in the transformation of health systems might involve decentralization and autonomous structures of health systems (Berman et al., 2019). Hence, the decentralized government-owned and operated health care systems would be delegated to lower levels. In the Zimbabwean context, the decentralization model was achieved through the establishment of hospital management boards at various levels as enshrined in the Health Service Act (Chapter 15:16).

The functionality of a central hospital is based on the assumption that it is a legal persona, hence operate independently with capacity to either sue or be sued in its own name (Health Service Act: Chapter 15:16, Section 18). According to Bloom et al. (2009), efforts should be made for the improvement in health care system and quality of health protection, clinical results and patient satisfaction through the adoption of the institutional autonomy concept.

The autonomy of hospitals can be achieved through various models, which include delegation, deconcentration, devolution and privatization. The efficiency and accountability at a lower level can be increased due to decentralization of authority in health system (Mills et al., 1990). In terms of hospital governance, hospital autonomy is when there is reduced interference by government agencies, through drastic changes on the day to day decision making from national to hospital management (Castaño et al., 2004). Zimbabwe adopted a delegation structure where the authority was transferred from the MOHCC to hospital management boards. The structure adopted provides that the ministry maintains its regulatory authority. The increased hospital autonomy results in greater efficiency, improved quality of services rendered, improved level of accountability, increased interaction with the community and improved distribution of service provision (Preker and Harding, 2003).

### **3.6 Resource mobilization by hospital management boards**

All central hospitals have the mandate to mobilize their own resources, which can be financial, medicines, borrowing, lease, pledges and other transactions as highlighted in the Health Service Act: Chapter 15:16, Third Schedule in the Abuja Declaration of 2005 enunciated that at least 15% of the total national budget commitment ought to be channeled towards health care financing. However, it is noted that the annual budget allocations to the health ministry in Zimbabwe is usually far below this requirement as revealed in the percentage budget allocations of 9.3% (2016), 8.23% (2017), 8.40% (2018), 8.15% (2019) and 12.33% (2020) (<http://www.zimtreasury.gov.com>), hence central hospitals rely on other sources to finance their operations and sustainability. Hospital management boards should implement the financing strategies that were proffered under the Zimbabwe National Financing Strategy (2017). The Zimbabwe National Health Strategy is intertwined with the National Financing Policy of 2016 which is skewed towards the improvement in health financing for the people of Zimbabwe. Furthermore, the financing strategy is earmarked at

partnering with government agencies, development partners and private sector entities.

To ensure sustainability of public hospital operations, the Health Service Act (Chapter 15:16), the Public Finance Management Act (Chapter 22:19) and the Health Service Fund manual provide hospital management boards the mandate to collect revenue or mobilize resources subject to the provisions of the aforesaid Acts. Central hospitals in Zimbabwe as public entities are allocated funds annually under the annual national budget commitment, thus the Appropriation Act. The funds collected under the health service fund are earmarked to supplement the budget allocations from the Treasury or Ministry of Finance. Therefore, the health service fund should be utilized for the direct benefit of patients or health service provision, subject to the provisions of the manual or any other circulars that are issued through the Accounting Officer of the MOHCC.

Hospital management boards are mandated by relevant statutes, for example, the Health Service Act (Chapter 15: 16) and the Public Finance Management Act (Chapter 22:19) to devise any means of financing or investments that ensure the continuity of hospital operations and sustainability. Furthermore, the surplus health service funds may also subject to authorization by the hospital management board which may include investment in other income generating projects. The Public Finance Management Act (Chapter 22:19), Section 44, tendered that it is the responsibility of the accounting authority to efficiently and effectively manage risk through evaluation before undertaking any capital projects. The accounting authority being referred to in the Act is the hospital management board.

In the case of Nigeria, there are six major financing models or mechanisms implemented in the mobilization of resources for health provision in public hospitals. The mechanisms include, government budget, individual health financing, cash transfers, community based health financing and donor financing (Onwujekwe et al., 2019). Central hospitals in Zimbabwe through their hospital management boards, can adopt some of the financing models with the aim of improving the health systems. However, the adoption of new models should be viable.

In an effort to acquire national status and sustainability, the health financing policies in low income countries need sufficient stakeholder support. Health systems in several countries

lack sufficient resources, expertise and the capacity to reform the health financing policies. The incapacitation by the health administrations results in other players or actors, like the external partners and experts making contributions to close the existing gaps (Kiendrébégo and Meessen, 2019). The hospital management boards in Zimbabwe are also mandated to accept any donations from partners or other well-wishers, but the donations or pledges should be in compliance with relevant statutes. The donations can be in the form of medicines, surgicals, hospital equipment, finances, vehicles or other essential requirements that enhance the smooth running of hospital operations and sustainability. The acceptance of donations should follow guidelines or regulations, that are dictated in the Public Finance Management Act (Chapter 15: 16).

Resource mobilization can be achieved through private sector engagement, thus the Public-Private-Partnerships (PPP) arrangements. The PPP model within the public health systems is highly considered in the face of various economic challenges being experienced (Caballer-Tarazona and Vivas-Consuelo, 2016). The interventions in health provision by the private sector has a greater capacity on freeing pressure on investment by the central government on public hospitals (Barlow et al., 2013). Central hospitals in Zimbabwe are encouraged to get into partnerships with the private sector entities to have sufficient resources at any given time to ensure sustainability.

In the case of the Public-Private Partnership (PPP) model implementation in Spain, it resulted in good performance and efficiency on the investments though not always better than those that are directly managed (Caballer et al., 2016). In Portugal, hospitals under PPP arrangement or model delivered health services which were as good as those offered by public hospitals. The benefits derived from PPPs include sustainability, efficiency in use of resources, timely care, maximum security and equitability on patient care (Ferreira and Marques, 2020). It is the obligation of the hospital management board to network with various stakeholders who might include the banks, mining companies, insurance companies, international organizations, funeral parlours and other players, with a view to sustain hospital operations.

### 3.7 Health care provision by hospital management boards

The hospital management board has a mandate to provide health care in compliance with the Health Service Act (Chapter 15:16) and the Public Health Act (Chapter 15:17). Hospital management boards have a duty to provide treatment to clients at their respective central hospitals. Decisions made by the hospital board are based on information and advice provided by the executive management. The provision of health care quality is based on regular reporting of data, hence reports need to enable hospital boards in crafting better decisions and taking corrective action to address pertinent issues, that is reporting for improvement (Brown, 2019).

The provision of health includes such services like early diagnosis, prevention, management of diseases or curative, health promotion and education, research and development. The objective of any health system is to control and manage both infectious and non-infectious diseases. The performance of health care system should be based on efficiency, accessibility and the quality of care. The measurement of efficiency performance encompasses productivity functions, the responsiveness to demand and length of stay. Accessibility performance indicators include affordability access by patients, physical access to care and time access or patient waiting time. The quality of care ought to be based on three indicators which are structure, which deals with the quality of staff, then process which is concerned with adherence to treatment guidelines while screening of patients and the outcome which concerned with mortality and rehospitalization rates (Kruse et al., 2018).

In principle, both the Health Service Act (Chapter 15:16) and the Public Health Act (Chapter 15:17) provides that the available resources at the hospital ought to be channeled towards the direct benefit of the patients. Furthermore, the MOHCC's Patient's Charter (Health Rights) provides certain rights that patients should be aware of and enjoy, for instance the right to health care and treatment. The rights of every patient in Zimbabwe include the following as highlighted in Table 4 below:-

Table 4 : Patients' Rights

Health Rights	Expectations
Accessibility to competent health care and treatment	Patients have the right to access services from competent and reputable workforce regardless of age, gender, ethnic origin, religion, political affiliation, economic or social status
Provision of sufficient information	It is the patient's right to know the identity and professional status of the service provider
Freedom of choice of care	Patients have the right to seek second opinion or alternative consulting services
Claim damages	Health workers should exercise due diligence and standard of care, failure of which clients can claim damages for injury or illness encountered
Participate in decision making	Active involvement and empowered in matters affecting health provision
Seek and obtain comprehensive information	Provision of sufficient information on preventive, curative and post treatment care
Healthy environment	Conducive environment which adheres to reputable standards and good health
Confidentiality and privacy	Examined, interviewed and treated in a conducive environment

Source: MOHCC Patient's Charter, Zimbabwe (2019, p.1-3 )

The patient satisfaction is premised on five quality dimensions which are responsiveness, assurance, reliability, tangibles and empathy (Al-Neyadi et al., 2018). Ahenkan et al. (2017) also proffered that patient satisfaction on service quality can be measured using five performance indicators which are empathy, communication, culture, tangibles and priority. Hence, for services offered, clients or patients expect good quality which makes it imperative for both the board and management to foster continuous quality improvement in a sustainable manner.

From the foregoing discussions, it is clear that hospital management boards have the duty in ensuring the provision of good quality treatment to clients in an equitable and accountable manner. Therefore, the quality monitoring and evaluation of health service delivery system is necessary as it enables continuous quality improvement. Due to monitoring and evaluation mechanisms, patient satisfaction is achieved since health professionals and policymakers are

given feedback and corrective actions on issues raised (Ahenkan and Aduo-Adjei, 2017).

### **3.8 National health policy implementation by the central hospitals**

Central hospitals through hospital management boards should provide health services being guided by the provision of the Constitution of Zimbabwe, which explicitly dictates the right to health care in Sections 76 and 77. It is the duty of hospital management boards to spearhead health services delivery to the people of Zimbabwe in a conducive environment.

The hospital management boards for central hospitals are mandated to implement national health policies with respect to central hospitals. The guide to policy implementation emanates from the National Health Strategy (NHS) for Zimbabwe (2016-2020). The NHS is a five-year plan which provides a framework that guides the efforts of the MOHCC and all stakeholders on the achievement of the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIMASSET) and Sustainable Development Goals (SDGs). Furthermore, it is the responsibility of the hospital management boards to align the NHS with government programmes for example the ZIMASSET and the Vision 2030 with the aim of achieving the upper middle income status by 2030. The ZIMASSET has four clusters and the MOHCC is focused on two clusters, which are Food Security and Nutrition and Social Service and Poverty Reduction. Health contributes immensely to development of any nation, hence hospital management boards should be spearheading the implementation of national policies with a focus on quality health provision.

The Health Service Act (Chapter 15:16) provides that, hospital management boards are mandated to come up with annual plans on how they intend to utilize their budgets to fulfill their functions during the year. The plans crafted by every health institution are referred to as the Departmental Integrated Performance Agreement (DIPA), which provides an outlay of how the hospital would fulfil the goals and objectives of the MOHCC. The performance indicators laid out in the DIPA have to be agreed upon by the accounting officer of the MOHCC. Hence, the performance of the hospital management board is measured based on the DIPA framework.

### **3.9 Formulation of institutional health policies by hospital management boards**

The NHS is a guide to national health policies, hence hospital management boards are mandated to come up with their own strategic plans in their respective institutions. The hospital management boards are not supposed to conduct the day-to-day operations or activities in hospitals, rather they are to give policy directions or guidelines. The executive management and other middle and low level managers of the hospital are mandated to implement the daily activities in terms of health care provision.

Generally, boards in all sectors have a responsibility for the establishment of a clear direction for the organization, monitoring mechanisms, determination of the organizational culture values and being answerable to and stakeholders. The unnoticed slow to decline of an entity emanates from too much time spent on aspects of compliance and less of strategy formulation (Chambers et al., 2017). Hospitals are difficult organizations to change, hence most managers and staff are very skeptical on improvements in efficiency, equity and responsiveness. The policy formulation or decision making process in hospitals is affected by several factors, which include the normal organizational, health professional and governance or political dysfunctionality. The other three factors that are contextual in nature and affects policy formulation and change are the clinical complexity, market failures and the generalized anxiety (Edwards and Saltman, 2017).

In the case of an Independent Public Inquiry into the UK Mid Staffordshire NHS Foundation Trust, for the period 2005 to 2009, it was revealed that there is convincing and irresistible evidence on failure by the board to satisfy the patients' needs (The Francis Reports, 2010, 2013). In the health sector, boards have a prerogative of ensuring the safety, positive health experience, effective and efficiency of patient care (Chambers et al., 2017). The formulation of hospital policies by the hospital management boards in Zimbabwe should be guided by the national health policies, thus the NHS of Zimbabwe.

### **3.10 Financial management in central hospitals**

The management of funds in public hospitals, including central hospitals in Zimbabwe is in compliance with requirements of the Public Finance Management Act (Chapter 22:19). The

Act provides that all funds that are retained should be receipted and maintained in proper books of accounts and spent according to stipulated guidelines. The efficient utilization of inadequate resources consider the community needs, national interests, health planning, external funders and financial management (Mburu, 1994, Tsofa et al., 2017). There is greater need to align planning and budgeting to ensure efficiency and effectiveness in the utilization of financial resources. Hence, this suggests that the hospital management board should come up with a board committee which looks into issues of financial management.

Budgeting is another key function in a central hospital and this is why every HMB should prioritise budgeting function. In line with the Public Finance Management Act (Chapter 22:19), every year each health entity is mandated to submit estimates of revenue and expenditure. The health financing system should implement functions that support the provision of quality health care. The budgeting system should classify budgets based on administrative classification, functional classification, programme-based classification and economic classification (Cashin et al., 2017). In a study that was undertaken in Kenya on the evaluation of the budgeting and planning process in two hospitals, revealed that in coming up with a budget and plan for the hospital, consequentialist principles are considered, that is efficiency, equitable distribution, stakeholder satisfaction, stakeholder appreciation, priority ranking and execution of decisions (Barasa et al., 2017a). From this finding, it implies that every central hospital is encouraged to use the programme-based budgeting and results based management system in its operations. As postulated in the Public Finance Management Act (Chapter 22:19), the budgets that are prepared by the hospital management board ought to be in accordance with the generally accepted accounting practice.

Financial performance is very crucial in the enhancement of the provision of quality health care. Weerasooriya et al. (2014) suggested that the performance of non-profit organizations is determined by factors which include client satisfaction, strategic planning, staff development and training. In the case of Vietnam health system, the results revealed that the decrease in financial performance in hospitals was influenced by factors such as quality standards, organizational mission, efficiency of revenue and expenditure, treatment quality and client expectations (Tran and Vu, 2018). These results revealed that financial performance has a direct impact in most hospital functions, hence aspects pertaining to financial management should be prioritized.

Tran and Vu (2018) suggested eight maneuvers for the enforcement of financial performance in public hospitals as outlined and briefly discussed below.

*a) The efficiency of the revenues and expenditures*

Hospitals should increase patients' satisfaction, hence attract many patients to the hospitals, resulting in boost or increase of revenues. Furthermore, hospitals have to enforce budgetary planning and control expenditures, for example administrative costs.

*b) Mission*

In a bid to increase financial performance, public hospitals should focus on setting priorities that meet their mission goals and improve efficiency, for example through strategy development and formulation of the mission for the hospital.

*c) Equity of treatment*

The hospital is responsible for the examination and treatment of diseases. Service quality is measured based on the reduced rates of referrals, reduced duration of treatment and reduced rate of complications after surgery. The improvement in efficiency can be achieved through skills development for health staff and technicians. This would automatically boost the financial performance in hospitals.

*d) The ratio of doctors*

The doctor/citizens ratio is a factor that can contribute to efficiency and improved financial performance of hospitals.

*e) Service quality standards*

The rate of compliance with quality standards, procedures and methods of service delivery contribute positively to the financial performance, through medical examinations and treatment services.

*f) Service quality and quantity satisfaction*

Hospitals should improve on the quality and quantity of services to meet the demand of patients. This has positive impact on the financial performance in that once the quality and quantity increase, automatically there would be an increase in patients' satisfaction

and expectations.

*g) Services that meet patients' satisfaction*

Hospitals should actively explore the desire, meet the demand for service users and bring more satisfaction to patients. If the expectations of patients are met, then more people would demand for services, hence improve in financial performance.

*h) Productivity of staff*

The quality of medical personnel is key in service delivery. The quality of service provision highly depends on the quality of health workers, for example doctors, nurses and other support staff. This definitely entails that financial performance of a hospital is dependant on the acumen of health workforce who render the service.

The Health Service Act (Chapter 15:16), Section 22, promulgates that it is the responsibility of the HMB to maintain required financial documentation. Furthermore, the Public Finance Management Act (Chapter 15:17), Sections 32 to 38 provides that the finance director has the prerogative to prepare the required financial statements in the year concerned. Hence, the hospital management board at the every financial year end shall cause the preparation of audited accounts indicating the hospital operations in the year concerned. The generally accepted accounting practice ought to be adhered to when preparing the financial statements. It is within the scope of work of the hospital management board to ensure that the finance director should prepare financial statements monthly, quarterly and annually. The revenue and expenditure actual performance should be reflected in the financial statements, thus distinguishing between capital and recurrent expenditure.

The HMB of a central hospital has a duty to establish, maintain and enforce robust internal control systems for their respective institutions. Furthermore, every central hospital should have the capacity to carry out an evaluation of capital projects or investments. The central hospital as a procuring entity should have appropriate procurement system in place as per the dictates of the Public Procurement and Disposal of Public Assets Act (Chapter 22:23). Therefore, risk management and procurement issues should be prioritized by hospital management boards.

### 3.11 Audit assurance by hospital management boards

The Health Service Act (Chapter 15:16), Section 23, provides that financial records should be subjected to audit by the Auditor-General, whose functions are enshrined in the Audit Office Act (Chapter 22:18). The Public Finance Management Act (Chapter 22:19) elucidate that, the Auditor-General is mandated as the external auditor for all government departments. Therefore, it is mandatory to establish an audit function in central hospitals. The internal audit profession is changing the roles and broadening the scope of participation in governance process. The functionality of the internal audit is critical in providing a range of consulting and assurance services.

The results from a study conducted in Nigeria revealed that 67% and 85.37% of public and private sector entities respectively, have established internal audit functions (Madawaki and Ahmi, 2018). Hence, good internal audit function is a tool that enhances the corporate governance mechanism and enables high quality governance process in both private and public organizations. This suggests that it is imperative for, hospital management boards in central hospitals of Zimbabwe to consider adopting the functions of internal audit as an important management tool. It is important to note that, the internal audit function has been changed from being a watchdog to a consultant (Shamki and Alhajri, 2017).

In accordance with the Health Service Act (Chapter 15:16), members of the hospital management board or health service provider should not hinder, obstruct or refuse to provide any clarification or evidence required by the Auditor-General. The importance of internal auditors was revealed in a study that was conducted in Kosovo. It was noted that the performance of internal auditors can be enhanced through audit team's quality, capability, objectivity and support from management (Rudhani et al., 2017). Internal auditors have an obligation to assist management through their consultancy role which support the organization to effectively evaluate, identify and implement risk management methodologies to manage risks (Badara and Saidin, 2013).

The audited financial statements by the Auditor-General provides assurance to all interested stakeholders like the government through parliament, MOHCC officials, donors or partners, citizenry, civil society and others. Therefore, in order to guarantee the independence,

objectivity and competence of internal auditors, free from undue influence and interference, there is need for support from management, government and other stakeholders (Ojo, 2019).

The Public Finance Management Act (Chapter 86-88), provides procedures to be followed when accounting officers, accounting authorities or employees of public entities are involved in acts of misconduct. Therefore, hospital management boards and the hospital management have a duty to perform within the confines of the statutes and guidelines. In the case of a study that was conducted at Mengo Hospital in Uganda (2017), the focus was to analyse the performance of internal auditors. The results revealed that, the management of financial resources and assets of an organization ensure the quality of service rendered and sustainability of a hospital, hence not only specialist doctors and advanced hospital medical equipment guarantee the performance of a hospital (Mpaata et al.). In this regard, both internal and external auditors have an obligation to unearth any fraudulent activities, malpractices or corruption within the health sector. In order for auditing to expose corruption or malpractices in the public sector, the auditing standards must include some concepts on corruption in the definition of fraud. This way, private and public sector auditors can exchange information and cooperate in the detection and efforts to address corruption in the health sector. Furthermore, auditing professions should also incorporate anti-corruption matters and certifications (Jeppesen, 2019).

### **3.12 Chapter summary**

The chapter provides an overview of the functionality of hospital management boards in Zimbabwe as enshrined in the statutes, for instance the Health Service Act (Chapter 15:16), the Public Health Act (Chapter 15:17), Public Finance Management Act (Chapter 22:19) and the Public Procurement and Disposal of Public Assets Act (Chapter 22:23).

The literature extant can help towards the development of relevant models and recommendations, therefore the importance of reviewing the literature. The next chapter is devoted to review of literature on health care governance.

## CHAPTER FOUR

### LITERATURE REVIEW

#### 4.1 Introduction

The literature reviewed was that on governance aspects with regard to the standardization and strengthening performance of hospital management boards. The literature on each of these two aspects were reviewed in chapter two and its sub-sections. The following aspects illustrated below form part of the literature review framework in this chapter.

- Healthcare governance
- Good healthcare governance, components and its benefits
- Models of hospital governance
- Healthcare governance structure
- Healthcare strategic management and its benefits
- Governing structures and delegation
- Strategies that strengthen hospital board performance

Hospital governance is gradually accepted as a vital aspect in health service delivery, yet theoretically and essentially the understandability is more compromised and often subjected to ambiguous and conflicting concepts on both its role and weaknesses (Brinkerhoff and Bossert, 2014). HMBs in the current environment are supposed to have an in-depth understanding of health needs, influences and outcomes with diverse board leadership, in a bid to counter the complexities associated with the operating environment (Sundean et al., 2019). In general, there is greater attention on health systems strengthening, better governance approaches and action plans (Shakarishvili et al., 2010). Furthermore, the existence of boards of directors is a matter that is unanimously agreed, but it remains unclear on the their influence on innovation within the organization (Jaskyte, 2012).

The general organizational accountability, its existence within the sector and welfare can best describe governance. There is a clear distinction between good governance and supervision or management (Fennell and Alexander, 1989). In essence, hospital governance encompasses top-level decision and policy making (Bader, 1993) (Alexander et al., 2003). In the

Zimbabwean context all central hospitals have hospital management boards and executive managers. Managers are for specific functions which include the finance, operations and clinical. In order to achieve organizational strategic goals, public hospitals require accountability, economic, efficiency and effectiveness in utilization of funds. Furthermore, expert management and capable governing structures should be put in place (Ditzel et al., 2006). Different stakeholders have different expectations as far as the performance of hospitals is concerned. Expectations provide significant challenges to both health care workers and hospital boards (Quigley and Scott, 2004).

## **4.2 Standard functional structures of hospital management boards**

The hospital management boards are crucial in supporting hospital management through financial monitoring, resource mobilization, stakeholder relationships and strategic decision making (Thiel et al., 2018). The mission of an organization is fulfilled through the implementation of good governance (HIDETO DATO et al., 2020). In this regard, it is very important to analyse the corporate and non-profit making boards in terms of number of directors, structure and functioning (Lee, 2016). Functional structure of a not-for-profit organization should be in accordance with its own expectations and stakeholder requirements (Labie and Mersland, 2011). The hospital management boards in Zimbabwe fall under the not-for-profit organization category. It should be noted that, the majority of the not-for-profit organizations are now designing their governance frameworks in tandem with those of the for-profit entities (Helmig et al., 2004).

### **4.2.1 Health care governance**

From the viewpoint of Abor (2014), the health care governance plays an important part in the general functioning of hospitals. The composition of the hospital management board and clarity of the functions of CEO and the chairperson of the board have great impact on the performance of the entity (Abor, 2016). There is overwhelming evidence that the inclusion of medical doctors in hospital boards is associated with higher quality services, hence in many countries medical leaders occupy prominent positions to foster both quality of governance and the safety within healthcare (Jones and Fulop, 2021). Obviously, the management of patient well-being remains the main focus in the value-chain of health care service provision in various health systems. Executive boards are prone to increased scrutiny with the

realization that hospital governance continue to be hypothetically and operationally weak (Freeman et al., 2016). Due to failures encountered in various health institutions in many countries, hence great need to put more focus on the mandate of hospital management boards. However, existing literature has focused more consideration to the possible effects of board structure and processes and less on the scrutiny of the impact of hospital board capabilities (Mannion et al., 2017). Fundamentally, both the IODSA King IV report and the National Code on Corporate Governance, Zimbabwe discourage the dual performance of the duties of both chair of the Board and CEO of an entity. The presence or absence of certain factors have an influence on the performance of the CEO as was suggested by the leadership and strategic management literature extant (Clark et al., 2014).

In health care governance, the gender parity significantly contributes to the financial and clinical performance of hospitals (Abor, 2017). A study was conducted in Ghana to ascertain the gender diversity on the boards revealed that women representation on the boards highly depends on the owner's perceptions. The impact of women participation in governing boards and management was further highlighted in the study which was undertaken to examine the influence of women on the National Health Service Foundation Trust boards of directors in England (Ellwood and Garcia-Lacalle, 2015). The results revealed that the negative social outcomes, for instance lowering of negligence costs with little effect on financial management were reduced due to female representation as board chairs and chief executives.

The development of knowledge and judgment by board members essentially has got an influence on health service delivery while upholding responsibilities to remain focused on strategic issues. The mandate underlines the need for the board to develop internal capacity for continuous quality improvement and not necessarily the monitoring and control issues (Alexander et al., 2009). China conducted a pilot-test on the redefinition of the mandate of health management and governance reforms that were aimed at increasing the public hospitals' autonomy (Allen et al, 2014). The central government disburses insufficient funding to the public hospitals as exposed from the study results, but despite the low disbursements hospitals are able to pay staff incentives from profits made. The arrangement created a tendency to increase charges to patients excessively for health care services.

It is should be pointed out that the current literature is largely focused on non-profit entities

that are adequately financed and big (Aulgur, 2016). On another dimension, research was conducted on the identification of challenges that might affect operations and management of health institutions in the public hospitals of the British Columbia (Greenwald, 2017). The results revealed that hindrances were experienced in terms of dealing with the needs of powerful stakeholders, adjusting to government regulations, adherence to fixed budgets and accessing capital from the government. This implies that management of challenges and potential responses are important considerations in reforming health system.

#### **4.2.2 Good health care governance**

In practice, the public sector reforms of management have engaged the services of business specialists to take a lead in the governance of public sector organizations, but the outcome of this arrangement is not well articulated (Kirkpatrick et al., 2017). A study was conducted focusing on the English National Health Service hospital boards to find out if the involvement of business expertise has any significant relationship with organizational performance. The results revealed that although the engagement of experts in business appears to have no influence on service quality, the financial performance is not positively affected.

Taylor (2000) propounded that every management expert and leader should implement good governance principles which are hinged on research or observation-based theories. These theories can then be considered in the context of hospital management. Due to various changes in health care systems and policy, hospital management, researchers and policymakers are progressively confronted with a challenge concerning the meaning of good hospital governance and its application in hospital organizations (Eeckloo et al., 2004). Taylor then suggested nine values of good governance which can be useful in a hospital setting. The suggestion by Taylor was then considered by Ditzel et al. (2006), who then tailor-made the nine suggested principles of good governance to suite health care management.

The development of health specific interventions or obtaining advice on health care issues is increasing getting attention through substantial literature on involvement of the public (Baxter et al., 2017). The mechanisms to enhance public health efficiency involve creating community participation in dissemination of health information to clients, establish community activism groups to empower consumers and the involvement of non-

governmental organizations in provision of health care (Berlan and Shiffman, 2012).

In the study by Borlea and others (2017), factors that adversely affect the performance of firms in Romania as an emerging country are legislature, privatization, shareholding, quality of information, political situation, economic systems social and cultural issues. The corporate governance model has been in practice since 2008 in Romania. Thus, companies in Romania have not yet fully applied and practiced the concept of corporate best practices (Borlea et al., 2017). However, Pointer and Ewell (1995) posits that hospital boards were adopted in the USA many hundreds of years ago, thus in the 18<sup>th</sup> century. Since 1756, the USA instituted hospital boards, hence hospital governance has been responding to the ever changing health care environment. In the Zimbabwean context, the issue of hospital autonomy was first discussed in 1995. This was at the time when the government recommended the decentralization of hospital financing and the promotion of privatization of selected hospital functions, with the upper tier consisting of six central hospitals (Needleman et al., 1996).

Despite pressure from stakeholders to revamp the functions of hospital boards, authorities actually adopted reforms on the board composition and the selection criteria for directors. A study was carried out in the USA to investigate the relationship between broader expertise among hospital board members, board involvement in strategic decision making and the hospital's strategic focus (Ford-Eickhoff et al., 2011). The results indicated that the external focus is achieved if hospitals deploy broader expertise on the boards, swiftly respond to changes in the operating environment through the absorption of the organizational complexity and sense-making. Another study was conducted in Vietnam firms on the board diversity index such as demographic attributes of board members (Hoang et al., 2017). The findings indicate that there is a significant positive correlation between board diversity and earnings quality. These results denote the existence of a positive relationship on board's composition and performance whilst the board members' demographic attributes have a variable effect on firm performance. In a bid to support diversity in board composition, Hideto et al. (2020) suggested that hospital board structure of the not-for-profit organizations should be assessed based on board size, female director representation or ratio and the number of board meetings.

### **4.2.3 Benefits of corporate governance**

In practice, corporate governance should not be perceived as an extra workload to any business or institution but rather as a catalyst for improved compliance that should lead to improved board management and organizational performance. The involvement of both internal and external board members on corporate boards, board size and frequency of board meetings improve financial performance (Puni and Anlesinya, 2020). The major benefits of business governance include the empowerment of all stakeholders, enhances business reputation, improve efficiency and innovation, increases value of the institution, increases investor and market confidence, enhances competitive advantage and encourages compliance with financial, legal and statutory obligations (Hendrikse and Hendrikse, 2003). All these benefits, if applied in hospital governance, would definitely enhance or strengthen hospital board performance and ultimately the institution.

### **4.3 Components of good health care governance**

The high degree of complexity and absorption of huge budgetary resources are variables that are both associated with hospital entities. Highly competent management is vital for hospitals and its stakeholders (Budimir et al., 2017). In situations of financial resource constraints, hospital management ought to be tremendously multifaceted and this might require the utilization of high quality management information.

Greer et al (2016) argue that transparency, accountability, participation, integrity and capacity (TAPIC) are the building blocks of governance. The TAPIC framework adds value to the development and implementation of robust governance instrument that can be practically applied in both the private and state-owned health enterprises. Challenges of governance are attributable to one or more of these features, which can mean too much, too little or the wrong kind of them. In the view of Kendall (2009), individuals who serve as board members for the not-for-profit organizations are deemed to be the real ambassadors, advocates and community representatives who function as stewards of the public trust by exercising a legal and fiduciary responsibility.

### **4.3.1 Transparency**

Transparency is often conflated with accountability and yet it is technically and practically different. Thus, in practice it is possible to have transparency without accountability simply because an entity chooses to keep the world informed but not answerable to its actions. On the other hand, there can also be accountability but without transparency. Transparency mechanisms might include, board committees, inspectorates, regular reporting and performance reports. The common subject of transparency instruments is that they make it possible to understand the institution, identify possible mismanagements or unskillfulness and adapt plans to its behavior. In principle it can also be an anti-corruption measure and has worked as such (Vian et al., 2010) .

The key drawback on transparency is that it can miscarry in systems where civil society is weak and interest representation is biased. On the positive side, it can give well-resourced lobby groups more time to prepare campaigns and start to influence policy (Best, 2005).

### **4.3.2 Accountability**

Accountability comprises clarification and authorization (Weale, 2011: 64). It is about updating and clarifying, thus giving an account of one's actions. Accountability mechanisms include but not limited to the following: contracts, competition in bidding, separation of duties, conflict of interest policies, regulation, standards, codes of conduct and laws that specify objectives and reporting. The administrative discretion is enhanced through good accountability. Klitgaard (1988) posits that monopoly of a power plus discretion minus accountability equals corruption. In practice the concept of accountability might seem to be forthright in its application, but actually there is a high degree of complexity which includes the management of finances, organizational performance and political or democratic styles (Brinkerhoff, 2004b). In terms of the organizational operation like the health sector, accountability focuses on various mechanisms that result in the reduction in abuse of resources, assurance in compliance with set standards and procedures, improvement in performance and continuous learning. Generally, health systems globally are progressively holding boards of health care organizations answerable for the quality of health care or service provided. In England a study was carried out in 15 health care facilities. The results

revealed a higher level of maturity and an in-depth understanding of the mandate of boards in enhancing quality improvement (Jones et al., 2017). Board members should be accountable to its stakeholders and one of the strategies to enhance answerability by public officials is achieved through selection of public representatives to supervise their performance (Stewart et al., 2016). Some countries around the world have adopted the selection of board members directly to health care facilities. For example Canada, New Zealand, England and Scotland are some of the countries that practice direct elections of board members. However, as shown by available evidence in these countries, democratization alone cannot be solved through the introduction of elections due to the complexity of the health systems.

### **4.3.3 Participation**

Involvement or participation denotes the inclusion of interested parties in decision-making and power so that they acquire significant stake in the work of the institution (Banyan, 2007, Weale, 2007, Tritter et al., 2010 and Stewart, 2013). Participation mechanisms might comprise stakeholder meetings, conferences, voting, appointed representatives, advisory committees, surveys and joint budgets. The involvement of public representatives would go a long way in scuttling conflicts and enhancing trust between management and the public (E. and J., 2010). In the study conducted in the UK National Health Services, the public consultation of stakeholders was found to be appropriate to other areas of health care and national policymaking (Campbell et al., 2017).

Nevertheless, it should be noted that it is not always easy for representatives of the disadvantaged groups might produce meaningful contributions, legitimacy and ownership. For instance, clients in the health sector are diverse and fragmented as a group. In view of this, representation at policy making level might be difficult. Sometimes people are reluctant to participate in issues of national interest. In addition, not all citizens want to exercise choice and decision making in the health sector (Greer et al., 2014). It is apparent that participation requires a clear understanding of policies, interests and structures.

### **4.3.4 Integrity**

It is based on the assumption that processes of representation, decision making and enforcement should be clearly specified. All stakeholders should be in a position to

understand and predict the processes by which an institution will take decisions and apply them. However, integrity can be used interchangeably with various terms like predictability, anti-corruption and ethics (Larmour, 2012 and Sabet, 2012). Integrity mechanisms include internal and external audit, human resources policies, legislative mandate, budgets and clear organizational roles and purpose. In practice integrity is good for nation-building (Silberman, 1993) and democratic solidity (Cornell and Lapuente, 2014).

#### **4.3.5 Policy capacity**

Every organization should be able to advance policies that are associated with the available resources in pursuit of goals or set targets (Forest et al., 2015). Mechanisms that can improve policy capacity include intelligence on performance, intelligence on process, staff training, hiring procedures, procedures to incorporate specialist capacity in decision making, good buy or make decisions and research or analysis capacity.

### **4.4 Models of hospital governance**

The literature reviewed revealed that most hospitals consider the philanthropic and corporate models of governance. The major difference between the two models of governance is that, the philanthropic is a volunteer or unpaid assistance board model. The major differences arise in terms of the size, sub-committees and board expectations.

#### **4.4.1 Philanthropic model**

In not-for-profit organizations, the board members have the prerogative for protection of the interests of various stakeholders like the founders, donors, beneficiaries and the society through guiding the organization with due care, skill and integrity (Andres-Alonso et al., 2006, 2009). On the other hand, public entities are open to public inspection or scrutiny hence should ensure transparency and accountability in their operations. This model is most ideal for public hospitals because of its bias towards public sector governance expectations. The good governance processes are positively associated with evolved strategic approaches to philanthropy (Boesso et al., 2017).

#### **4.4.2 Corporate model**

This model consists of one system wide with no other boards at any other level. It is very simple and has clear lines of authority. Its key characteristics make it not ideal for not-for-profit organizations or public systems (Lawrence, 2003). The corporate model is normally associated with the commercial sector (Alexander, Morlock and Gifford, 1988). It is clear in the literature, that although it is derived from the corporate governance model, it does not operate well in a set up where the influence of patients and the citizens of the region are of great significance and shareholders do not exist (Hoek, 1999). In general, the corporate model is not suitable for central public hospitals since they are not for profit making but rather for cost recovery.

Even though there are general agreements on the requisite of a more central role for governance, significant challenge still remains about the form of hospital governance most appropriate for improved hospital board functioning (Weiner and Alexander, 1993). For the purpose of this study the philanthropic model is highly considered due to its characteristics of structure and stakeholder expectations.

#### **4.5 Health care governance structure**

Generally, it is argued that scholars are giving inadequate attention to change management in a volatile situation, whilst great emphasis is accorded to the functions of boards on resource mobilization and monitoring (Zhu et al., 2016). A study was conducted in Canada to ascertain boards' contribution in strategic decision making and benefits derived in shaping the organizational performance. The enquiry involved 217 for-profit and 156 not-for-profit entities. The results indicated that organizational performance is strengthened due to board's lively participation in decision making.

Fundamentally, due to changes in hospital governing structures and financing modalities, modifications to the governance of public hospitals is critical, mainly through enhancing the autonomy and reconstituting the functions of health authorities (Allen et al., 2014). Furthermore, due to the greater concern by interested state authorities and specialists to engage clinicians on the management of health institutions, literature extant has proffered that

there are several benefits that are derived from contributions obtained made by clinicians in strategic decision making of hospitals (Aidemark and Lindkvist, 2004). Basing on the limited existing literature, the findings support the notion of greater clinical partaking in hospital management and substantial implications on policy making and practice. Furthermore, there is close link between board structure and performance in countries with well constituted ownership and highly variable corporate governance practices (Berezinets et al., 2017).

The performance of non-profit hospitals was discovered to be influenced by the size and the involvement of government officials in hospital boards (Bai, 2013b). Furthermore, Bai (2013) posits that in both profit and nonprofit making hospitals board size can either negatively or positively impact on social performance. However, the presence of government officials on the board was discovered to either positively or negatively related to social performance in for-profit and non-profit hospitals (Bai, 2013a). The literature shows that, the financial performance can be enhanced through the involvement of other professionals apart from board size and physician participation (Kuntz et al., 2016). Basically, the involvement of physicians varies greatly in a hospital leadership, but consideration of the interests of both business and clinical matters have to be ascertained in fulfillment of hospital environment aspirations (Kuntz and Scholtes, 2013). Significant progress has been made to include medical personnel in leadership roles in National Health Systems. However, there are many challenges or barriers involved in carrying out their mandate effectively in leadership roles and in most organizations. This suggests the need for strategies and steps which might include increasing the time commitment of medical professionals and the proportion of medical doctors in formal leadership roles and developing the culture of engagement (Dickinson, 2013).

Nurses largely contribute to issues of quality and patient safety, hence their involvement to serve on hospital boards is highly commendable (McBride, 2016). This can be strengthened by ensuring inclusion and their dynamic participation at all levels of the boards. However, members of the board need more training in financial management and a specific designed orientation process (Walton et al., 2015). Health care system by its nature includes professionals of diverse backgrounds in terms of expertise or technical knowhow. Therefore, focus should not be solely centered on the interests of nurses, but other professions as well. Currently, several hospitals in the US have non-physicians in leadership positions comparable

to the scenario in the beginning of the 20<sup>th</sup> century when physicians of over a third of hospitals were occupying strategic positions (Falcone and Satiani, 2008). The physician CEO is most likely to bring in acumen in terms of skills to the business of medicine, especially when faced with complex and challenging situations in a health care system.

The hospital board governance or skills have a positive bearing on staff attitudes to raise concerns about client care issues and highly motivated that their organization would address their concerns, is worthy of further and more sustained consideration (Mannion et al., 2016). Jinsong and others (2016) tendered that the government conduct a pilot study on the granting of autonomy in selected public hospitals. Then after piloting, an independent evaluation can be conducted to ascertain if the granted autonomy enhance the achievement of the desired set targets for instance equitable resource distribution, quality of services rendered, efficiency and sustainability. Board members should be independent, avoid conflict of interests and apolitical (Schrappe, 2009).

#### **4.6 Health care strategic management**

Due to the ever-changing operating environment, newly established hospitals need to be more sustainable and existing ones must improve their standards. In recent decades, this need has been tackled by adopting policies and initiatives that have attempted to divert development towards more sustainable paths (Buffoli et al., 2014). Dan (2016) expertly gave specific cases and challenges of coordination. The author argues that conflicting interests and goals associated with specific hospital system cultures provide the best explanation for the effectiveness within which public hospitals are coordinated (Dan, 2017). The changes in health trends globally, for example in terms of surge in disease burden, increasing clients' expectations and cost limitations pose a challenge for health systems in trying to maximize benefits. The reforms to be adopted might include affordable healthcare provision, responsive health protocols and staff related planning strategies (Abdelaleem, 2018). Furthermore, health care managers are undergoing rapid changes since health care reform. Currently, health care is constantly changing and all future health care managers need to be adequately prepared for their managerial roles. A CEO study conducted in the United States hospitals identified that there may be some potential gaps in the importance of characteristics that are essential for health care manager to possess (Collins et al., 2015).

Many hospitals nowadays are implementing the management concept of lean production in their operations. However, the existing literature indicates that hospitals differ in their strategies and sustainable participation in organizational development (Eriksson et al., 2016). Alotaibi et al. (2016) are of the view that client safety is pointer to quality of service being offered. The organizational control environment influences employees' commitment, skills and ultimately improve organizational performance (Eqab Aiyadh et al., 2014). In practice, boards of directors that have a leadership role on corporate strategic planning go beyond merely caring for shareholder interests and take proactive role in the success of the business. They achieve this by setting strategic direction and evaluating company performance (Adrian et al., 2002).

National governments are now concerned with efficient, economic and effective resource utilization at all levels. The focus has shifted to multi-level forms of governance that encompass public accountability and more managerial or professional relationships (Mattei et al., 2013). This also suggests that central hospitals ought to adjust inn tandem with the dynamic operating environment, hence either remain with current services being offered, develop new set of services or improve the quality of services with the resources available. Given the scarcity of financial resources, the self-sustenance of hospitals is needed and to close the gap on over-reliance on government grants or donated resources to meet their obligations (Gapenski, 2007). Hospital boards should be highly innovative and understand factors that may contribute to their effectiveness and financial performance. Research should focus on investigating the development of quality management systems by boards and optimization of service delivery by medical professionals. The current operating environment necessitated the need to discover models of governance and present such frameworks in solving governance challenges that arise due to the volatile operating environment in the health sector (Dixit, 2017). The research by Dixit (2017) proposed that the limitation in resources inspire the adoption of robust governance frameworks by either policy makers or hospital managers of public hospitals with the target of containing costs whilst meeting the demand for healthcare. In most countries the health care restructuring is given high priority in policy making plan (Haley and Bég, 2012). The limited budget allocations hinder health institutions in the developing countries in achieving health needs, hence policy reformation is highly commendable.

Further research on association involving hospital management practices and quality productivity outcomes was conducted by Dorgan et al. (2010). A research team comprised 40 interviewers who conducted interviews in almost 1200 hospitals in Canada, France, Germany, Italy, Sweden, the UK and the US. The results indicated that high levels of patient satisfaction and better financial performance were experienced in hospitals that had higher management practice. The research revealed a strong correlation between management practice and policy related variables. The policy related variables included levels of competition, percentage of clinicians who are hospital managers, hospital size, managers' autonomy and ownership type (Dorgan et al., 2010).

In today's increasingly complex world, it is difficult to define health systems, what it consists of, where it starts and where it ends. A proactive study was conducted to discuss challenges and opportunities around global health care systems in the next 25-30 years (Durrani, 2016). The study was aimed at reviewing bottlenecks and milestones that both developed and developing countries encounter in pursuing the desired health outcomes. Strategies that have been proposed for future success include partnering with players, advocacy and the engagement of both health workers and specialists in generating effective leadership in the health care sector. In addition, to develop an integrated information system, improve public health efficiency, growing provider networks, care systems and resource management.

There might be various challenges like inadequate financial resources, poor or inadequate technical resources and political decisions which incapacitate hospital boards to deliver as expected by the different stakeholders. In the Zimbabwean context, there is need to close the gap between the hospital boards' performance and the expectations of the stakeholders. Governance is an important component for the development and policy implementation, though certain limitations may hinder entities from achieving the intended results. Hospital boards should not be viewed as not fit for the purpose by stakeholders, but instead a governance structure that delivers the anticipated or desired results. This therefore implies that research on how hospital boards can be strengthened to deliver, whilst adhering to good governance principles is a necessity.

#### **4.6.1 Benefits of strategic management**

Strategic management is vital in any organization in that the volatility in the health operating environment can be extinguished through counter strategies and leadership acumen (Ginter, 2018). Provision of well-designed thinking and practices are some of the benefits derived from strategic management. This allows for translating dreams into effective visions, missions, strategies and plans that will move organizations towards their desired goals and objectives. The nature of health care changes respond to political or legislative, economic, social or demographic, technological and competitive. Wheelen (2017) further supports the notion that strategic management evolves around an organization's clear vision and managing the complex operating environment. The well-articulated strategic vision, prioritization of the strategically important activities and scanning of dynamic operating environment are the three most highly related benefits of strategic management (Wheelen et al., 2017).

#### **4.7 Governing structures and delegation**

The IODSA King IV Report (2016) posits that the governing body should serve as the focal point and custodian of corporate governance in the organization. The recommended practices are: -

- i. The body should exercise its leadership role such as steering the organization and setting its strategic direction, approving policy and planning, overseeing monitoring and control and execution by management and ensuring accountability for organizational performance,
- ii. The governing body should ensure that its role, responsibilities, membership requirements and procedural conduct are well documented in a charter to ensure effective functioning,
- iii. Approve the protocol to be followed in the event of the body or any of its members or committees seek or obtain independent external advice that may cost the organization,
- iv. Approve protocol to be followed by non-executive directors for requesting documentation from or setting up meetings with management,
- v. Disclose the number of meetings held during the reporting period and attendance at such meetings.

The IODSA King IV Report went further to outline that the governing body ought to ensure that the discharging of governance mandate is executed independently, effectively, objectively and diversity of ideas. Board diversity is associated with greater number of areas in which corporate social responsibility (CSR) is strong and a few areas in which CSR is a concern (Harjoto et al., 2015). The verdicts are in concurrence with the stakeholder theory which encourage board diversity and satisfaction of various stakeholder clusters.

In the case of Australia, the outdated and disjointed models are inadequate to provide appropriate accessible care to communities, hence government agents, professional bodies and the society at large are advocating for reforms in the health sector. The proposed strategies involve health service integration through cohesive governance modalities. In addition a clear separation between governance and operational management and careful measurement of the process, impact and outcomes of such activities are key and often overlooked (Jackson et al., 2017).

Furthermore, in the case of Australia many not-for-profit boards are facing challenges in engaging competent and qualified members of the board to tackle the governance functions in a business environment that becoming more complex. The succession planning for these boards is highly compromised due to lack of the necessary expertise, time and required resources (Varhegyi and Jepsen, 2017). Consequently, the policy on succession planning for board of directors is not widely practiced. The results from the 88 directors that were involved in the study revealed that there is a positive correlation between succession planning and board effectiveness. Directors in the not-for-profit entities consider succession planning in terms of the value and practice.

In the last 40 years, boards' effectiveness was examined which resulted in significant management insinuations for nonprofit organizations (Jaskyte, 2017). The development of a board prospectus which focuses on six key areas or competencies was established based on the results from the studies conducted. These are contextual, educational, interpersonal, analytic, political and strategic in improving the performance of governing boards (Chait, Holland and Taylor, 1996). Further study by Jackyte (2018) showed that not only board attribute variables and board process variables were directly related to innovation, but they also had a potential to affect innovation and capacity for innovation indirectly through board

effectiveness (Jaskyte, 2018b). Consequently, the effects of board culture, cognitive social capital and human capital were either partially or fully transmitted through board effectiveness.

In the literature, it is clear that the high corporate performance is associated with the involvement of women and independent directors on the boards. However, there is limited knowledge on the modalities connecting board composition to corporate performance (Post et al., 2015). A study was undertaken to carry out empirical tests on the board composition and corporate environmental performance in the USA oil and gas companies. The sustainability of organizational operations was achieved due to the higher the involvement of women on the boards as indicated in the research findings. Furthermore, the sustainability of the firm is associated with higher independent directors engagement on the boards.

#### **4.7.1 Roles and benefits of board committees**

The board committees enable accountability through the assignment of specific tasks and responsibility (Harrison, 1987). The board committees have benefits like knowledge specialization, task division efficiency, accountability and information segregation. Furthermore, board committees play a monitoring role on the executive management (Chen et al., 2016). It should be noted that, the board should efficiently allocate individual board members to board committees based on their expertise and interest. Board members with professional skills are assigned to committees such as the audit, finance, investment, program and compensation. For instance, in the not-for-profit organizations, the finance committees have the responsibility for budgets and overall expenditures (Callen et al., 2003).

The mandate of the board of directors is directed at ensuring that proper structures are put in place through delegation of functions to committees to enhance the execution of the broad functions of the board. The actual board committees to be set include the audit committee, risk governance or management committee, remuneration committee and the social and ethics committee. The specific tasks are delegated to committees composed of independent directors, hence firms benefit through mitigation of costs. Using the return on assets (ROA) and economic value added (EVA), the research findings have indicated that board size is positively associated with firm performance when firm use more than three monitoring committees (Upadhyay et al., 2014). Over all, the performance of the board should be done to

ensure that the efficiency and effectiveness of the board is achieved through its committees, chair and individual members. However, it should be noted responsibility and authority cannot be delegated but duties to committees only.

## **4.8 Board performance**

Despite the limited resources, non-profit organizations adapt managerial styles and processes from the private sector to become more efficient and effective (Anderson and Lannon, 2018). Generally, the boards of not-for-profit organizations are assigned to have an oversight role and ensure that the organization remains committed to its mission and operate in a financially responsible manner in accordance with the laws of the country (Preston and Brown, 2004). In fact, there is a positive relationship between board performance and organizational effectiveness. Thus, the performance of board should often include policy formulation, strategic planning, program monitoring, financial planning, financial control, resource development, board development and dispute resolution (Green and Griesinger, 1996).

### **4.8.1 Board performance indicators**

Hospital performance indicators are defined as mechanisms that are used in ascertain quality of health care to strengthen quality of service offered and management of systems. In order to ensure quality improvement some health systems have adapted performance indicators as tools applicable at national, regional and institutional levels. Boards are responsible for setting executive compensation, identification of potential board members and overseeing financial controls (Kolev et al., 2019). Health care performance can be monitored and measured with the ultimate goal of achieving organizational quality, safety, effectiveness and efficiency (Braithwaite et al., 2017a). The hospital board should hold its CEO accountable in pursuance of the entity's mission through strategies that are implemented to align budgets and operational plans. Furthermore, performance indicators should be anchored on transparency, accountability, relevant leadership style, effectiveness, staff assets and the mode of operation or metrics (Friedman and Rabkin, 2018).

## **4.9 Board evaluation**

The boards should ensure that management refines its strategies and implements them

successfully (Neville, 2011). Traditionally, most non-profit organizations used external auditors to evaluate their performance. However, self-assessment is becoming more common (Ellis and Gregory, 2008). The logic models are commonly used by the non-profit organizations to measure and evaluate board performance. Logic models include the inputs, outputs and outcomes in service delivery (Carman and Fredericks, 2008). The determination of board evaluation is hinged on the type and independence of external facilitators and the timing of adoption of external board evaluation (Sobhan and Adegbite, 2021). The Public Entities Corporate Governance Act (Chapter 10:31), Section 25 elucidate that each member of the board for a public body should have a performance contract with the line ministry. In case of hospital management boards, the MOHCC is the line ministry for whom each board member of the hospital board is to have performance contract with the responsible Minister.

#### **4.10 CEO evaluation**

The Zimbabwe Code on Corporate Governance of 2014, Section 121 proffers that the CEO or managing director is mandated to execute the daily operations of the firm, hence some of the duties and functions might be delegated by the board. This entails that the CEO should have a performance contract or agreement which the board should evaluate on a periodic basis. Furthermore, the Public Entities Corporate Governance Act (Chapter 10:31), Section 23 provides that the CEO of public entities should undergo periodic performance reviews by the board for an aggregate period of ten years. The performance contract of the CEO and other senior executive officers should be specified and detailing the person's performance indicators which would be measured every six months by the board.

#### **4.11 The process of appointing hospital management boards**

The board is considered to be the link between the shareholders and monitor management. The board wield several responsibilities which include the controlling, strategic decision making, the advisory and resource mobilization (Madhani, 2017). The general assumption by policymakers is that decentralized health systems enhance service delivery through improvement in the authority, autonomy, accountability and community participation (Tolera et al., 2019). In the next four sub-sections, the aspects of appointment of the hospital management boards are discussed.

#### **4.11.1 The appointing authority for hospital management boards**

In practice, the owners or shareholders of the health care organizations have the mandate to appoint a governing board which is responsible for achievement of the entity's purpose for existence. Furthermore, the governing board has the mandate to appoint the senior management. Hence, the board has got the responsibility for setting the strategy and monitor performance whilst the senior management does the implementation of strategies (Stoelwinder, 2019). In most developing countries, the government is fundamentally assisted by the Ministry of Health, to keep its authority directly or indirectly, for instance on the recruitment, selection and appointment of board members for public hospitals (Geyndt, 2017).

In the case of Victoria Hospitals in Australia, the Minister of Health has the mandate to create an independent commission, which is the Board Appointments Advisory Commission. The Board Appointments Advisory Commission has the responsibility of ensuring that the appointment process and recruitment of board members for public hospitals and public health service boards are done based on appropriate skills mix to ensure board diversity (Duckett, 2017). A study conducted in Uganda with a focus on promoting proper accountability in the system of recruiting hospital managers revealed that boards in are appointed by the central government to monitor the functions of the hospital executive directors. However, there is dual supervisory role in that the Health Services Director for the District also supervises the hospital directors (Bakalikwira et al., 2017). In the case of Ghana, the appointment of board members in public hospitals is done in accordance with the Act 525 (1996). The appointment of board members or directors for public hospitals in Ghana is done by the Ghana Health Service Council. These three studies in Australia, Uganda and Ghana indicate the importance to have independent hospital boards with full mandate to monitor and evaluate the executive management of hospitals.

#### **4.11.2 Selection criteria for hospital board members**

The recruitment of public servants has been politicized and this has brought some challenges in issues of public administration. Most Latin American countries continue to recruit public

managers by way of political appointment with highly skewed discretion in the decision making. Therefore, there are no proper formal selection criteria except for age and formal education with a university degree requirement. It is imperative that the appointment occurs whether or not the position requires high level of technical or policy expertise. It was also noted that there are no formal performance agreements (Cortázar et al., 2016) which means that board assessment in this regard is not systematic or may not be carried out at all.

#### **4.11.3 Board diversity**

The general assumption is that, the greater inclusion of clinicians in governing and management roles has wide benefits to the efficiency and effectiveness of healthcare organizations. The study conducted on the engagement of clinicians suggested a possibility of bringing a wide range of benefits to the hospital. This is in terms of financial and operational performance, quality of healthcare provision and hospital social performance (Sarto and Veronesi, 2016).

Furthermore, a study that was conducted in Ghana revealed that there is a tendency of appointing more women in governing boards for not-for-profit hospitals. The appointment of more women on the boards of the for-profit and not-for-profit making hospitals was designed to attract the attention of donors and international partners which encourage women empowerment and gender diversity (Abor, 2017). Furthermore, in large hospitals board members with diversified background are appointed to the boards to enhance oversight of hospital operations in various units effectively and efficiently.

#### **4.11.4 CEO appointment in public hospitals**

In the Latin American countries, the recruitment of public managers hinges on political-based criteria. This is largely a way to reward those who would have participated on political campaigns and are needed to foster alignment of government policies to political agendas (Cortaza et al., 2016). However, the selection of the CEO is usually endorsed by the Board of Directors (Geyndt, 2017). In the case of the English National Health Services (NHS), the hospital boards in the individual public hospitals are given the mandate to appoint and reward individual CEOs in an autonomous fashion (Janke et al., 2019).

In the English NHS, the hospital boards use guidelines from the central government which is the regulator on making senior appointments, thus including the CEO. The board chairperson and the committee responsible for appointment, make use of private sector human resources consultants for the selection and appointment of the CEO. However, during the recruitment and selection of the CEO, the board chairperson and the committee have discretion to consult or include government representatives who are responsible for overseeing the NHS. The appointment of the CEO is based on their experience, which is either of leading private sector organizations or NHS organizations. Furthermore, the remuneration of the CEO is set by the board (Janke et al., 2019).

#### **4.12 Challenges encountered by hospital management boards**

Due to the ever-changing operating environment, financial sustainability and patient safety are paramount, but however the greatest hindrance is the high risk in service provision and unstable political environment (Chambers et al., 2017). There are number of challenges that hospital management boards face in carrying out their good corporate governance mandate. The challenges include financial, adherence to regulations, patient safety, patient experience, staff engagement, staff shortage, workforce capability and organizational viability (Smith et al., 2018). These challenges which the hospital boards face are categorized into organizational structure, work related, context related, leadership and human resources (Ghiasipour et al., 2017).

##### **4.12.1 Financial challenges in hospitals**

Financial resources is one of the major challenges that hospital managers face, both in public and private hospitals (Barati et al., 2016). In both the developed and low income countries, health financing is often below the expectations of the public and remains a matter of dissatisfaction among the citizens. In the case of Bangladesh, the inadequate financial support hinder the execution of various health care commitments which included primary health care services, universal emergency healthcare facilities and combating the rising cases of non-communicable diseases. The other commitments which could not be implemented were health insurance for the government employees and free-of-cost medical services for ultra poor, deprived and the disabled populations, thus the rise in treatment costs. Another financial related challenge hospital management often face is the inadequacy of allocation, inequity of

distribution and inefficiency of utilization of allotted funds in health (Fahim et al., 2019).

In a study that was conducted in Iran concentrated on leadership challenges that are met in hospitals, results revealed that the inadequacy of financial resources and its damaging effects on hospital activities, bonus and welfare facilities actually led to conflict of interests and operational malpractices in the health system. Furthermore, the inadequate financial resources resulted in unfavourable conditions and lack of equipment and accessories. All these tended to cause stress and conflict in the working environment (Ghiasipour et al., 2017).

#### **4.12.2 Staff shortage in hospitals**

The shortage of staff especially nurses and medical doctors is quite problematic in most hospitals and this leads to high workload of managers who end up with little time to adequately attend to all their responsibilities (Barate et al., 2016). In Iran, the shortage of human resources and its improper allocation became an obstacle in hospital management. Due to the rising workload and scarcity of the required staff, hospitals experienced an escalation in tensions and conflicts among management and staff. Furthermore, the increase in workload and staff shortage resulted in decrease in the opportunity to establish friendly relationships between subordinates and superiors (Ghiasipour et al., 2017). The shortage of human resources for health worldwide is an enormous challenge to both national and international health care systems (Figueroa et al., 2019).

In a study that was conducted at four regional hospitals in KwaZulu Natal Province in South Africa (2018), the results revealed that the shortage of critical health staff like doctors, nurses, allied therapists and other support staff who include drivers, cleaners, porters and security officers was causing an increasing workload, low staff morale and even negative attitude from existing staff (Govender et al., 2018). Strategies should be devised to close the critical staff shortage through initiatives such as training, coaching and other strategies for staff empowerment as part of capacity building in hospitals. Furthermore, the capacity building programme should cover leadership, management and staff in hospitals since some members lack the necessary skills and competencies required for the desired results (Govender et al., 2018).

#### **4.12.3 Organizational viability**

The autonomy in most public hospitals is not fully implemented, thus the implementation of management skills is highly compromised. This is because most of the instructions are issued from the top management and little comprehended at the lower levels of the organizational structure. There is lack of necessary authority in the role of hospital boards, hence limited congruence between authority and responsibility with accountability (Barati et al., 2016). In many countries, public hospitals significantly depend on public funds, hence the impact on the national or government budgets which explains difficulties normally experienced in hospital management (de Campos et al., 2017).

The general change in health care setting globally, increased incidences of chronic illnesses which in itself increases expectations coupled with cost escalations of health services. In an effort to address this situation, Egypt embarked on health system reform to maximize benefits to the citizens and overcome health care challenges in hospitals. In a study that was conducted in that country (Egypt) on the corporatization of public hospitals, the findings revealed that there is high percentage of poverty and the general population depends on government hospitals to get health care services. Hence, the transformation of public hospitals into revenue generating organizations affects accessibility for the poor in the country. Fundamentally, in responding to the financial challenges of the vulnerable, the Egyptian authorities established an insurance scheme that is designed to protect the poor against the commercialization of healthcare services (Abdelaleem et al., 2018).

The highest disease burden of 24% is being experienced in the Sub-Saharan Africa region. Due to the unresponsive, inefficient, inequitable and unsafe conditions, a study was undertaken in Northern Ethiopia's West Amhara public hospitals on motivation of healthcare employees. The results suggested that human resource factors hinder the provision of quality healthcare. Generally, the quality of health service greatly rely on motivation of health staff to offer better quality (Weldegebriel et al., 2016). Therefore, it is critical to note that the changes in the trend of disease burden require a well-motivated workforce to manage and enhance the quality of service provided in public hospitals.

The National Health Strategy for Zimbabwe (2016-2020), proffered that the public health

system financing was greatly reduced due to the general economic challenges. The available statistics revealed that in Zimbabwe, HIV/AIDS (54.41%), influenza and pneumonia (4.8%), tuberculosis (3.7%) and malaria (2.9%), hence the biggest hindrances bedevilling the health system. Hence, the economic setbacks that started in the late 1990s and was exacerbated in the hyperinflationary environment of the 2000s strained the public health system. The economic challenges resulted in a reduction in budgetary allocations for the public health systems. As a result, citizens are forced to rely on the out of pocket health expenditure to access health care services. Therefore, the government of Zimbabwe is now considering the private sector as an important partner towards efforts to increase access to health by the general population (Mugwagwa et al., 2017). Faced with these challenges, hospital management boards in Zimbabwe should devise strategies to satisfy the needs of various stakeholders and as well as to manage the high disease burden. Govender et al. (2018) suggested that hospital leaders should be transformational, embrace innovation and creativity as core competencies aimed at achieving strategic goals and objectives of the hospitals.

In a study that was conducted in four regional hospitals in South Africa (2018), the results revealed that the aging infrastructure and obsolete medical equipment in hospitals resulted in an increase in maintenance and refurbishment costs. It was noted that the situation hindered the health care delivery system in a number of ways. Furthermore, the continuous shortage of essential supplies in hospitals is yet another bottleneck to efficient and effective health care service delivery. Examples of hospital supplies that were reportedly often in short supply include medicines, drugs, syringes, linen and pharmaceuticals (Govender et al., 2018). The challenge of infrastructure requires urgent attention from relevant stakeholders. In fact, a functional hospital infrastructure in order to enable hospital leaders and managers to execute their duties and responsibilities efficiently and effectively.

#### **4.12.4 Adherence to regulations**

The policy inconsistency in terms of multiplicity of rules and regulations and frequent changes in such rules is a great challenge faced by hospital boards (Barati et al., 2016). In health system setting, there is a challenge in compliance with diversity in professional guidelines which are implemented concurrently. Furthermore, in terms of clinical guidelines, they need alignment to external demands, which have to be adhered to by both leaders and hospital managers. Examples of external demands in the health system include rules,

regulations, standards, norms and performance indicators. Fundamentally, hospital boards are responsible for compliance management. In the case of Dutch hospitals, hospital boards of directors have the mandate to ensure that all quality standards in a hospital are adopted and implemented correctly (Blume et al., 2017). Therefore, it is imperative that hospitals with hospital boards need a degree of autonomy, such that they can make independent decisions.

A study conducted in Dutch hospitals with a focus on hospital board members to establish levels of adherence to guidelines. The study results revealed that hospital boards have a mandate to adopt all quality standards, hence they have an oversight role to enforce adherence to guidelines by all professions within their respective hospital organizations. However, one of the respondents was quoted saying, “*The number of guidelines is so large that I do not dare to say that we are aware of all guidelines*”. Therefore, in the process of ensuring adherence, boards experience the challenge of organizing tasks for compliance within their organizations (Blume et al., 2016).

#### **4.12.5 Workforce capability in hospitals**

Due to the work-related issues, tensions involved and the trauma encountered, all these contribute to hospital management challenges. Some of the hospital staff may not cope well with continuous confrontation with unpredictable problems, quick decision making, professional risks associated with volume of work and life-saving duties. These challenges in health matters have led to the high sensitivity of hospital jobs and tensions associated with them (Ghiasipour et al., 2017).

Fundamentally, healthcare organizations require a multisectoral approach to leverage on various capabilities that foster the delivery of high quality care. There are problems associated with the system and organizational level, which disproportionately affect institutional leaders, middle and low level managers. The resultant effect of this scenario is an increase and often conflicting responsibilities among the hospital management. In some countries, the number of professionals with health background is ballooning, while there is a crisis in other countries (Figuroa et al., 2019). The global challenge of health management workforce evolves around demographic and epidemiological change, efficiency-saving, human resources management, changing structures, intensified management and shifting

roles and expectations. Therefore, it is against this background that in ensuring high quality health service delivery, it is crucial to hire health leaders and managers with acumen.

The study conducted at four KwaZulu-Natal regional hospitals in South Africa (2018) on the leadership examination with the aim of strengthening healthcare services offered revealed that the lack of health care worker capacity affects the achievement of health care outcomes. This was attributed to the fact that the skills and competencies of health care professionals are crucial for the enhancement of patient care (Govender et al, 2018).

#### **4.12.6 Patient safety**

According to the WHO Report (2004), the safety of the patient is sufficiently described as follows:

*“...a fundamental principle of patient care and critical component of quality management. Its improvement demands a complex systemwide effort, involving a broad range of actions in performance improvement, environmental safety and risk management, including infection control, safe use of medicines, equipment safety, safe clinical practice and safe environment care. It embraces nearly all health-care disciplines and actors, and thus requires a comprehensive, multifaceted approach to identifying and managing actual and potential risks to patient safety in individual services and finding broad long-term solutions for the system as a whole”* (Organization, 2019), p.9.

The hospital boards are increasingly being scrutinized and this has led to the management of patient safety as a great challenge in all health systems (Freeman et al., 2016). Therefore, effective hospital management at all levels is required to enhance or improve patient safety (Boamah et al., 2018).

It is important that professional bodies or organizations, foundations and the government through health ministries support efforts to change how clinicians are educated, creation of safe learning environment, integration of care, safety for healthcare workers, engagement of patients and their families at all levels of care and promote transparency (Gandhi et al., 2018). Furthermore, the active participation by patients is a priority in healthcare. The hospital boards and management should understand the patients' preferences and needs for care.

Therefore, it is critical to establish good relationship with various categories of patients. This can be achieved through sharing of information, being informed, possession of knowledge, taking part in discussions and decision making process, having a voice and participate in specific safety activities (Ringdal et al., 2017).

The hospital boards and management have the mandate to come up with policies and interventions on patient safety and implement policies respectively for the betterment of healthcare delivery. The patient safety interventions can be classified into three, thus system level interventions, organizational or institutional level interventions and clinical level interventions. Examples of system level interventions are safety standards, linked to accreditation and certification and mandatory reporting of adverse events. The organizational interventions include clinical governance systems and frameworks for safety, clinical incident reporting, integrated complaints reporting systems, human resources interventions and medical equipment sterilization guidelines or protocols. In addition, building a positive safety culture, infection detection and reporting and surveillance systems. The examples of clinical interventions include medication management, transcription of error minimization and procedural or surgical checklists (Slawomirski et al., 2018). In a study conducted which involved four hospitals boards in England on the enactment of corporate governance of healthcare safety and quality. The findings revealed that hospital board members faced challenges in terms of artefacts at their disposal and limitations associated with good board practices (Freeman et al., 2016).

#### **4.12.7 Patient experience**

In order to ensure quality improvement in hospitals, the hospital boards, through management and staff, should collect the views and experiences from patients. The views and experiences of patients should be highly considered on the agenda of hospital boards. In the case of a study that was conducted at 15 hospitals in England to assess the management of quality enhancement by hospital boards. The results revealed that board members held meetings with patient groups. One of the respondents who was the Director of Nursing was quoted saying,

*“We have something called a patient experience stakeholder forum which is a combination of staff, patients, governors and Health Watch, people who would have a whole view and then what we have been doing in feeding back to them. So they agreed our strategy, they have revised our plan of action because they didn't agree with the*

*focus and timing*” (Jones et al., 2017, p. 983).

The gaining of an in-depth understanding of patients’ satisfaction would enable a deeper knowledge of patients’ experiences, with the aim of improving service delivery. This can be achieved through the patient satisfaction surveys to include demographic questions and items in which patients report their experiences of care and of the facility (Rapport et al., 2019). The patient experience can be measured using the WHO Patient Responsiveness Survey measurement, which includes four pillars, namely communication, autonomy, dignity and confidentiality (Wang et al., 2019b). Fundamentally, the majority of health institutions are struggling to include patients in the decision-making and also learn from their experiences. The general consensus is anchored on the assumption that the greatest hub on patients’ information are the patients themselves, hence the need to pay attention to patient experience. Patient experience is concerned with the provision of feedback on the patients’ receiving of care and treatment. The feedback from patients experience is key in the provision of extraordinary quality medical service (Xie et al., 2019).

Many countries have incurred huge costs in an effort to facilitate data collection and dissemination of the results, health worker performance and patients’ experience. A study conducted in 11 high-income countries to analyse the public sector reporting on provider performance. The results revealed that England is the only country that complies with the publication of composite performance ratings on the quality of services rendered and patient safety by both public hospitals and general practitioners. Furthermore, not a single country amongst the 11 is reporting information of individual performance by individual general practitioners publicly and not a single country is intending to comply with the publication requirement. However, the entire 11 countries in the study are complying with the reporting of patients’ waiting times on treatment, which is aimed at increasing patient choice (Rechel et al., 2016).

#### **4.12.8 Staff engagement**

Prudently, hospital boards with a high quality improvement should engage and gather views and experiences of both staff and patients in the development of strategies. For this reason, staff welfare or well-being is highly noticeable on the boards’ agenda items. This can be

achieved through meeting staff and engage them through visits to other high performing hospitals. Another staff engagement is through the use of external networks like staff from regulatory bodies or agencies. In England, the culture of continuous quality improvement requires constant questioning and self-examination, in an effort to promote good corporate reputation and excellence. One of the respondents who was a board chairperson was quoted saying, “...we want to be the best out there” (Jones et al., 2017, p. 983). Furthermore, in the case of the England National Health Service, Swaminathan et al. (2016) revealed that there is positive relationship between higher levels of staff engagement and higher-quality services and better financial performance.

There is direct link pertaining to staff and patient satisfaction. In the case of a study that was conducted in India on employee engagement, the results suggested that the senior management play a significant part in the improvement of employee engagement. This finding suggests that it is fundamentally important to deploy strategies that are likely to bring positive change on the engagement of workforce. Therefore, there is need for constant engagement of employees and continuous modification of the existing conditions to achieve the highest level of engaged staff. The factors that enhance staff engagement include job, training and development opportunities. In addition, support from the team, supervisors, senior management and organization in general contribute to engaged staff (Swaminathan et al., 2016). It is critical for hospital boards and management to engage employees at all levels to have an appreciation of their needs or expectations in the achievement and improvement of quality health care.

#### **4.13 Strategies to enhance the functionality of hospital management boards**

Lillvis and Greer (2016) proposed that strategies to promote good governance by health policy makers can be classified into five categories. Thus, strategies for transparency, accountability, participation, integrity and policy capacity are vital to enhance the functionality of hospital management boards. Hospital management boards in Zimbabwe are mandated to formulate policies in their respective institutions to boost health care delivery in accordance with the Health Service Act (Chapter 15:16), Section 20 (2). Hence, it is critical and encouraged to embrace the strategy formulation based on the TAPIC framework discussed earlier.

#### **4.13.1 Strategies that enhance transparency by hospital management boards**

Transparency is when the public or citizenry is informed about the decision making process by the government or its agencies (Lillvis and Greer, 2016). In accordance with the United Nations definition, transparency is the accessibility to public information that is executed appropriately and consistently to enhance decision making and performance in the public (Armstrong, 2005). It should be noted that, in hospital governance, transparency and stakeholder participation are directly related to quality performance (Zehir et al., 2016).

##### **4.13.1.1 Board committees and inspectorates**

In accordance with the Health Service Act (Chapter 15:16), Second Schedule Paragraph 8, every hospital management board is obliged to create various committees that appropriately execute duties bestowed upon them by the board. Lillvis and Greer (2016) suggested the establishment of watchdog or inspectorate committees. The hospital boards can establish the internal audit or risk management committees which are most suitable for the purpose of establishing effective internal control systems.

A study that was conducted in Kenya on the examination of hospital autonomy suggested that there is need for the establishment of a legal framework to facilitate the formation of hospital management committees. The core function of such committees is to provide an oversight to hospital management and modalities to enhance community participation (Barasa et al., 2017). The governance systems should allow for advice, guidance and leadership at all levels with the ultimate aim of guaranteeing efficiency and effectiveness (Dwyer, 2019). The establishment of effective structures in public hospitals is very critical. This is because the governance of a health system should include determination of the policy making, strategic direction and goals, establishment of resources for strategic goals, formulation of rules and regulations. Furthermore, the governance should allow for monitoring and control mechanisms for achievement of strategic goals of a hospital (Jafari et al., 2019).

Public hospitals should have effective internal control mechanisms in the form of audit committees. The internal and external audits should be routinely conducted to ensure

preventive, detective and directive controls for the safety of patients. Furthermore, there is great need for effective and efficient utilization of resources (Dixit, 2017). The internal audit function is not confined to any particular function within an organization. In the Ugandan study to assess the internal audit function of 119 state owned enterprises, the findings revealed that both internal audits and corporate governance contribute positively to accountability in the management of statutory corporations. Furthermore, the results showed a close relationship between corporate governance and accountability (Tumwebaze et al., 2018). The establishment of an internal audit department in public bodies is in support of the suggestion by Lillvis and Greer (2016) that public sector entities must establish watchdog committees or inspectorates to detect and expose corruption.

#### ***4.13.1.2 Reporting system in public hospitals***

The reporting requirements in both public and private entities should be crafted with the intention of mandatorily facilitating information sharing (Lillvis and Greer, 2016). A study was conducted in Australia on the effect of public reporting on behavior change towards quality improvement. The study results indicated that there is need to strengthen public reporting of hospital performance data through multiple reinforcement strategies since reporting was quite limited in the country. The strategies include the engagement of clinicians and patients, improving timeliness reporting and improving communication of information so that it becomes accessible and meaningful to the diverse stakeholders (Canaway et al., 2018a).

The public reporting of hospital performance data is getting attention from a range of stakeholders, a study was conducted in Australia within the public and private health sectors. The results revealed that there is lack of agreement or consensus on the setting of objectives and stakeholders involved in the public reporting. This finding indicates that without clear understanding of the prevailing situation at a hospital, it becomes difficulty to devise ways of strengthening modalities and impacts of public reporting. Therefore, the involvement of all concerned stakeholders in the development of reporting frameworks highly commendable (Canaway et al., 2018b). Furthermore, in order to buttress the importance of reporting by hospital boards, a study was conducted in the 116 Dutch hospitals on guidelines adherence. The study results suggested that a variety of sources of information is used to keep informed

about the implementation process in hospitals. For example, conducting review meetings among peer medical specialists and special internal audits. Therefore, it is imperative that hospital boards of directors should be supported by input from all relevant and available guidelines to be able to organize adherence management (Blume et al., 2016).

#### **4.13.1.3 Performance-based measurement**

The concept is concerned with the regular assessment of program outcomes and the efficiency at which it was undertaken. The components of performance-based measurement include inputs, process, outputs, outcomes and impact (Hatry, 1999). The health governance system in Zimbabwe is very complex in that it brings in various interventions like preventive services, curative services, policy and planning. Hence, all performance interventions or activities that fall under the various programmes should be constantly monitored and evaluated to meet the set standards, goals and objectives of health care.

The government of Rwanda through the Ministry of Health engaged international accreditation experts who developed the national accreditation system. The accreditation system in Rwanda was adopted to meet the identified quality standard gaps in all its 43 district hospitals. The standards were affiliated with the national health sector priorities for assuring quality and safety. The accreditation standards focused on the leadership and accountability, competence and capable employees, safe operating environment for staff and clients, clinical care of patients and the improvement of quality and safety (Binagwaho et al., 2019).

The health services of Victoria, Australia were studied, to explore the impact of organizational quality systems on the quality care. The study discovered that health service boards were inadequately meeting their governance mandate to guarantee high-quality care. Additionally, the study revealed some clinical governance gaps between specified board and executive ambitions on quality and safety indicators. Confusion on quality system, limited staff engagement and over-reliance on compliance without innovation exacerbated the existing gaps on clinical governance. The five modalities were suggested to assist boards to close the governance gaps. The strategic modalities were holding CEOs accountable for pursuing consistently high quality care, ensuring board accountability on the provision of

high quality care, develop implementable and measurable strategy to actively pursue high quality care, actively monitor and respond proactively to quality strategy implementation and ensure effective quality system and appropriate culture to support strategy implementation (Leggat and Balding, 2019).

Moreso, to reinforce the need for hospital boards to strengthen performance initiatives, another study was conducted in China to analyse how the comprehensive performance of medical reforms is affected by the public hospital corporate governance structure. The study results suggested an improvement in the process of making decisions for public hospitals to ensure stakeholder participation, improvement in supervisory mechanisms through audit systems and enforcement of rules and regulations. Other aspects proffered for improvement were implementation of a transparent system of recruitment, reasonable assessment, salary and incentive modalities, to ensure segregation of duties for management and operation and strengthening of market competition (Xiong et al., 2018).

#### ***4.13.1.4 Access to public information***

In most health care systems, patients and other stakeholders are directly involved in decisions that have an effect to health services as part of strategies that boost the engagement drive. Lillvis and Greer (2016) proffered that public information efforts should be taken whenever there are policy changes and decisions. The stakeholder interaction can be in the form of general meetings, comprehensive annual reports and clarification on critical employees. Hence, hospital management boards ought to routinely engage citizens in order to gain media coverage. A study was conducted in three Flemish hospitals to evaluate the involvement of stakeholder committees in the internal decision-making processes for hospitals (Malfait et al., 2017). The stakeholder committee discussed 15 themes and 11 resulted in a considerable change. This implies that in a bid to inspire public answerability effectively, stakeholder involvement in hospitals' decision-making process is vital. Consequently, it should be noted that public payers could be the most important players in a world of comparative effectiveness. This is because of the large population covered and the amount of money spent (Rossiter, 2017). Moreover, it can be argued that public payers frequently set the payment rules for other private payers to follow. Therefore, the model of stakeholder committee is very vital in both operational level and decision-making process.

#### **4.14 Strategies that enhance accountability by hospital management boards**

Given the general understanding that accountability is a social relationship where parties concerned hold each answerable for their respective actions on a subject matter of common interest (Lillvis & Greer 2016; Stewart 1984). Therefore, it is imperative that strategies to improve accountability should focus on clarifications on stakeholder expectations and provide open lines of communication to report progress.

##### **4.14.1 Standards and codes of conduct**

Lillvis and Greer (2016) posit that standards and codes of conduct are concerned with the acceptable and intolerable behavior within an organization. Therefore, the established behaviors and expectations should be publicized in order to make deviant behavior more apparent and easier to address. The code of conduct provides the standards of conduct, principles of expressing responsibilities and the rules that apply to certain professions (Pozgar, 2019).

The code of conduct guidelines are key and this why they should be in every organization to address the unethical conduct. It has been observed that if academic, medical and research communities operate without the ethical code of conduct, individuals and institutes would get involved in unethical procedures which may result in unnecessary consequences. Therefore, the standards and codes of conduct are there to reinforce constructive behaviours and outline expectations that are relevant to members of staff in health institutions (Hardy, 2016). The governance of every entity should be able to provide confident and strong leadership, which leads to enhancement of accountability, oversight and assurance (Board, 2019).

##### **4.14.2 Conflict of interest policies**

According to Lillvis and Greer (2016), policies concerning the conflict of interest assist in ensuring that decision makers are not inspired by individual interest, but rather, to focus on organizational goals and the individuals being served. The reviewing of the conflict of interest policies should be done periodically in order to conceal all significant interests that can impede the individual or professional judgment.

Generally, conflict of interest is understood to mean a scenario where an individual or organizational decision making function might provide an unfair advantage or improperly benefit from decisions that are made. The benefit could be financial or non-financial (Besley et al., 2017). In this era, conflicts of interest are endemic and sometimes unavoidable because of the increasing social and economic challenges that affect many people in society. Against this backdrop, it can be argued that whilst they are problematic situations, they do not automatically constitute misconduct or breach of integrity. The conflict of interest in organizations should be managed through disclosure, education of staff, preventive measures and independent reviews. Therefore, it is important to manage conflict of interest in order to enhance professional ethics and personal integrity of health experts. This can be achieved through implementation of practical institutional governance mechanisms (Bélisle-Pipon et al., 2017).

In North America, many medical faculties have initiated the introduction of strict conflict of interest policies from the year 2010 onwards. This was in response to the 2009-2010 drug safety scandal that had been experienced. On this aspect, a study conducted in the French medical faculties which focused on 37 medical faculties found out that only 2 out of 37 had conflict of interest policies in their respective institutions. Furthermore, the 2 medical faculties had neither written documents nor publication on the medical faculties' websites. The delay in the establishment of the conflict of interest policies might be due to lack of action by the government or other bodies (Scheffer et al., 2017). This finding buttresses the notion that hospital management boards in public hospitals should come up with conflict of interest policies in their respective institutions. The conflict of interest policies should be both in written and electronic form and all board members should be aware of the policy. It is actually encouraged that the organizational conflict of interest policies be uploaded onto the institutional website for the benefit of internal and external stakeholders.

#### **4.14.3 Competitive bidding**

The competitive bidding is done to enhance competition among providers of goods or services, hence this can lead to lowering of costs and quality service. The competitive bidding process should have checks and balances or segregation of duties at all stages. The evaluation of tender documents should be conducted objectively before development of a contractual

agreement to finalize the relationship (Lillvis and Greer, 2016).

The Public Procurement and Disposal of Public Assets Act (Chapter 22:23) is the guiding document for all purchases conducted by public entities in Zimbabwe. The procurement methods which can be implemented by the procuring entities are stated in Section 30 of the Act, thus competitive bidding, restricted bidding, direct procurement, request for quotations and request for proposals. The terms and conditions for competitive bidding method are as stated in Section 31 of the Act. The bidding document is published or circulated in the widely read newspaper, internet or institutional website. Furthermore, all suitable bidders are acceptable regardless of any segregatory modalities on the submission of bids, hence the assessment is done in accordance with the set criteria. It should be noted that the bidding period, bidding documents, opening of bids, the consideration of opened bids, the evaluation of tenders and the contract award should follow provisions of the Act.

On the notion of bidding, a study was conducted in Kenya to ascertain the impact of procurement procedures on the performance of public hospitals. From the study results, it was recommended that the public hospitals should adopt best procurement practices by public health care entities for the enhancement of their performance. The study further revealed that hospitals review their procurement policies on supplier selection frequently which ensures quality of supplies (Oloo and Muturi, 2017). It is against this background that, the implementation of better procurement practices in public hospitals would lead to improved quality of health service provision to members of the public who form the bulk of tax payers. Thus, it can be seen that hospital management boards should put in place mechanisms that strengthen the procurement process in their respective institutions as a governance effort to minimize fraud, corruption and other procurement malpractices.

#### **4.14.4 Contracts**

The contracts are designed to bolster third parties in the achievement of efficient service delivery. The providers of goods and services ought to be guided by prototypes that are standard in the entire government departments for use in crafting contracts (Lillvis and Greer, 2016). In the case of public hospitals, they can design or adopt their contract forms or templates with pointers on performance of obligations.

In Lebanon, the Ministry of Public Health pursued modifications in hospitals' contracting system to encourage stakeholder involvement and participative governance in policy making. The contracting reform system adopted three committees, which are the Utilization Review Committee, Admission Criteria Committee and the Performance Contracting Committee. The adoption of the new mixed-model hospital contracting model has improved hospital contracting, better collaboration and informed new Ministry of Public Health policy (Khalife et al., 2017).

On the same subject matter of contracts, hospitals in Brazil were assessed on the outsourcing and dismantling of steady jobs at hospitals. The study results revealed that most of the hospital functions were being outsourced to various subcontractors who included medical specialists, pediatrics, exam sectors of examinations, radiologists, the blood bank, the pathology laboratories, cleaning and kitchen or catering services. Furthermore, approximately 90% of the medical doctors are on temporary contracts and for the nursing services approximately 54% of the staff were hired for a certain duration (Souza and Mendes, 2016). The contracts to be entered into by hospital management should be earmarked in achieving the desired goals and objectives of the institutions, hence conflict of interest should be eliminated. Contracts have to follow procedures in terms of sourcing, approval, implementation, monitoring and evaluation in order to enhance healthcare service delivery. Failure by the subcontracted companies, firms or individuals to achieve the needs and expectations of all relevant stakeholders would obviously harm the image of the hospital, hospital management board and the executive management.

#### **4.14.5 Privatization or corporatization of hospital services**

On another dimension, privatization or corporatization is another approach that might be adopted to strengthen efficiency in the public health sector. The concept of privatization is concerned with the limitation, reduction of direct government economic activities and functions (Oflaz, 2016). The notion of privatization or corporatization of public enterprises to enhance organizational performance is an essential tenet of the new public management concept or administration (Lindlbauer et al., 2015).

Another study to evaluate privatization was conducted in Pakistan, which is in the category of developing countries with over-reliance on private sponsors, non-governmental benefactors and international donors for its health services delivery (Reading, 2010). The results indicated that while privatization serves its citizens, it has some shortfalls. It was argued that the privatization model should take into consideration greater government involvement, and therefore the healthcare provision in developing countries should be pursued cautiously. In the case of central hospitals, hospital management boards can do partial privatization of some departments, services, patient wards or cubicles.

#### **4.14.6 Performance-based financing mechanism**

The performance-based financing has been implemented successfully in a number of countries with the objective of transforming the health system and improving maternal and child health (Shen et al., 2017). On another dimension, the financial mechanism is a model of pay-for-performance or performance based payment system which is adopted by government institutions through contracting third parties. The payment is done based on meeting the agreed targets (Lillvis and Greer, 2016).

In the case of Zambia, the performance based financing was implemented to address health workers' gratification, impetus and attrition. The study results revealed that there was a substantial positive shift in job satisfaction, a slump in attrition and however there was little effect on staff motivation (Shen et al., 2017). In order to buttress the effect of performance based financing, another study that was conducted in Cambodia to examine the utilization of the performance based financing model in an endeavor to address primary health employees' job satisfaction. The study results revealed that there was high job motivation and the promotion of a capability, offering community service and creation of job worthiness (Khim, 2016).

In another study that was conducted in Burkina Faso to explore healthcare employees' preferences for performance based incentives, the study results suggested that the majority of health workers preferred both financial incentives and team based incentives. This finding suggests that it is ideal that health workers and other relevant authorities ensure involvement in the designing of an appropriate incentive arrangement (Ye et al., 2016). To support the

notion that the performance-based financing is key in meeting the set targets in the health sector programmes, Zimbabwe implemented the model with the intention of staff retention of low-paid health care employees through the voluntary medical male circumcision programme. From the study findings, it can be seen that the performance-based financing increased motivation among the voluntary medical male circumcision teams and improved service provision at the facilities where the services were provided. The performance-based financing model enabled the rapid increase in programme scale up and achievement of set targets (Feldacker et al., 2017).

#### **4.14.7 Organizational separation**

Hood (1991) views organizational separation as the disaggregation of government units, whereby each unit focuses on a particular service or product. This ultimately assists in the establishment of clear roles and responsibilities for employees in various departments. The organizational separation is embedded in the internal control system.

The organizational separation as part of internal control system is designed as a system of financial controls and other management controls which strengthen the conduct of business desirably and efficiently. This helps to ensure adherence to management policies, safeguarding the assets and secure the completeness and accuracy of the records (Iyinomen and Nkechi, 2016).

Hospital management boards have the responsibility of enhancing departmental performance through the creation of competition. This can be achieved through the offering of awards to the best performing departments and other staff incentives. Furthermore, it might be prudent to create platforms for exchange programmes with other best performing departments in other institutions as part of continuous learning, continuous quality improvement and best practices. Healthcare providers, governments and professional bodies can make use of quality improvement strategies to enhance quality and safety of health care (McKenzie et al., 2017). In healthcare management, quality improvement outcome to both health worker and leadership are a result of the use of regulatory and performance methods. This can be achieved through conduct of staff meetings on regular intervals to expose possible challenges, constant reviews of performance and supporting the concept of continuous quality development (Silver et al., 2016).

#### **4.15 Strategies that enhance stakeholder participation**

In terms of the participation concept, those affected by the policies made should have access to the decision-making process and feel empowered to have their voice heard. The empowerment drive might involve directly reaching out to the citizenry, establishment of representative groups to convey the feedback and collaboration with other entities that offer services to similar clientele (Lillvis and Greer, 2016). According to the MOHCC Patient's Charter of Zimbabwe, it is the right of patients to partake in the decision making and have adequate information and consent on issues that affect their health. Therefore, hospital management boards should foster strategies or mechanisms that bolster stakeholder participation the various levels.

##### **4.15.1 Client or patient satisfaction surveys by hospital management boards**

The patient satisfaction survey plays a significant part in the aspects of healing and emotional well-being of patients (Marama et al., 2018). Furthermore, surveys on client satisfaction are important in evaluating the quality of the healthcare processes and assist hospital management to improve service delivery through the development of appropriate strategies (Shumba et al., 2017). The client survey is an evaluation tool to obtain feedback from the constituents who are involved in or affected by government decisions or policy changes. The surveys can be developed in-house or an organization can engage the services of a management consultancy firm for client survey assistance. Furthermore, a survey can be administered through the internet, mail, phone or face-to-face (Lillvis and Greer, 2016).

The quality of care is anchored on patient experience, clinical effectiveness and patient safety. A study conducted in Pakistan on the client satisfaction survey discovered that the overall satisfaction survey was 77%, dissatisfied clients rate was 13% whilst those who were uncertain was 10%. The study results revealed a positive correlation between value, honour and quality care given to a patient and the satisfaction derived by a patient (Hussain et al., 2017).

The client satisfaction in health service delivery is vital in increasing utilization of women for institutional based delivery and improve quality of health care, which is aimed at reducing

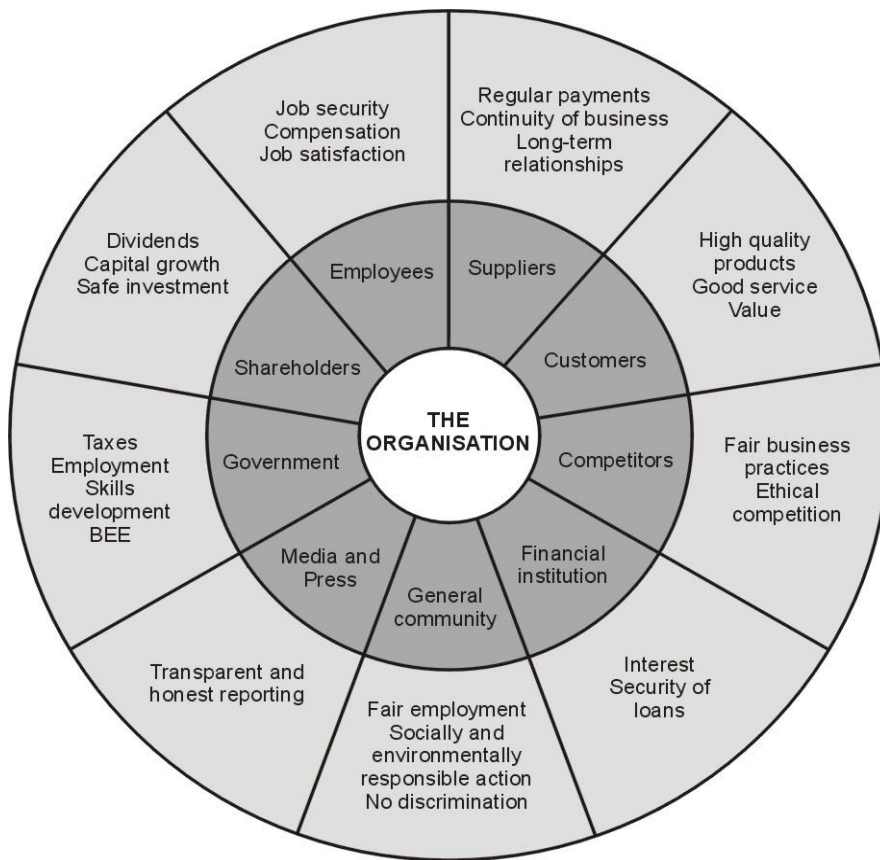
maternal mortality and morbidity (Tesfaye et al., 2016). Generally, the increase in the health care consumption is brought about by an increase in awareness on health care service. A study in Ethiopia conducted with the aim to assess the clients' satisfaction and associated factors among adults revealed that most clients were dissatisfied with the out-patient services offered. The patient satisfaction was low at 47%. Various problems were discovered which included lack of clean toilet in nearby waiting areas, lack of waiting area, inadequate furniture, shortage of drugs and supplies. Other problems found were lack of privacy in examination rooms, lack of direction signs and poor communication between the clients and staff (Berehe et al., 2018). This finding points to the fact that it is imperative that the hospital management should improve service provision in order to meet clients' expectations. The performance of a hospital management board is measured based on the extent to which patients' needs and expectations are met. In this regard, client satisfaction surveys are crucial as they help to enhance devising of strategies that foster quality health care provision.

#### **4.15.2 Stakeholder forums**

This is a forum that is designed to obtain feedback or to interface with stakeholders who have stake or vested interests in the organization's programmes and policies. Decision making process should involve stakeholder engagement, with a focus on ensuring effectiveness, multidirectional, meaningful and equity for both stakeholders and guideline developers (Petkovic et al., 2020). This should be a two way communication where suggestions or views would come from the representatives of the organization and on another dimension from the organization's stakeholders or clients (Lillvis and Greer, 2016).

The effectiveness and performance of a business leader is measured or identified through the ability to satisfy the needs and wants of its divergent and conflicting interested parties, on sustainable basis (Ehlers et al., 2010). The claims and expectations of stakeholders are depicted in Table 5 below:

Table 5 : Claims and Expectations of Stakeholders



Source: Cronje and Maritz (2010), Strategic Management, p.59

It can be concluded that stakeholders are interested parties and individuals who can influence or are influenced in terms of businesses or organizations' actions and that their needs and expectations are uniquely varied. It is therefore incumbent upon business leaders to ensure that unique and various needs of stakeholders are satisfied on sustainable basis. Stakeholder forces are likely to impact negatively on the organizational going concern concept, but government intermediation is necessary to bring harmonious working atmosphere in such circumstances. Notwithstanding, it should be noted that stakeholder pressure is necessary because without it, industries may self-regulate in self-saving ways (Barnett et al., 2018). The analysis suggests that collaboration between business, government and stakeholders is necessary to solve the obvious problems of sustainability in any organization.

#### 4.15.3 Advisory committees

According to Lillvis and Greer (2016), the advisory committee is there to advance constant

interface between an organization and the clients being served. The committee should be established based on the broad representation across the diverse stakeholder interests. In the case of hospital management boards, there is need to establish the various board committees which would focus on the needs and expectations of the hospital stakeholders like patients, government, community leadership, representatives from relevant professional bodies and others. However, it should be noted that the advisory boards have no legal oversight responsibility for financial and other corporate operations. They are established to provide input on patient and community relations (Calderwood Jr, 2016). It is imperative that large not-for-profit organizations like central hospitals should establish the advisory boards which would offer advice to both the management and fiduciary board of the respective hospital. In the long run, this would strengthen the performance of hospital management boards since they are kept abreast with the needs and expectations of its important stakeholders.

#### **4.15.4 Partnering with other organizations**

Partnerships with other organizations can be in the form of partnering with citizen groups, non-governmental organizations or the private sector entities that offer similar services (Lillvis and Greer, 2016). Assessments should be done prior to partnering with other organizations, in order to identify the benefits to be derived or any potential risks associated with the partnership arrangement. In line with WHO Guidelines (2010), partnership arrangement should be formalized through the memorandum of understanding (MOU). The MOU should include components such as the vision and programmatic activities of partners, goals of the collaboration, the resources assigned by each partner, duration of the MOU and the plan for review and optional renewal of the MOU.

The Public-Private-Partnership (PPP) is a model used in alleviating risk of investment in the health sector. The successful implementation of the PPP enhances the achievement of higher efficiency levels and harnesses the skills and experiences of the private sector for quality improvement (Barzegar et al., 2016). In addition to that, Kosycarz et al. (2019) proffered that the PPPs model is widely used by governments to limit their costs and increase investment in health care sector. The involvement of consumers in the delivery of health services is highly encouraged in many countries. In fact, studies have shown that consumer partnerships bring benefits like service planning, innovation and quality improvement (Farmer et al., 2018).

A study was undertaken in Poland to assess implementation of the PPPs in the health sector. The study results revealed that the health care system in Poland is very complex but at the same time, there are several opportunities in the health sector which require collaboration between public and private sector. One such an opportunity found is the joint shareholding by public and private partners in hospital operations. In an effort to develop workable PPPs, a number of barriers were encountered which included short-term contracts with public players and low level of financing for health care services by the government. It was further revealed that for PPPs to be successful in Poland, there was need for stable legal and economic conditions, allocation of risk, enough experience from both partners, use of reputable and competent private partners, sufficient initial capital and consistence in contract terms (Kosycarz et al., 2019).

In an effort to enhance the provision of health to individuals, communities, employers, and policymakers, the United States of America government has adopted the strategy of cross-sector collaboration through the involvement of community members, businesses, education sector, human service organizations, social services and public health specialists (Lyda-McDonald, 2019). It is imperative that, hospital management boards should strive to network with various stakeholders who would offer assistance or partnership of any form to strengthen the health service delivery.

#### **4.16 Strategies that enhance the integrity of hospital management boards**

The creation of reasonable expectations about the roles and responsibilities of an organization brings about its integrity to the society. The integrity of an organization is built through the strengthening of policies on financial, personnel and administrative issues. On the other hand, integrity may fail or get damaged due to engagement into irrelevant activities, sudden ending of certain programmes or policy inconsistencies (Lillvis and Greer, 2016). Therefore, hospital management boards should engage in activities or programmes that assist in building the reputation or integrity of their respective institutions.

##### **4.16.1 Internal audits**

The public sector hospitals should enhance risk assurance through various mechanisms such as periodic managerial and board committee reports, external and internal audits. The internal

audits of clinical areas should be conducted by independent internal auditors and the findings reported to the internal audit committee (Brown et al., 2015). Fundamentally, hospital management boards should ensure routine conduct of internal audits. This ultimately assist an organization to better understand the status of an organization in terms of financial management, operations, programme implementation, human resources management and other mechanisms that have an effect on hospital operations.

The internal audits should follow a sequence that involve the preparation, execution, reporting, developing and implementing an improvement plan and then follow or track the audit findings. The internal audit results should meet certain conditions for them to be of great value to the audited institutions. The conditions involve the execution of an audit by an independent and experienced audit team. The audited activities should be specific to the risks of patient care and the audited information should meet the standards and norms of the audited staff. In addition, sufficient tools should be provided to perform issues raised by the audit, the hospital board should ensure compliance with improvement measures and to ensure that audit contribute to quality improvement of health care services (Hanskamp-Sebregts et al., 2020).

A study conducted in Dutch hospitals to evaluate organization's internal audit function and its effectiveness in guaranteeing patient safety indicated that internal audits are considered effective governance mechanisms for patient safety. Therefore, it is incumbent that hospital boards are assisted through internal audits to detect challenges associated with the safety of patients, bolster patient safety and then offer assurance for patient safety. The internal audits further assist hospital boards with structured, standardized, formal and periodic reviews of quality and safety problems (van Gelderen et al., 2017). So strategically, hospital boards use matters raised in internal audits to improve the health care service provision.

#### **4.16.2 Budgeting**

A budget is a tool that provides a sense of direction in the financial management of an organization and with this understanding, it is vital that every entity that collects or receives and spends funds should have a budget (Arthur, 2016). Lillvis and Greer (2016) postulate that, a budget enhances the integrity of a hospital and in this regard, the hospital budget should cover one fiscal year, detailing the revenue and expenditure for the period. Therefore,

there should be wide consultation or participation by all organizational departments and interested parties.

Budgeting is a critical exercise, hence every hospital regardless of size and complexity relies on budgeting to forecast and establish predetermined goals, report on actual performance and evaluate performance. In order to buttress the importance of budgeting in the performance of an organization, a study was conducted at Kenyatta National Hospital in Kenya to assess the effect of budgetary process on budget performance. The study results revealed that budgetary participation, budgetary control and budgetary reports positively affect the budget performance of the hospital. Therefore, it was against this background that a recommendation was proffered in that, staff engagement is key during the crafting of the budget for the hospital. Furthermore, budget reports should be periodically prepared to strengthen clear communication channels on budget performance (Kamau et al., 2017).

Health managers and administrators are obliged to come up with planning mechanisms that co-ordinate and facilitate control of activities. This is achieved through budgetary control mechanisms. The budget guide results in efficiency in the management of incomes and eliminate expenditures which do not address the core objective of quality health service delivery, hence budgets should be linked to organizational goals and objectives (Arthur, 2016). The budgeting process should take into consideration various stages for it to be comprehensive as depicted in Table 6 below:-

Table 6 : Hospital budgeting process

Budgeting process	Activities
Communication of organizational objectives	-Liaise with all departments with the hospital set up -Responsible officers should communicate the overall objectives of budgeting
Identification of budget limiting factors	-Management should identify any challenges that might affect the budgeting process and devise strategies to counter such hindrances
Ascertain the initial budget	-Relevant departments should prioritize their plans and come up with reasonable budgets/proposals
Budget negotiation	-Management and budget committees discuss, compromise and reach a consensus on budgets through involvement of various departments
Budget acceptance	-This stage involves consultations and reviewing of the budgets in accordance with the organizational workplan. Estimates of revenues and expenditures are considered before final approval and dissemination to implementing departments
Budget implementation	-The implementation of budgets is done in tandem with the set objectives/goals of the departments and hospitals
Budget review	-Periodic monitoring and review of budgets should be undertaken during the budget year to identify any variances, hence corrective action is taken
Budget evaluation	-Budget evaluation is done through monitoring and reviewing of budgets by comparing actual outcomes versus targets

Source: Arthur (2016, p.70-73)

It is prudent that hospital management boards should enforce the crafting of hospital budgets putting into consideration the interests of various departments with the respective institutions and other stakeholders. The relevant committee of the board should spearhead the budgeting process, so the hospital management board is kept informed of the process and outcomes.

#### 4.16.3 Financial audits

The financial audits in a hospital are conducted routinely with the aim of conveying an independent judgment on the organization's financial statements. The audit ought to establish if the financial documents are prepared in compliance with the professional rules and the generally accepted accounting policies and standards (Raymond and Désiré, 2019). The financial audits of an organization should be conducted by an independent audit firm, with the aim of reviewing all the organization's revenues, expenditures, equipment and financial investments. The assessment should focus on the reconciliation of accounts and management of assets in terms of depreciation requirements. It is key to note that, the conducting of

financial audits work should be in collaboration with budgets to ensure transparency (Lillvis and Greer, 2016).

In accordance with the provisions of the Health Service Act (Chapter 15:16) and the Public Finance Management Act (Chapter 22:19), the hospital management boards have the mandate to prepare the financial statements. The financial reports ought to be compiled monthly, quarterly and annually through the director of finance. The financial statements ought to be examined by the Auditor-General annually.

#### **4.16.4 Hospital board operating procedures**

The hospital board procedures are an important factor in ensuring the integrity of a hospital. Fundamentally, hospital board provide guidance on the decision making process of the organization, hence board members are prone to either tarnish or build the reputation of the institution. Therefore, this means that hospital management boards should develop or adopt procedures that guide the behavior of their members. The procedures should be in written form with clear stating of the frequency of meetings, quorum, termination of membership of the board, conflict of interest declarations, orientation of new members and other issues that are pertinent to the smooth operations of the board (Lillvis and Greer, 2016).

### **4.17 Strategies that enhance policy capacity for hospital management boards**

Policy capacity is a key determinant of the extent to which policy actors are capable of addressing the public problems (Wu et al., 2015). Pointer and Pierre (2005), buttressed the definition of policy capacity as the utilization of necessary organizational resources in order to make intelligent collective choices. From this definition, it is clear that setting strategic directions and allocate scarce resources to fulfill public demands it's a key function of policies in an organization. It should be noted that, policy capacity combines the skills and resources at organizational level and skills and capabilities at individual level, which combined collectively enable the performance of policy functions (Gleeson et al., 2009).

#### **4.17.1 Forecasting**

Forecasting is an effective tool that can be used to decide future demand, scheduling of staff

in tandem with future workload and stocking of inventory required for future stock requirements. Hence, forecasting is key in the achievement of effective and efficient planning of an organization. The forecast can be short-term, medium-term and long-term (Hyndman and Athanasopoulos, 2018). Therefore, hospital managers and leaders can use forecasting to predict the future as accurately as possible, through the use of available information. The information that aid forecasting includes data from past events and intelligence on any future undertakings that might impact on the projections.

Hospital management should gather intelligence on performance, thus the identification of possible challenges and opportunities and the consequences associated. The intelligence gathering and analysis assist hospital management and leadership to forecast costs and benefits that an organization is likely to face and this enables it to be prepared to devise counter strategies. The likelihood scenarios might arise due to strikes, natural disasters, government policies and economic challenges, which have an effect on internal resources and public need (Lillvis and Greer, 2016). The intelligence on hospital performance enables strong policy leadership by both hospital management and hospital boards in that decision-making would be based on relevant and reliable information.

#### **4.17.2 Staff recruitment and retention in health care systems**

The concept of recruitment is concerned with the attraction and selection of staff to an organization or role, whilst retention is the length of time between commencement and termination of employment. Therefore, in practice, good recruitment procedures is a pre-requisite for retention of staff (Humphreys et al., 2017). The hospital managers and leaders should develop staff recruitment strategies that provide the organization with the necessary skills and competencies that would bolster the implementation of programmes and services successfully (Lillvis and Greer, 2016).

WHO Report (2009), proposed that health workers can be retained through modalities like monetary compensation which can be direct or indirect, education and regulatory incentives and other non-monetary benefits including management support, good working environment and social support. The retention of health workers in the health care sector is very critical and this is why staff retention is significantly considered than hiring. Health care

organizations can hire knowledgeable employees for the job, but it essential to develop and implement strategies to retain the best employees (Peggy et al., 2016).

On this aspect of staff retention, a study conducted in public hospitals of Mombasa County in Kenya, revealed that recruitment strategies have a positive effect on organizational performance. This finding clearly shows that organizational performance depends largely on recruitment strategies (Peggy and Bernard, 2016). The recruitment strategies that were proffered include the following as depicted in Table 7 below:

Table 7 : Recruitment strategies in public hospitals

Recruitment strategies	Action plan
Hospital plan to avert staff shortage	<ul style="list-style-type: none"> <li>- Make staff bids</li> <li>-Review the establishment to meet the current demand in workload</li> <li>-Retaining strategies in current workforce through staff incentives</li> <li>- Advocate for more trainings to close the staff shortage gap</li> </ul>
Actively address shortage of nurses and doctors	<ul style="list-style-type: none"> <li>-Create database for prospective employees</li> <li>-Promptly seek replacements</li> <li>-Seek treasury concurrences promptly</li> </ul>
Selection and employment of suitable cadres	<ul style="list-style-type: none"> <li>- Seek replacements through adverts</li> <li>- Headhunting of specialized personnel</li> </ul>
Carefully consider skills and competencies	<ul style="list-style-type: none"> <li>-Conduct interviews</li> <li>-On job or in-house trainings and refresher courses</li> </ul>

Source: Peggy and Bernard (2016, p.43)

#### 4.17.3 Research and analysis capacity

The hospital management boards should re-invigorate the research and analysis capacity in their respective institutions. According to Lillvis and Greer (2016), in order to strengthen the research and analysis capacity of hospitals, it is prudent that the hospital managers and leaders have to engage staff with acumen and be associated to renowned research institutes for ongoing advice. The hospital staff needs to be capacitated in fields such as epidemiology, communication, health education and promotion. In an effort to develop research capacity, health care systems need to invest and plan strategies that foster research in their respective

institutions. In the UK, research is considered as a core function which is planned through research and development strategies. The initiatives in the UK health service organizations are aimed at promoting research activity and research capacity development for sustainable improvement of health care services (Gee and Cooke, 2018).

The enhancement or building of research capacity among health care professionals might be in three levels which include, the foundation skills in using research, participating in research and leading in research. Therefore, it is incumbent to all levels of leadership and management to create an enabling environment and support a research culture in their organizations. With a sustained research culture and practice, the organization is able to generate new knowledge and opportunities whose evidence for decision-making or policymaking. In this regard, a systematic review of frameworks for capacity building on all health professions was conducted. The study results revealed that in order to achieve research capacity and analysis in hospitals, there is need to support clinicians or health professionals in research, working together as a team in research and value research for excellence (Matus et al., 2018).

#### **4.17.4 Decentralization and autonomous capacity of hospital boards**

The other strategy to enhance board effectiveness and performance is through decentralization. In order to enhance the quality and efficiency of hospitals in low income countries, the adoption of the decentralization approach through the launch of hospital governing boards has been considered desirable (McNatt et al., 2014). The literature reviewed indicated that studies conducted to date on the subject emphasized significantly on scrutinizing the decentralization process, but not much has been documented on implementation of decentralization with regards to hospital governance.

A study was conducted in Kenya to examine the association between hospital board functioning and hospital performance. The results revealed that hospitals with greater management standards met had governing boards that paid members and reviewed performance periodically. Furthermore, new revenue generating models were developed, subcontracting of services, reviewing of patients' complaints and expert members in both business and financial management are some of the positives witnessed in certain hospitals. In particular, results proffered that the hospital performance might be boosted due to the

strengthening of governing boards to perform essential financial and operational functions. However, to some extent decentralization face some limitations in its implementation. This was highlighted in the case when operations to control tropical diseases were decentralized in Tanzania (Mubyazi et al., 2004). During the survey, interviews and discussions were held with key informants and the results revealed that the concept of devolution was not fully implemented since district activities were being managed adhering to national and international plans and not based on local ones. The financial management aspects, planning of activities and authorizations were largely not practical but rather theoretical in at operational level.

Whenever reforms are undertaken, politicians and policy makers have argued that the new system remedies have fundamental flaws in the old, but sometimes the reforms appear to introduce further unintended consequences that they themselves require remedy (Martin and Carter, 2017). Like with other areas of health policy, reform is often anchored on changing ideas about good public governance, how best to motivate public servants and respond to the preferences of citizens and communities (Le Grand, 1997). However, it should be noted that there is no consensus in the case of involvement, simply because the rationale behind involving citizens, consumers, patients, users and others in the health care decision making are also varied.

#### **4.17.5 Transformational leadership by hospital boards**

In a bid to achieve a thriving and sustainable health service delivery system, there is need to engage health care leaders who possess transformational capabilities. Hence, an effective leader should possess a blend of intelligence, personality traits and management style (McDonagh et al., 2014). On transformational strategy, a study conducted in Czech Republic (2009-2012) to explore the successful implementation of corporate governance tenets in hospitals. The transformation model involved the disbursement of funds to hospitals in respect of the subsidies generated through the health insurance scheme. The contribution was a response to effectiveness of corporate governance to the direct fiscal injection and indirectly on health system for the entire country (Pirozek et al., 2015). The methodology involved a sample of 100 hospitals that was investigated in 2009 immediately after the transformation had been completed and then three years later in 2012. The results on the concept of

corporate governance statistically proved that transformation of hospital management boards enhanced efficiency in hospital management which was reinforced by such factors like the size of the hospital, the size of the supervisory board and medical experts among the senior managers. This implied that the model can be implemented in the formulation of health policies for the entire country.

Generally, the prevalent conjecture across health systems suggest that extensive benefits from the efficiency and effectiveness of hospitals can be derived due to the greater clinicians' contribution in governance and management functions (Sarto and Veronesi, 2016). The study was conducted through a Boolean search strategy from ISI Web of Science citation and search source. The study concentrated on renowned management and public sector governance journals. The results indicated that, the clinical leadership contributed immensely to the financial and social outcome of health institution, with only a few cases highlighting negative impact. Furthermore, due to the growing interest of policy makers and practitioners on the involvement of clinicians in governance and management of health care organizations, the results have suggested that greater clinician participation at the strategic decision making level potentially has a wide range of benefits for the hospitals. The results from a study conducted on the health sector in the UK National Health Service also supports the clinical participation on hospital governing boards, with a view that it significantly improves the patient experience of the care provided (Veronesi et al., 2013, Veronesi et al., 2014) (Veronesi et al., 2015).

#### **4.18 Chapter summary**

In this chapter, the researcher selected analyzed relevant literature, in order to achieve the objectives of this study as outlined in Chapter One. Overall, the literature reviewed focused on good healthcare governance principles in relation to the performance of hospital management boards. Specifically, on the various components health care governance were covered which include models, governing structures and strategies that enhance the performance of hospital boards. Good healthcare governance practices are well articulated through the scrutiny of the current systems and the possible implementation arrangements or systems. It became clear that the majority of organizations in the private sector are at an advanced stage in implementing good governance practices, while the public sector entities

are at basic practice governance level.

The next chapter details strategies, examines and provides the research methodology used in this study. Also, the justification of the selected methodology is discussed in tandem with the aforesaid reviewed literature in this chapter.

## **CHAPTER FIVE**

### **RESEARCH DESIGN AND RESEARCH METHODS**

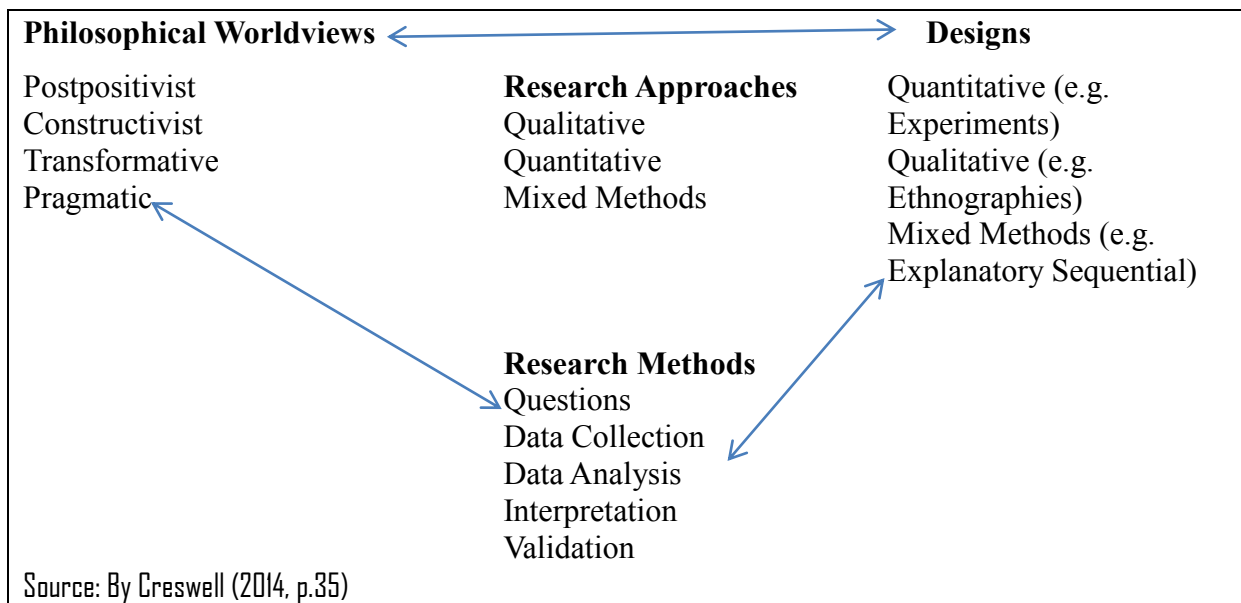
#### **5.1 Introduction**

The previous chapter was a review of literature on good health care governance principles in relation to the performance of hospital management boards. The current chapter provides an outline of the selected research methodology study and explanation for the study detailing the data collection and analysis. Obviously, description for the methodology employed is crucial as it informs similar studies in the future. Thus, the chapter covers justification for the research paradigm, research approaches, study population, study sample and data collection tools used. In the chapter, the discussion on how the methodology addressed the research questions and ethical issues considered in the study. The reliability and validity of data collection was also discussed.

#### **5.2 Philosophical paradigms**

Despite the fact that philosophical notions remain mainly concealed underneath research (Slife and Williams, 1995), the research practice is influenced and which make it imperative to identify them. The philosophical notions are called paradigms by other scholars (Lincoln, Lynham and Guba, 2011; Mertens, 2010). The different philosophical paradigms in research are shown in Figure 1 below:

Figure 1: Philosophical Paradigms



As extensively discussed in Creswell (2014), philosophical paradigms are constructive, positivism, transformative and pragmatism. Positivist worldview holds the view that causes determines the outcome and the knowledge developed through positivist is based on measurement of the objective and researchers use validity and reliability tests to eliminate bias.

Constructivist worldview believes that individuals develop subjective meanings from the study participants and the researcher interprets the meanings about the world through interactive discussion rather than starting with a theory. Subsequently, transformative view does research inquiry that is entangled with politics and change program that address social issues (Creswell, 2014).

A pragmatic paradigm is more concerned about what works and solutions to problems and pragmatic researchers emphasize the research approach that uses different approaches to understand the problem (Creswell, 2014). The pragmatic paradigm was considered in the current study hence the adoption of the mixed methodology approach.

### 5.3 Research design

The study used a mixed methods approach which combines qualitative and quantitative

research approaches to collect data was used and the rationale being that the issues of governance practice required quantification and understanding of experiential issues within the contextual dynamics of Zimbabwe. Qualitative data does not have predetermined responses hence is open-ended whilst quantitative data is usually associated with closed-ended responses that are provided on questionnaires and psychological instruments (Creswell, 2014).

### **5.3.1 Qualitative research method**

The core attributes of the qualitative research approach are specific to the approach or method. The major characteristics include the natural setting of the study which includes various sources of data, researcher being the key instrument and logical data analysis (Creswell, 2013; Marshall and Rossman, 2011). The data collection in qualitative research designs is anchored on interviews (Adhabi and Anozie, 2017). In this study, the researcher is the key instrument and made use of interview guides as the main instruments.

The researcher used interviews to complement data collected through structured questionnaires. Most respondents feel uncomfortable to express their feelings in writing, hence prefer interviews. In practise, interviews entice participants to express their feelings, insights and expectations (Morgan, 2016). The conducting of interviews was done after the administration of questionnaires, in order to make further clarifications on certain issues which could not fit into quantitative data collection method. Thus, interviews were conducted to address all open-ended questions of the study. Interviews can be conducted through direct interface with respondents, telephone conversations, focus group discussions or other electronic channels like email, internet and Skype interview (Creswell, 2013). For this study qualitative interviews were done through direct or face-to-face for accurate capturing of interview notes and recordings through voice recorder by the researcher. During interviews the researcher has direct contact with participants when collecting data (Rahman, 2017).

Accordingly, Creswell (2014) and buttressed by Morgan (2016) posit that interviews have various advantages and some disadvantages which are as follows:

#### **Advantages**

- Provision of historical information by participants,

- The researcher can regulate the interview process , thus making it more flexible and allowing opportunity for clear understanding of the question, deviation, clarification and expansion of responses,
- Controlled by the interviewer through interjection where necessary,
- Mixed framework on analysis,
- The interview can be conducted through use of telephone, face-to-face, messenger and email,
- Useful when participants cannot be directly observed.

### **Disadvantages**

- Response bias might be experienced,
- Face-to-face interviews might be very costly,
- Require a long time to accomplish,
- Failure to articulate, small proportion handling, challenges in accomplishing appointments and need expertise in good interviewing (Creswell, 2004: Creswell, 2013: Singleton and Straits, 2010: Morgan, 2016). In this study CEOs and chairpersons in all the six central hospitals of Zimbabwe constituted the respondents to the interview schedules.

Table 8 : Respondent's identification

Respondent's number	Respondent's details
CEO 1	Chief Executive Officer 1
CEO 2	Chief Executive Officer 2
CEO 3	Chief Executive Officer 3
CEO 4	Chief Executive Officer 4
CEO 5	Chief Executive Officer 5
CEO 6	Chief Executive Officer 6
Board Chair 1	Board Chairperson 1
Board Chair 2	Board Chairperson 2
Board Chair 3	Board Chairperson 3
Board Chair 4	Board Chairperson 4

Source, Field Data (2019)

Table 8 above denotes the respondent's identification details as used in the study.

### 5.3.2 Quantitative research method

The quantitative approach measures the relations between and among variables. It can be achieved through answering hypotheses and questions through conducting surveys and experiments on closed-ended questions. The statistical data generated provides measures or observations which can be used to test a theory (Creswell, 2014). The meaningful interpretation of data can be drawn from the statistical data provided. The study instruments used were structured questionnaires and interview schedules, designed in English language. The researcher developed a standardized questionnaire with closed-ended questions and was personally administered with the assistance of the Board Chairperson or Secretary during board meetings to ensure high response rate and quick turnaround time.

In this study, questionnaires and interview guides were the data gathering methods used in addressing the outlined objectives in Chapter One. Therefore, blend of data gathering methods was preferred as it allowed the researcher to take a broader and complementary view of the research problem. Thus, the approach adopted triangulation of data sources which sought congruence amongst qualitative and quantitative methods (Jick, 1979). Triangulation is a data collection approach that promotes social change, eliminate bias, add depth to data

collected and enhance saturation through use of multiple sources of data (Fusch et al., 2018). The author further indicated that triangulation is a technique which allows for the use of different data collection methods within the study, hence overcoming potential bias or weakness of a single method approach.

The study was conducted to enhance theory building guided by the interpretivism research philosophy. The resultant theory from the study is expected to be adopted and implemented by policymakers as is characteristic of research outcomes (Becker et al., 2012). The standardization and strengthening of the functionality of hospital management boards was established through investigation of the current governance system and processes in central hospitals studied. Furthermore the research methods utilized, allowed for determining challenges encountered and views on how hospital boards' effectiveness could be strengthened.

A self-administered questionnaire is sometimes referred to as self-completion questionnaire. This entails that respondents answer questions by completing the questionnaire themselves. The self-administered questionnaire can come in different forms, but the most common one are the postal or mail questionnaire (Bryman, 2016). Accordingly, Bryman propounds that a self-administered questionnaire tend to have the following characteristics:

- Fewer open-ended questions since closed-ended questions are easy to answer,
- Easy to follow instructions to minimize the risk of misunderstanding of the instructions by the respondent,
- Be shorter in order to reduce the likelihood of fatigue by the respondent.

Furthermore, Bryman (2016) suggested the following advantages and disadvantages of using the structured questionnaires:

### **Advantages**

- Cheaper to administer because interviewing can be expensive,
- Quicker to administer: Can be administered through postal or email and in large quantities at the same time,
- No interviewer variability: Do not suffer from the interviewer asking questions in a different order or in different ways,

- Convenience for respondent: Respondents can complete the questionnaire when they want and at the speed they want as well.

### **Disadvantages**

- Cannot prompt: No one present to help respondents if having difficulty in answering questions,
- Cannot probe: There is no opportunity to probe respondent to provide an appropriate answer,
- Cannot ask questions that are not salient to the respondents,
- Difficulty of asking other kinds of questions,
- Greater risk of missing data,
- Cannot collect additional data,
- Lower response rate if not well managed,
- Do not know who answers: Can never be sure if the right person has answered the questionnaire.

In this study, there were three parts in the questionnaire, namely:

**Section A:** Characteristic information, which provides information about hospitals and its board members

**Section B:** Identification and examination of good hospital management practices

**Section C:** Dealt with the examination of hospital board performance

The Likert scale is the sum of responses to several Likert items displayed. Accordingly, the “Likert scale is simply one based on forced-choice questions, where a statement is made and the respondent then indicates the degree of agreement or disagreement with the statement on a 5 or 7 point scale” (Brooke, 1996). Bryman (2012) further supports that the Likert item is a statement that the respondent is asked to evaluate in a survey. It is one of the most common techniques for measuring beliefs, opinions and attitudes. In this study, the Likert scale was in the format of 1-5, thus:

1. Not important
2. Not sure
3. Moderately important

4. Important
5. Very important

The use of the Likert scale improved the results of the study, because it measured the degree of agreement on a wider scale rather than the use of responses like Yes or No. In this study, 54 board members constituted respondents to the structured questionnaires, thus 18 executive and 36 non-executive board members.

#### **5.4 Study population and data source**

As already pointed out earlier, a total of six central hospital management boards were studied with each comprising seven non-executive and four executive board members. In other words, 42 and 24 non-executive and executive board members respectively constituted the population at central hospital level, this being 66 study contributors. The common aspect of the study participants in this category is that they are responsible for ensuring good governance practice in their respective central hospitals in the country. To consider commonality is the most important determinant to select a population in a given study as propounded by Cooper and Schindler (2010).

The data source is composed of three (3) central hospitals in the Northern Region and the other three (3) in the Southern Region and all state-owned.

#### **5.5 Sampling and sampling technique**

The sampling process involves the selection of representatives from the study population to be part of the study, hence the characteristics or parameters signifying the whole population (Cooper and Schindler, 2010). The sample selection of research participants was drawn from Parirenyatwa Group of Hospitals, Harare and Chitungwiza Central Hospitals in the Northern Region and United Bulawayo Hospitals, Mpilo and Inguthseni Central Hospitals in the Southern Region. Furthermore, for quantitative data all the six central hospitals were included.

The purposive sampling was employed for the collection of qualitative data from the six executive boards. Purposive sampling for qualitative component of the study with sample size of 12 (6 Board Chairperson and 6 CEOs) was chosen because of their role in decision making (Creswell, 2014 and Sekaran and Bougie, 2013).

Random sampling for quantitative component, sample size was 63. In this study all the 54 participants were selected after considering the 12 under purposive sampling, determined using sample size tables guidelines by Fowler (2009) , Krejcie and Morgan (1970) and Sekaran and Bougie (2013) with 95% confidence interval level and  $\pm 5\%$  margin of error. Size determination using tables was used due to known finite population.

## **5.6 Data collection technique**

All the six central hospitals in Zimbabwe were visited in the process of data collection. The chairpersons and the CEOs were the key informants for interviews which were conducted and questionnaires were administered to all the other hospital board members and the executive managers during the period January to June 2019. Face-to-face interviews were conducted on the 9 out of 10 (90%) respondents, since the majority were not willing to respond through electronic media citing lack of internet connectivity. Only 1(10%) respondent who was outside the country on private business was interviewed through Skype.

The questionnaires were distributed physically to the boards' secretaries to facilitate further administration to the respondents during board meetings. The administration of questionnaires to board members was done during the period January to June 2019. Data was captured directly into SPSS version 25 for quantitative data, while for qualitative data interviews were conducted in respective institutions or workplaces across the two regions and results from the 10 members were either recorded using the voice recorder or manually captured on the interview schedule. Data from the interviews was transcribed using transcribing software and then captured in the NVivo software for analysis.

## **5.7 Procedure for data collection**

### **5.7.1 Ministry of Health and Child Care permission to**

## **conduct a study**

The researcher wrote a letter to the Secretary for MOHCC seeking permission to carry out a study in the six central hospitals. The request was accompanied by approval communication from the UKZN Graduate School of Business and Leadership, Higher Degrees and Research. Accordingly, permission was granted through the Permanent Secretary for MOHCC for the researcher to conduct the study.

### **5.7.2 The pilot study**

This is a small study that is conducted in testing the research protocols, data collection instruments, strategies to recruit the sample and study techniques that can be adopted for the larger study (Hassan et al., 2006). This is an important stage in the research process to allow for identification of possible hindrances and shortfalls on the integrity of research instruments prior to full implementation of the study.

On this aspect of a pilot study, Hassan and others (2006) contended that a pilot study has the following benefits:

- Determination of the achievability of the study procedure and identify flaws in a study,
- Test study instruments,
- Use the interview techniques and self-completed questionnaires to test for data collection appropriateness,
- Approximation of time taken to complete the questionnaire and participants' willingness in the study,
- Testing for appropriateness of data entry, statistical tests and coding

In this study, a questionnaire was randomly distributed in June 2017 to 5 people at Harare Central Hospital (thus 4 executive board members and 1 non-executive) to test the suitability of questionnaire. The pilot study also provided construct and face validity of the study questionnaire. On completion of the pilot-testing of the questionnaire, certain adjustments were made to the set of questions and format.

## 5.8 Reliability and validity

Medical educators attempt to create reliable and valid tests and questionnaires in order to enhance the accuracy of their assessment and evaluations. Fundamentally, validity and reliability are two fundamental elements in the evaluation of a measurement instrument (Tavakol and Dennick, 2011). Validity is a measure of what a questionnaire is supposed to measure and reliability is a data issue concerned with the ability of an instrument to measure what it is supposed to measure consistently. It is important to note that reliability of an instrument is closely linked with its validity.

In this study, face-to-face interviews were conducted on the 9 research participants. For the 10<sup>th</sup> respondent, an interview was conducted through Skype. Saturation on interviews was achieved. A voice recorder was utilized during interview sessions and transferred to the computer for safe keeping and storage. Furthermore, all interviews were done in English making it easier for the researcher in terms of data capturing, processing and analysis.

### Challenges encountered

- Time limitation by some respondents was a major challenge, hence scheduling of sessions was considered.
- Travelling expenses highly increased due to tight schedules by some respondents especially in the Sothern Region.
- Huge accommodation and subsistence costs were incurred during visits to some institutions.

#### 5.8.1 Cronbach's alpha test

The Cronbach's Alpha is a measure of the internal consistency or reliability items, which could be questions, rates or indicators that form a scale in a questionnaire. Accordingly, Sekaran and Bougie (2009), Cronbach Alpha is a reliability coefficient that indicates how well items in a set are positively correlated to one another. In this study, the questionnaire was subjected to reliability tests using the Cronbach's Alpha to determine its appropriateness. The purpose of testing using the Cronbach's Alpha was to identify data which is unreliable as

collected by the questionnaire and such questions can be eliminated. In testing the reliability of the questionnaire, the table below provides the interpretation criteria. For qualitative purposes, reliability should be conducted through documenting procedures, detailed protocol and database, checking of transcripts for errors and consistency in coding (Gibbs, 2007 cited in Creswell, 2014).

Table 9: Interpretation of Cronbach's Alpha Model

No	Description of Measures	Expected Outcome
1	For a value above 0.8	Reliability is considered good
2	For a value between 0.6 and 0.8	Reliability is considered acceptable
3	For a value below 0.6	Reliability is considered unacceptable

Source: De Souza & Dick (2009)

For any research to be valid, it must conform to certain tests or measures. Yin (2003) posits that any study should conform to and pass the following design tests:

- Construct validity: Establishing the correct operational measures for the concepts being studied,
- Internal validity: Establishing a causal relationship whereby certain conditions are shown to lead to other conditions,
- External validity: Establishing the domain to which a study's findings can be generalized,
- Reliability: Demonstrating that the operations of the study or data collection can be repeated with the same result.

In qualitative research, validity of data is greatly affected by the researcher bias which may arise from selective collection and recording of data. Validity can also be difficult to achieve due to interpretation which might be based on personal perspective or opinion. In order to minimize some of the challenges that might compromise on data validity, triangulation can be implemented. Babbie and Rubin (2007:106) supported the concept of triangulation to overcome challenges of researcher bias. Triangulation forms an important part in data validation process. In this study, both qualitative and quantitative methods were used to collect data in order to improve validity of data.

Yin (2003:46) further argued that qualitative and quantitative methods should be viewed as complementary rather than rivalry camps. This is buttressed by Creswell (2014) who also suggested the notion that validity can be achieved through triangulation, bias clarification, time and member checking. In this study, board chairperson and CEOs were asked the same questions which were open, probing and closed ended. Furthermore, the structured questionnaire was in English which is the official language in the hospital management system.

## **5.9 Data analysis**

The data from the field was analysed through use of SPSS software Version 25, thus coming up with univariate, bivariate and multivariate analysis tables for example the descriptive and inferential statistics. Furthermore, the use of analysis software resulted in the formulation of several statistical tables that assist in the analysis and interpretation of the data collected for instance the frequency tables, correlation matrices and principal component analysis.

The NVivo software Version 12 was used to analyse data collected from the interviews conducted. Data was coded and entered in a bid to come up with themes that assist in the analysis and interpretation. Thematic and not content analysis was used to analyse the data.

## **5.10 Ethical considerations**

Ethics in research practice are generally understood to be a set of doctrines that guide appropriate conduct throughout the research process. Business research ethics are based on two philosophical standpoints, the deontology and teleology. In deontological evaluation, individual behaviours are compared with predetermined norms or beliefs. Examples of beliefs are product safety, confidentiality of data and respondent anonymity. In contrast, the teleological evaluation is focused on the perceived consequences of each alternative to various stakeholders. In other words, the probability of occurrence to each stakeholder, importance of each stakeholder and the ultimate desirability or undesirability of each consequence. Generally, both the identity and importance of stakeholder groups often vary across individuals and situations (Nill et al., 2015).

On the same subject of ethics, Creswell (2013) posits that, the study respondents' desires, values, rights and needs ought to be respected by the researcher. This shows that there are

certain issues to which the researcher should be aware of before, during and after the research has been conducted. Some of the ethical issues for researchers' consideration are the informed consent, harm and risk, honest and trust, privacy, confidentiality and anonymity, intervention and advocacy (Miles et al., 1994).

In this study, the informed consent forms and ethical clearance approval from the UKZN adhered to the University of KwaZulu-Natal Human and Social Sciences Research Ethics Committee Guidelines which ensure that:

- Participation is completely voluntary,
- Informed consent: research participants are fully informed about the risks and procedures involved,
- No harm to human participants: participants are not placed in any position that may result in physical or psychological harm,
- Confidentiality and privacy: the participant's confidentiality is insured and information obtained from the individual is not made available to anyone who is not directly involved in the study.

The researcher adhered to the Human and Social Research Ethics Committee terms of reference and standard operating procedures of 2014.

## **5.11 Chapter summary**

This chapter provided an overview of the research methodology, which the researcher used to collect and analyze data. The main aspects presented in the chapter include the philosophical paradigm and justification, study population, sample and the sampling procedure, data collection instruments used and data collection procedures. The validity and reliability of research instruments and ethical issues in the study were also discussed. The research questionnaire and interview instrument were used to collect data from both the executive and non-executive directors in all the six central hospitals.

The next chapter provides an analysis of data collected from the respondents through the questionnaire and interviews. In the data analysis outputs are presented through use of tables, graphs, figures, charts and other applicable forms.

## CHAPTER SIX

### DATA ANALYSIS AND PRESENTATION OF FINDINGS

#### 6.1 Introduction

In chapter one, the research objectives were articulated and the pivotal focus was the standardization and strengthening the performance of hospital management boards in central hospitals of Zimbabwe. In an effort to achieve the study objectives he, the researcher used a questionnaire and interview instrument to collect data following the research methodology discussed in Chapter Five. Creswell (2009) asserts that data analysis is very critical in any research since it helps to make conclusions and generalization of findings to problem statement identified. This chapter is designated to the analysis and presentation of the study finding gathered through structured questionnaire and interview instrument. Data analysis for qualitative component was transcribed, coded into themes and exported to NVivo Version 12 to generate themes for thematic analysis and interpretation, a process extensively discussed in McQueen and Namey (2012), Flick (2014) and Paulus et al (2014). For quantitative data, this was carefully captured in SPSS Version 25 and analysis ensued to generate descriptive and inferential statistics.

#### 6.2 Response rate

Mouton (2001) argues that a response rate of 50% is adequate for analysis and reporting, 60% is good and 70% is very good. In this study, the researcher distributed 66 questionnaires during the period January to June 2019 to target all executive and non-executive board members. For quantitative data the response rate was 35 out of 54, giving a 64.81% response rate. For qualitative data the target was 12 of which 10 responded, giving an 83.33% response rate.

#### 6.3 Characteristic descriptive analysis

The characteristic data section provides both demographic information and relevant information about the study participants regarding age, sex, level of education, profession and

the duration the participants have been with their respective organizations.

The Cronbach Alpha test was conducted on the research questionnaire as depicted in Table 10 below.

Table 10 : Cronbach's Alpha Test

Reliability Statistics	
Cronbach's Alpha	N of Items
.716	33

From Table 10 above the Cronbach's alpha is **0.716**, which indicates a high level of internal consistency of the analyzed data in the questionnaire. Therefore, according to De Souza and Dick (2009) the reliability of the questionnaire at 0.716 was acceptable, hence, the data collection instrument was considered sufficient to address the research objectives.

Table 11: Number of respondents by hospital

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Harare Central Hospital	7	20.0	20.0	20.0
	Chitungwiza Central Hospital	3	8.6	8.6	28.6
	Parirenyatwa Group of Hospitals	6	17.1	17.1	45.7
	United Bulawayo Hospital	3	8.6	8.6	54.3
	Mpilo Central Hospital	8	22.9	22.9	77.1
	Ingutsheni Central Hospital	8	22.9	22.9	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

The analysis in Table 11 above provides information on the representativeness of the 35 respondents on the research questionnaires administered. Ingutsheni and Mpilo central hospitals had the highest number of respondents, thus 8 (22.9%) contribution each, Harare central hospital 7 (20.0%), Parirenyatwa Group of Hospitals 6 (17.1%), Chitungwiza central hospital and United Bulawayo hospitals 3 (8.6%) contribution each.

The contribution of respondents by region was southern region 19 (54.3%) and northern

region 16 (45.7%). On gender most of the hospital boards are male dominated with 29 (82.9%) while female 6 (17.1%).

The majority of board members are in the age range of 44 to 56, thus 22 (62.9%), followed by 12 (34.3%) in the age group of 57 years and above whilst the least number of respondents by age group was in the range 31 to 43 being represented by 1 (2.9%).

The analysis in Table 12 below reveals that the highest number of board members have been members of hospital boards for at least one year as represented by 8 (22.9%). Furthermore, it is also clear that 7 (20.0%) have been in the board for 4 years, 3 (8.6%) for 5 years and another 3 (8.6%) for 10 years. The other 2 (5.7%) have been in the hospital board for 3 years. Board members who set in boards for at least 4 years and some months, 11 years, 16 years and 37 years are represented by one member (2.9%) each. It is also noted that 8 (22.9%) are board members who did not disclose the duration of their stay in hospital boards.

Table 12 : Number of years as board member

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	8	22.9	22.9	22.9
	3	2	5.7	5.7	28.6
	4	7	20.0	20.0	48.6
	5	3	8.6	8.6	57.1
	10	3	8.6	8.6	65.7
	11	1	2.9	2.9	68.6
	16	1	2.9	2.9	71.4
	37	1	2.9	2.9	74.3
	4	1	2.9	2.9	77.1
	N/A	8	22.9	22.9	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

In terms of the level of education 33 (94.3%) had postgraduate degrees, 2 (2.9%) with either college certificate or diploma and technical certificate or diploma respectively. The board members' professional mix is indicated in the Table 13 below:

Table 13 : Board Members' Profession

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Medical	15	42.9	42.9	42.9
	Administration	9	25.7	25.7	68.6
	Legal	2	5.7	5.7	74.3
	Accounting or Finance	7	20.0	20.0	94.3
	Other, please specify	2	5.7	5.7	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

The data shown in Table 13 above depicts that the professional background for board members were represented by medical 15 (42.9%), administration 9 (25.7%), accounting and finance 7 (20.0%), while legal and other professions has a representation of 2 (5.7%) each. The two board members are in the field of consultancy and banking respectively.

## 6.4 DATA ANALYSIS

### 6.4.1 Introduction

The set of questions are sub divided into two broad sections, thus hospital governance practices and hospital board performance. Furthermore, data was also collected through use of interview schedules with a set of open ended questions. The responses and data analysis generated are aimed at achieving the goals of the research objectives.

### 6.4.2 Standard functional structures of hospital management boards in central hospitals of Zimbabwe

The effectiveness of hospital management boards is anchored on the functional structures and various performance indicators. In terms of the stakeholder perspective, the effectiveness of boards are more likely to address the interest of both the shareholders and the rest of the organization's stakeholders (Garcia-Torea et al., 2016). The functional structures of hospital management boards have to be responsive to the desire for good corporate governance practices.

#### 6.4.2.1 *Number of board members*

The study found 10 (83.33%) respondents representing 6 central hospitals. Out of the 10, it emerged that 8 (80%) respondents, representing 4 (66.67%) central hospitals, expressed that their boards had seven members including the CEO. Furthermore, the 2 (20%) respondents from the 2 (33.33%) central hospitals without functional hospital management boards have proffered that a board should have seven members including the CEO in compliance with the Health Service Act (Chapter 15 :16). This entails that the non-executive board members are supposed to be six, since the CEO is part of the hospital executive management. The other three executive directors who comprise the finance director, operations director and clinical director are ex officio and only co-opted as and when they are required to provide technical information and/or advice.

#### 6.4.2.2 *Board committees and composition*

The creation of board sub-committees has been strongly suggested as an appropriate tool for improving corporate governance. As discussed in the literature, this can be achieved through the delegation of specific duties of the main board to a smaller group to allow for the gathering of contributions from non-executive directors (Spira and Bender, 2004).

Table 14: Number of board committees per institution

How many governance committees are there in your organization?		Attributes										
		Central Hospital						Region		Number of Years as board member		
Number of governance committees in an organization?	Number of interview participants who mentioned the same	UBH	MP	HRE	PARI	CHT	INGU	N	S	1 - 5	More than 5 years	
Five	1						✓		✓	✓		
Four	3		✓	✓	✓			✓✓	✓	✓✓✓		

Source, Field Data (2019)

Table 14 above depicts that out of the four central hospitals with hospital management



The inclusion of executive management in board sub-committees were echoed by the CEO 4 who said that, “The committees include the executive and the non-executive members. So in this case while my directors are not board members they are then incorporated into those committees for example the clinical director is involved in the clinical committee, the operations director is also included in the operations committee, the finance director is also included in the finance committee, but the audit committee has no one in the executive but what they do is they then invite the internal auditor to come and make presentations” (CEO 4).

Table 15: Names of board committees by institution

State the name of each committee, composition of each and the number of non-executive and executive director		Attributes									
		Central Hospital						Region		Number of Years as board member	
Name of Committees and composition	Number of interview participants who mentioned the same	UBH	MP	HRE	PARI	CHT	INGU	N	S	1 - 5	More than 5
		Operations and human Resource	5	✓	✓	✓	✓		✓	✓✓	✓✓✓
Financial and Audit	4	✓		✓	✓		✓	✓	✓✓✓	✓✓	✓✓
Clinical Audit	5	✓	✓	✓	✓		✓	✓✓	✓✓✓	✓✓✓	✓✓
Risk Management	3		✓	✓	✓			✓✓	✓	✓✓	✓
Housing and Amenities	1			✓				✓		✓	

Source, Field Data (2019)

Table 15 above denotes that UBH and Ingutsheni have the operations and human resources, clinical audit as well as the finance audit committees. Mpilo has got operations and human resources, clinical, risk management and the finance and audit committees. Harare has operations and human resources, clinical audit, risk management, housing and amenities as

well as the finance and audit committees. Parirenyatwa has got the operations and human resources, clinical audit, risk management as well as the financial and audit committees.

**Table 16 : Rating of board committees mentioned by respondents**

Word	Length	Count	Weighted Percentage (%)
Clinical Audit	8	22	4.93
Internal Audit	5	20	4.48
Finance	7	20	4.48
Operations	10	8	1.79
Human Resources	5	7	1.57
Technical	9	7	1.57
Fundraising	11	6	1.35
Social Amenities	9	3	0.67
Housing	7	3	0.67
Risk Management	4	3	0.67

Source, Field Data (2019)

The analysis in Table 16 highlighted 10 sub-committees that exist in different health institutions. The committees that exist in different hospitals are the clinical audit, internal audit, finance, operations, human resources, technical, fundraising, social amenities, housing and risk management. They were ranked according to the number of responses obtained under each committee. The committee that was mentioned most frequently is the clinical audit committee (4.93%) whilst the least are the social amenities (0.67%), housing (0.67%) and risk management (0.67%).

### **6.4.2.3 Number of years as a board member**

The term of office can be defined as the duration or length of time the person occupies an office as a leader in an organization (Fujianti, 2018). The hospital management board's terms of office vary according to institutions. Some board members and CEOs have served in hospital boards for longer terms of up to 17 years, whilst others have been with respective institutions for shorter periods of at least one year. It is possible that long tenure can help the CEO to develop a high reputation, thus leading to greater commitment to the company (Sittihpongpanich and Polsiri, 2015). However, the term limits on board service are crucial

in keeping boards fresh and effective (Shalev and Prodan, 2018).

Table 17 : Duration as board member and board's term of office

<b>Respondent</b>	<b>Duration as board member</b>	<b>Board member's term of office</b>
Board Chair 1	3 years	3 years and renewable
Board Chair 2	4 years	2 years and renewable
Board Chair 3	Since July 2018	3 years and renewable
Board Chair 4	Since 2015	5 years and renewable
CEO 1	1 year and 6 months	2 years and renewable
CEO 2	12 years	3 years and renewable
CEO 3	17 years	3 years and renewable
CEO 4	3 years	3 years and renewable
CEO 5	1 year	3 years and renewable
CEO 6	5 years	No response

Source, Field Data (2019)

The analysis in Table 17 above entails that the highest number of years served as a board member is 17 years whilst the least number of years is 10 months (since July 2018). The highest number of responses out of 10 was 6 (60%) who proffered that the board's term of office is 3 years and renewable, whilst 2 (20%) mentioned 2 years and renewable and only 1 (10%) mentioned the board's term to be 5 years and renewable. CEO 6, thus 1 (10%) did not respond.

Table 18 : Years of experience as board member

<b>Years of Experience</b>	<b>Number of Respondents (n=9)</b>	<b>Percentage Responses (%)</b>
Less than 6 years	7	77.78
6 – 10 years	0	0.00
10 years and above	2	22.22

Source, Field Data (2019)

The analysis in Table 18 above indicates in terms of experience, out of the 9 boards members who responded, 7 (77.78%) served in hospital boards for less than 6 years whilst 2 (22.22%) had served in hospital boards for more than 10 years. The board members' experience as a CEO or a general manager, industry specific experience, international experience of running

similar organizations and the level of academic achievement have positive moderating effect on the performance of an organization (Sivakumar et al., 2017).

#### **6.4.2.4      *Alignment of organizational goals with those of its stakeholders***

The stakeholders of an organization include all those who are in and affected by the organization and operation of the project group (Levitt et al., 2019). The internal stakeholders include financial agents, stockholders, managers, employees and contractual partners, whilst external stakeholders include all those groups and individuals that can affect or are affected by the accomplishment of the firm's organizational purpose. The affected groups include project or program partners, government regulators, consumers, affected communities and interested associations (Freeman, 1984).

Table 19: Alignment of organizational goals with stakeholder expectations by institution

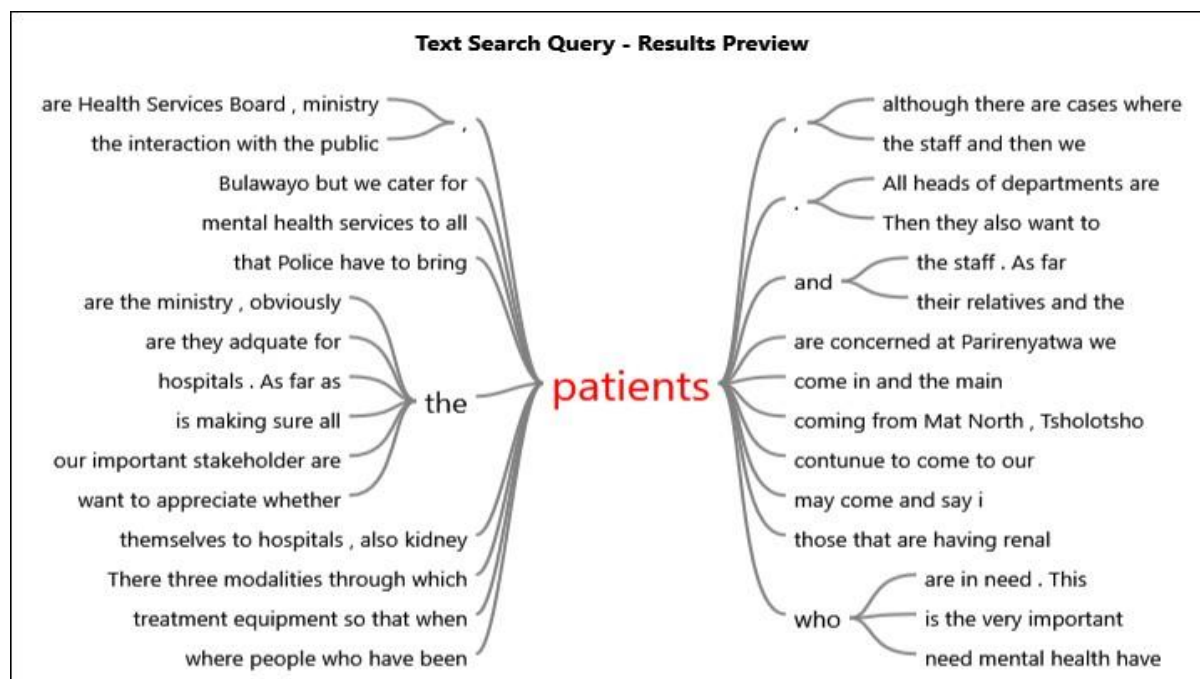
Explain how the board of directors has aligned the goals of the organization with those of its stakeholders, which are namely the government, employees, patients, or clients, donors and partners and suppliers of goods and services and the public?		Attributes									
		Central Hospital						Region		Number of Years as board member	
Themes emerged on alignment of organization`s goals with those of stakeholders	Number of interview participants who mentioned the same	UBH	MP	HRE	PARI	CHT	INGU	N	S	1 - 5	More than 5
		By carrying out Monitoring and Evaluation	1						✓		✓
By having a Strategic Plan	1				✓			✓			✓
Aligned with respect to the National Health Strategic plan	1	✓							✓		✓

Source, Field Data (2019)

Table 19 above indicates that hospital management boards align their goals in line with National Health Strategic plan and institutional strategic plans, as highlighted by UBH and Parirenyatwa respectively. In a bid to meet the expectations of various stakeholders, hospital boards carry out monitoring and evaluation in their respective institutions as highlighted by Ingutsheni central hospital.

In a hospital set up, the hospital management boards strive to align strategic goals with those of stakeholders, with the ultimate goal of improving the health service delivery, the patients being the main stakeholder as found in the study and should in Figure 3 below.

Figure 3 : Board of directors aligning goals with those of its stakeholders



Source, Field Data (2019)

As the Figure 3 above indicates, the important stakeholders in a hospital set up are the patients. Clearly, this means that the decisions made by the board of directors should be for the benefit of the patients. One of the CEOs stressed this notion saying, *“The board is making sure all the patients who need mental health have access to the hospital in terms of medication, food, detergents, facilities, linen, housekeeping issues”* (CEO1). The goals of the hospital to satisfy the needs of its stakeholders were summarised by one of the board chairpersons who remarked that, *“With any board, before you do anything you have to do a stakeholder consultation. By stakeholder consultation what we have done is to first sit down as the board to say right, we have been appointed, where do we wish to take the institution to and where does the Government of Zimbabwe want to see our hospital under the Ministry of Health. We then had to look at the current goals of the government to say that by 2030 this is what the Government of Zimbabwe wants to achieve, access to health for all at reasonable access to health for most”* (Board Chair1).

There are various other stakeholders for the health institutions which should be considered as depicted in the responses given in Table 20 below. Other stakeholders mentioned are government, ministry, staff, suppliers, management and departments. The important

stakeholders of a hospital were highlighted by Board Chair 4 who reminded that “*The Health Services Board delegates the task to the hospital management boards, so which means the principal stakeholders are Health Services Board, ministry, patients and the staff*”.

Table 20 : Important stakeholders versus organizational goals

Word	Length	Count	Weighted Percentage (%)
Hospital	8	16	1.80
Patients	8	15	1.69
Government	10	12	1.35
Ministry	8	11	1.24
Institution	11	9	1.01
Staff	5	8	0.90
Suppliers	9	8	0.90
Management	10	6	0.68
Departments	11	4	0.45
Doctors	7	4	0.45
Equipment	9	4	0.45
Private	7	4	0.45

Source, Field Data (2019)

The link between goals of the hospital management board and its stakeholders was summarised by CEO 4 that, “*When we look at those committees, they try to address the link or the sink between or amongst stakeholders for example when we are talking about the clinical committee which looks at the clinical side they obviously want to know the availability of medicines, do we have medicines and are they adequate for the patients. Then they also want to look at the performance of the health workers like for instance do we have doctors and nurses in the hospital and how is their performance. They then want to appreciate whether the patients who are the very important client in our situation whether they are getting what they should get from the hospital*” (CEO 4). The board committees should be constituted based on the mandate of an organization, hence the focus is to achieve the expectations of diverse stakeholders.

#### **6.4.2.5**      *Formulation and implementation of business and corporate strategies*

Strategic management is a process which involves the development of strategies and formulation of policies that achieve the desired goals and objectives of an organization. The process must consider both external strategies and internal capabilities. Generally, strategic management should relate organizational resources to the challenges and opportunities in broader environment (Steiss, 2019).

In health care organizations, strategic planning is positively related to organizational performance including employees' and patients' satisfaction as well as organizational productivity. Furthermore, strategic planning is very effective and hence it provides a clear and focused direction for health care organizations (Esfahani et al., 2018). Hospitals are lifesaving institutions and as a result, their services are of great importance to the various stakeholders. It should be pointed out that the strategic planning and implementation process should be results oriented to allow for achievement of the desired organizational goals within the set time frame.

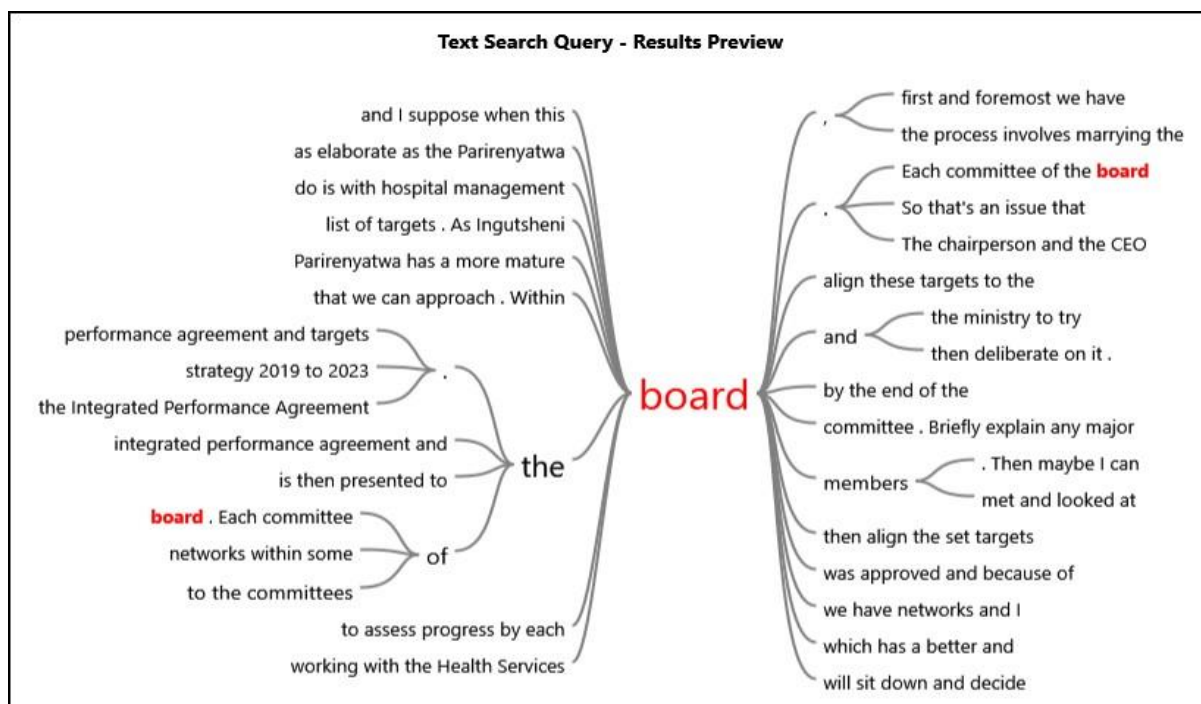
Table 21: Formulation and implementation of business and corporate strategies by institution

Briefly describe how the business and corporate strategies of your organization are formulated and implemented?		Attributes									
		Central Hospital						Region		Number of Years as board member	
Themes Emerged on how business and corporate strategies are formulated and implemented	Number of interview participants who mentioned the same	UBH	MP	HRE	PARI	CHT	INGU	N	S	1 - 5	More than 5
		Consultation of the board management	3	✓	✓				✓		✓✓✓
Carrying out Review meetings and planning	2	✓			✓			✓	✓		✓✓
Carrying out SWOT Analysis	1		✓						✓	✓	
Carrying out Monitoring and Evaluation	1					✓		✓		✓	

Source, Field Data (2019)

The analysis in Table 21 above denotes that board members for UBH, Mpilo and Ingutsheni involve the executive management in the crafting of the business and corporate strategies for their respective institutions. Board members for UBH and Parirenyatwa carry out planning and review meetings regularly to enhance the formulation and implementation of business and corporate strategies. For Mpilo hospital, board members scan the operating environment through the use of the SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis. On the other hand, Chitungwiza hospital board proffered that board members carry out monitoring and evaluation to facilitate the formulation and strengthening of business and corporate strategies for the institution.

Figure 4: Formulation and implementation of business and corporate strategies



Source, Field Data (2019)

The analysis in Figure 4 above depicts that there are various modalities which are utilized by hospital management boards to enhance effective formulation and implementation of business and corporate strategies for example the setting of integrated performance agreements, targets, networking with various stakeholders and strategic planning.

According to Board Chair 1, “*We sit down and then we identify organizations that we can approach. Within board we have networks and I suppose when this board was approved and because of its diversity is to take advantage of the networks within some of the board members. Then maybe I can approach maybe six, seven or ten organizations that I have close relationship with to say look this is our hospital and the community or companies plough back. The community then came up with the solution to say we will donate a dollar, we call it Buy- A- Brick*” (Board Chair 1). Furthermore, Board Chair 3 mentioned the alignment of hospital goals to the national vision as quoted, “*Well how we formulate is we align to what is the vision of the government and right now the vision of government. Right now the vision of government is Zimbabwe is open for business mantra. So we are actually looking for partners who are going to be long term partners. Our vision will be short term, intermediate and long term plans*” (Board Chair 3).

According to CEO 5, “*The hospital aligns its goals to the National Health Strategic plan. The ministry come up with a detailed plan annually*”. As for Parirenyatwa Group of Hospitals an external consultant was engaged especially for the 2018-2020 plans and Ingutsheni central hospital has a five year strategic plan which covers the period 2019-2023. Quarterly and annually reviews for the implementation of the strategic plans are conducted. Hospitals develop integrated performance agreements which are aligned to set targets. Thus, the integrated performance agreement is developed after consultations with board committees, executive management and heads of departments. The document is submitted to the ministry of health following deliberations by the full board. The hospital board ensure that the work of the sub-committees is aligned to the set targets so that the broader objective of the hospital is achieved.

#### 6.4.2.6 *Best practices by hospital management boards*

Table 22 : Best practices in achieving good corporate governance mandate

<b>Respondent</b>	<b>Best Practices</b>
Board Chair 1	There are quite a number of best practices which, the first one is accountability. One thing we try to put and what we have managed to do in line with expectations of government is to work on issues of fighting corruption, transparency, accountability and performance. We recently received awards in Harare for the Best Public Financially managed institutions, efficient Debt Administration and Management, Budgeting and Financial Planning and Financial Turnaround.
Board Chair 2	Various medals were won by the institution for example the 2018 Award for Excellence in Accounting, Auditing and Financial Reporting, Budgeting and Financial Planning and Financial Turnaround and Innovative Resources in Financial Engineering.
Board Chair 3	We have a brilliant peadiatric unit. Our peadiatric did separate siamese twins. Our surgeons are doing extremely well and even our students, thus masters students are always performing well in Eastern and Central Africa. Our nurses do extremely well, so as a training institution we are really the best.
Board Chair 4	We are probably the only hospital that develops five year strategic plans and then we actually identify a management company to come and work with our senior management in the process of implementation and monitoring of that strategic plan.
CEO 1	We come up with integrated performance agreement and annual plan but when there are no targets that are set at times is very difficult to shoot and if you shoot someone can't tell you that you have missed the target. So you really need to have targets and thus a best practice.  We won some medals last year for Finance Management for Excellence in Overall Best Management of the Year Award, 2018 Award for Excellence in Accounting, Auditing and Financial Reporting, Budgeting and Financial Planning, Financial Turnaround and Innovative Resources in Financial Engineering. The

	institution is legally compliant with regulations, procedures and statutory instruments that govern how we do business. We have had unqualified audit reports.
CEO 2	Conducting of meetings, which are done monthly or frequently as we go lower. Furthermore, routine audits are conducted at the institution. The CEO was awarded the first runner of the year in 2018, thus the CEO of the year in Matebeleland region.
CEO 3	Best practices include unqualified opinion by external auditors of the annual audits. Various Public Sector Management awards from the Office of the President and Cabinet were won by the institution which includes the most trusted public health service brand, accounting, auditing and financial reporting award, revenue collection and credit control and risk management award, overall best financial management award of 2018.
CEO 4	The institution is now submitting financial statements to the Auditor General annually. The institution was given an award for being the best innovative institution in financial management. The other area is that of reduction of the maternal mortality rate. Our team is very strong in that area, we have never referred any patient to any other institution because even in terms of consultancy that area is very strong.
CEO 5	The hospital has vibrant internal control systems in place in terms of resource utilization. Another best practice is the transparent recruitment process especially on student nurses. Various interventions and controls were adopted to reduce nepotism. We also managed to attract the best surgeons or consultants.

Source, Field Data (2019)

The 9 responses in Table 22 above have provided some insights on best practices that assist to enhance the good corporate governance mandate. The best practices that foster good corporate image include awards won, robust internal control systems, unique service provision and strategic planning.

Generally, board's best practices in discharge of good corporate governance mandate can be viewed in different perspectives as often indicative through board selection and appointment process, board functioning, board independence, board committee structures, board relationship with the executive, monitoring and reporting (Holburn and Fremeth, 2019).

Table 23: Major best practices by institution

Briefly explain any major best practices that your hospital board experience in the discharge of good corporate governance mandate		Attributes										
		Central Hospital						Region		Number of Years as board member		
Themes emerged on Major best practice hospital board in the discharge of cooperate governance	Number of interview participants who mentioned the same	UBH	MP	HRE	PARI	CHT	INGU	N	S	1 - 5	More than 5	
		Updated Internal Control systems (ICS)	1			✓				✓		✓
Transparent	1			✓				✓		✓		
Reduction of the maternal mortality rate	1		✓						✓	✓		
Intervention of external auditors	1				✓			✓			✓	
Conducting of meetings frequently	1	✓							✓		✓	
Supporting of Innovation	1						✓		✓	✓		

Source, Field Data (2019)

The analysis in Table 23 above has shown that central hospitals have some best practices in their institutions. Harare hospital has got a transparent and robust internal control system. Mpilo hospital reported a reduction of the maternal mortality rate. CEO 4 was quoted saying, “The other area is that of reduction of the maternal mortality rate. Our team is very strong in that area, we have never referred any patient to any other institution because even in terms of consultancy that area is very strong.”

Parirenyatwa indicated the engagement of external auditors as a best practice which fosters a strong internal control system. CEO 3 was quoted saying, *“Best practices include unqualified opinion by external auditors of the annual audits. Various Public Sector Management awards from the Office of the President and Cabinet were won by the institution which includes the most trusted public health service brand, accounting, auditing and financial reporting award, revenue collection and credit control and risk management award, overall best financial management award of 2018”* (CEO 3)

The conducting of meetings frequently is also considered as a best practice. This was revealed at the UBH when CEO 2 was quoted saying, *“Conducting of meetings, which are done monthly or frequently as we go lower. Furthermore, routine audits are conducted at the institution. The CEO was awarded the first runner of the year in 2018, thus the CEO of the year in Matebeleland region.”* (CEO 2)

Ingutsheni hospital experienced best practice in supporting innovation at the institution. CEO 1 was quoted saying, *“We won some medals last year for Finance Management for Excellence in Overall Best Management of the Year Award, 2018 Award for Excellence in Accounting, Auditing and Financial Reporting, Budgeting and Financial Planning, Financial Turnaround and Innovative Resources in Financial Engineering. The institution is legally compliant with regulations, procedures and statutory instruments that govern how we do business. We have had unqualified audit reports.”* (CEO 1)

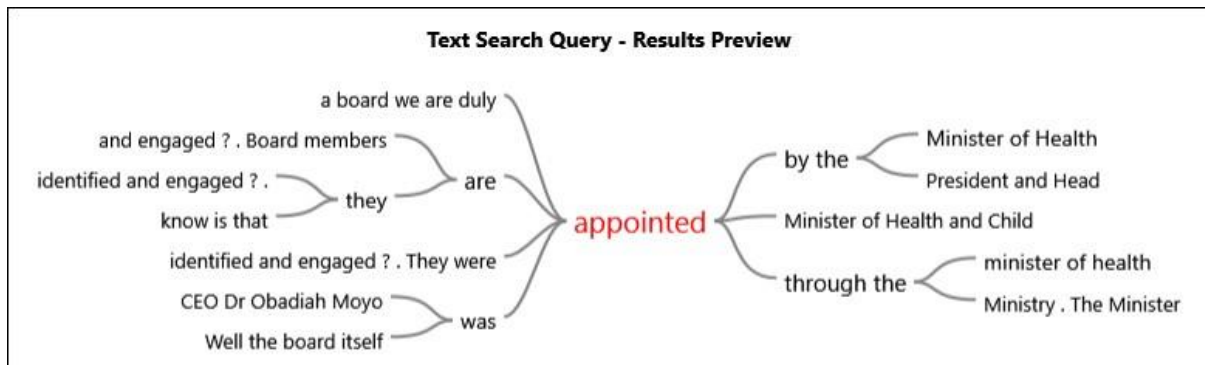
#### **6.4.3 Process of appointing hospital board members in central hospitals**

The process of appointing board of directors should ensure diversity in terms of, among other attributes, gender, board size and separation of duties of the CEO and chairperson. Firms with a large board size, more female directors and separation of CEO and chairman positions are more likely to engage in corporate social responsibility (Liao et al., 2018).

### 6.4.3.1 *Appointing authority for board members*

The appointing authority for board members is as illustrated in Fig 5 below.

Figure 5 : Appointing authority for board members



Source, Field Data (2019)

The responses in Fig 5 above indicate the involvement of the Minister of Health and Child Care and the President and Head of State in the appointment of board members. CEO 1 was very clear on the appointment of hospital board members or directors saying that, “*The appointing officer for directors is the Honourable Minister of Health and Child Care*”. This was buttressed by Board chair 1 who stated that “*Well the board itself was appointed through the Ministry.....So as a board we are duly appointed by the President and Head of State*”.

### 6.4.3.2 *Appointment of board members at institutional level*

The appointment of board members in respective institutions was further analysed in Table 24 below to establish the appointing authority of board members at institutional level. The respondents composed of four board chairs and six CEOs.

Table 24 : Appointing authority at respective institutions

<b>Respondent</b>	<b>Appointing Authority</b>
Board Chair 1	Ministry and President and Head of State
Board Chair 2	Minister of Health and Child Care
Board Chair 3	Minister of Health and Child Care and Health Service Board
Board Chair 4	Minister of Health and Child Care
CEO 1	Minister of Health and Child Care
CEO 2	Minister of Health and Child Care
CEO 3	Minister of Health and Child Care
CEO 4	Minister of Health and Child Care
CEO 5	Minister of Health and Child Care
CEO 6	Minister of Health and Child Care

Source, Field Data (2019)

The 10 responses in Table 24 above indicates that 8 (80%) proffered that board members are solely appointed by the Minister of Health and Child Care, whilst 1 (10%) indicated appointment by the Minister of Health and Child Care and the Health Service Board. Furthermore, only 1 (10%) indicated appointment of board members through the Ministry and President and Head of State.

#### **6.4.3.3 Identification and engagement of board members**

The identification and engagement of board members was illustrated in Tables 25 and 26 below.

Table 25: Identification and engagement of board members as revealed by CEOs

Explain how each non-executive director (Including the Chairperson) was identified and engaged~		Attributes									
		Central Hospital						Region		Number of Years as board member	
Identification and engagement Process of each non – executive director	Number of interview participants who mentioned the same	UBH	MP	HRE	PARI	CHT	INGU	N	S	1 - 5	More than 5
		Appointment by Honourable Minister	5	✓	✓		✓	✓	✓	✓✓	✓✓✓
Via formal vacancies	3	✓	✓				✓		✓✓✓	✓✓	✓
CEO Solicit for CV's from perspective board members in the province	2	✓	✓						✓✓	✓	✓
Drawn from various disciplines	2		✓		✓			✓	✓	✓	✓

Source, Field Data (2019)

The analysis in Table 25 revealed that the process of identification and engagement of board members is conducted through direct appointment by the Honourable Minister of Health and Child Care. Five respondents from UBH, Mpilo, Parirenyatwa, Chitungwiza and Ingutsheni indicated the appointment through the Honourable Minister of Health and Child Care. This was reinforced by CEO 4 who revealed that, *“They are appointed by the Minister of Health and Child Care. The letters of appointment are sent to the institution. The board members are a mixture of different skills for example lawyers, accountants, medical and others...”* (CEO 4)

The identification and appointment of board members is done through formal vacancies and prospective board members submit their CVs as revealed by CEO 1 who was quoted saying, “The appointing officer for directors is the Honourable Minister of Health and Child Care. So when there are vacancies in a board they identify eminent persons with various skills and usually they look for people who are eminent persons, professionals or business people in their own skills and with experience in the health sector. Out of that list he will then discuss with his team in head office, the permanent secretary and the principal directors. Usually i think they use to also get clearance board members from the OPC, Chief Secretary's office. Because these are government entities and the people who are there need to be cleared by the government but i am not so sure if that is still happening but it’s usually the process. At times also there is a database in the OPC where eminent persons and professionals either apply or they are nominated there is a database...” (CEO 1).

Table 26: Identification and engagement of board members as revealed by board chairs

Explain how each non-executive director (Including the Chairperson) was identified and engaged~		Attributes									
		Central Hospital						Region		Number of Years as board member	
Identification and engagement Process of each non – executive director	Number of interview participants who mentioned the same	UBH	MP	HRE	PARI	CHT	INGU	N	S	1 - 5	More than 5
		Appointment by Honourable Minister	4		✓	✓	✓		✓	✓✓	✓✓

Source, Field Data (2019)

The analysis in Table 26 above revealed that all board chairs for Mpilo, Harare, Parirenyatwa and Ingutsheni concurred that the Honourable Minister is responsible for the appointment of board members. Board Chair 2 was quoted saying, “They were appointed through the Minister of Health and Child Care.....”

Organizational board of directors are one of the most important subgroups within most modern organizations, performing critical advisory, monitoring and resource dependency roles. Furthermore, board diversity is positively associated with market valuation (Ntim, 2015). Hence, the selection for hospital management board members should be conducted in a transparent and independent manner to achieve effectiveness in performance.

#### 6.4.3.4 Selection criteria of board members

The criteria for the selection of board members is revealed in Table 27 below. The respondents composed of four board chairs and six CEOs

Table 27: Board member selection criteria

Respondent	Selection Criteria
Board Chair 1	The Minister of Health did his own search I suppose through his offices of people in the private sector and also in the medical fraternity who could comprise the board. Then these names were then sent through to the Office of the President. Then from there for approval in the Office of His Excellency of the Republic of Zimbabwe.
Board Chair 2	They were appointed through the Minister of Health and Child Care basing on their skills and experience in the health sector. The clearance to appoint board members is obtained through the Office of the President and Cabinet.
Board Chair 3	Well I don't know, I was approached by the then minister that he intended me to go and help the management board of Harare hospital. It was through the Health Service Board i understand. Two of the guys were from the previous board i think to carry institutional memory, one is a lawyer and a lady who is a nurse by profession. They are two medical doctors. Then CEO was also a medical doctor. There is a lawyer and is a long serving retired civil servant, who knows about housing and amenities.
Board Chair 4	The minister asks for possible nominations from senior health officials in the ministry. Then from those submissions he then appoints people.
CEO 1	So when there are vacancies in a board they identify eminent persons with various skills and usually they look for people who are eminent persons, professionals or business people in their own skills and with experience in the health sector. Out of that list he will then discuss with his team in head office, the permanent secretary and the principal directors. Usually i think they use to also get clearance board members from the OPC, Chief Secretary's office. Because these are government entities and the people who are there need to be cleared by the government but i am not so sure if that is still happening but it's usually the process. At times also there is a database in the OPC where eminent persons and professionals either apply or they are nominated there is a database. The Chief Secretary's office and what usually then happens at times actually people are requested there is an advert in the public media which advertises for people to submit their names for consideration on appointment to boards. So there is that database on the one hand but not every time you don't get those people every time you require then the minister as the appointing officer also goes and identifies eminent people he and his team and they come up with the list and they appoint.

CEO 2	The CEO solicits or request for curriculum vitae from prospective board members. The prospective board members or directors should be members from the community, thus within the province. Cadres to be short listed should have the relevant experience, members of the business community and experts in capacity building. Prospective cadres selected might include doctors, nurses and other health professionals. The CEO in consultation with hospital management then forward names to the Permanent Secretary and Minister of Health and Child Care. However, according to previous experience some names suggested at hospital level are left out or not considered in the final list from the Minister. Even some board members in the list from the Minister are not from the region.
CEO 3	The letters of appointment are sent to the institution. The board members are a mixture of different skills for example lawyers, accountants, medical and others.
CEO 4	The identification I am not so sure because that is the responsibility of the Minister. We were not consulted. The minister is the one who identifies them. He asks for their CVs to then enable him to make his decision. So in our case the board members that i know, the chairperson was picked from the community where she was involved in education where she was running schools. The other board members are doctors, they are three. The other board member is a business person and then the other one is a commissioner.
CEO 5	Board members are appointed through the minister of health and child care basing on their experience, skills or expertise. They are drawn from various disciplines for example nursing, medical doctors, lawyers and other professions.
CEO 6	Not so sure but what i know is that they are appointed by the Minister of Health and Child Care. However, Chitungwiza Central hospital does not have a substantive CEO since the former CEO Dr. Obadiah Moyo was appointed Minister of Health and Child Care in September 2018. An advert for the CEO was done towards end of year 2018.

Source, Field Data (2019)

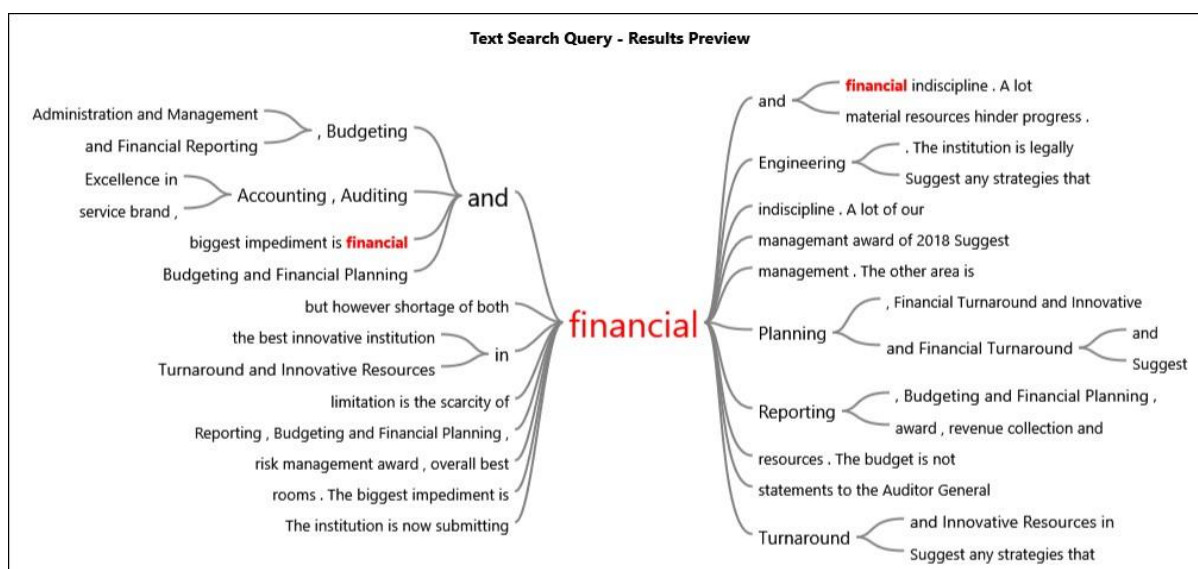
The analysis of 10 respondents in Table 27 above entails that board members are identified through the Minister of Health and Child Care based on their experience, skills or expertise. Board members are solicited from both the public and private sector. The board members are composed of various professional backgrounds which include medical, finance, legal, community leaders and business. CEO 2 was quoted saying, “*The CEO in consultation with hospital management then forward names to the Permanent Secretary and Minister of Health and Child Care*”. Board chair 1 and CEO 1 also mentioned the involvement of the President of the Republic of Zimbabwe and Office of the President and Cabinet being involved in the selection process of board members respectively (CEO 2).

#### 6.4.4 Challenges faced by hospital management boards in carrying out their mandate

##### 6.4.4.1 Limitations that are experienced in the discharge of good corporate governance mandate

In short, hospital management boards are expected to perform in line with the expectations of its stakeholders. However, during the carrying out of a board’s good corporate governance mandate, challenges or limitations are sometimes encountered which impact negatively on the overall performance of the hospital concerned. The study found that limited financial capacity was cited as a major constraint across all the six central hospitals studied and this is highlighted in Figure 6 below.

Figure 6 : Limitations experienced on achieving good corporate governance mandate



Source, Field Data (2019)

##### 6.4.4.2 Major limitations highlighted by the respondents

The analysis in Table 28 below revealed that the major challenge faced by hospital management boards is the unstable macro economic environment prevailing in the country. Four respondents from Mpilo, Harare, Chitungwiza and Ingutsheni echoed that price instability and inflation negatively impact on the operations of central hospitals. CEO 4 suggested that the economic situation prevailing in Zimbabwe is a hindrance to health service

provision as quoted, *“The greatest challenge that we have is the economic environment. Our economic environment specifically in Zimbabwe where we have to import most of the items we that we use or even the suppliers that we rely on, they import their products. So, one of the biggest challenges is lack of foreign currency. You might flight a tender and you may identify people who would supply certain equipment for example anaesthetic machines. They respond and go through the adjudication process and award. After you have awarded as you follow up you find six months will lapse and they are telling you we are looking for foreign currency. This actually works against the institutional goals”* (CEO 4).

Table 28: Major limitations as highlighted by CEOs

Briefly explain the major limitations that your hospital board experience in the discharge of good cooperate governance		Attributes									
		Central Hospital						Region		Number of Years as board member	
Themes emerged on Major limitations hospital board faced in the discharge of cooperate governance	Number of interview participants who mentioned the same	UBH	MP	HRE	PARI	CHT	INGU	N	S	1 - 5	More than 5 years
		Economic environment(Price instability and Inflation)	4		✓	✓		✓	✓	✓	✓✓
Bad Policies	2	✓			✓			✓	✓		✓✓

Source, Field Data (2019)

To support the notion that good corporate governance mandate cannot be achieved as perceived due to economic challenges, CEO 1 proffered that, *“Good corporate governance it may not be the board issues, it’s not about the board. The fluid micro economic environment we are operating in is a very big hindrance because even if you plan your plans can be compromised by price inflation or price instability on the market. Price instability will affect the staff your motivation. There are factors that are outside the health sector that can affect*

*the way you do business and how you can achieve that you are supposed to be doing” (CEO 1).*

Financial constraints have a negative effect on hospital boards resulting in failure to achieve the desired goals as expected by stakeholders. CEO 3 highlighted that, *“The institutions might have very strategic plans but however, shortages of both financial and material resources hinder progress”*. The limitation in financial resources was reinforced by CEO 5 who proffered that, *“The major limitation is the scarcity of financial resources. The budget is not adequate to cater for the various needs of the institution. The other limitation is the increase on the rate of inflation and price distortions which ultimately affect the supply chain or procurement cycle” (CEO 5).*

Bad policies is a limitation in the achievement of good corporate governance mandate as was echoed by CEO 4 who suggested that, *“The staff freeze and staff establishment is another limitation. The current establishment in terms of manpower there is a serious limitation in that you cannot quickly improve the numbers as you wish because everything has to go through Treasury concurrence. The principles which the Treasury people look at is for how long has this post been vacant, if it has been vacant for the past five years so you can do without. So we are operating with a very old establishment which cannot meet the current demand” (CEO 4).* The sentiments for bad policies were bolstered by CEO 3 who was quoted saying, *“Furthermore, the employment freeze is affecting the achievement of strategic goals and plans considering the high disease burden and trends”*. The analysis revealed that the staff freeze negatively affects staffing levels or requirements, hence the governance of hospitals is highly compromised.

CEO 5 highlighted staff shortage as a limiting factor in the achievement of good corporate governance mandate. CEO 5 was quoted saying, *“.....the staff shortage and the current freeze on recruitment is also a major limitation”*. The staff shortage was bolstered by CEO 4 who was quoted saying, *“The other challenge that is quite serious is that of human resources in terms of specialists. When you do not have certain specialists then as a referral centre you end up referring to other referral centres. So in the end you are like a referral centre working like a district or provincial hospital when you are supposed to be the last level of reference”*

(CEO 4). This entails that staff shortage, for example medical specialists in health institutions is a cause for concern in the achievement of the desired goals.

The weak referral system in health institutions is negatively affecting the achievement of good corporate governance mandate as was highlighted by CEO 4 who proffered that, *“The other challenge is a weak referral system. While running a central hospital which should deal with complicated cases but you find sometimes operating like a clinic, where you find patients from the community wake up one morning with a headache and they just walk in and we cannot chase them away. Rather as a referral centre we should be receiving complicated cases like caesarean section”* (CEO 4).

Hospital equipment breakdown is a hindrance in the achievement of good corporate governance mandate. The sentiments were echoed by CEO 5 saying, *“The equipment breakdowns at the institution also affect the smooth running of the institution”*. This entails that hospital management boards might be having good corporate governance practices but without functional hospital equipment they might fail to fulfill their mandate.

Table 29: Major limitations as highlighted by board chairs

Briefly explain the major limitations that your hospital board experience in the discharge of good cooperate governance		Attributes									
		Central Hospital						Region		Number of Years as board member	
Themes emerged on Major limitations hospital board faced in the discharge of cooperate governance	Number of interview participants who mentioned the same	UBH	MP	HRE	PARI	CHT	INGU	N	S	1 - 5	More than 5
		Economic environment (Price instability and Inflation)	2			✓			✓	✓	✓
Lack of funds	1			✓				✓		✓	
Lack of experience from appointed board members	1				✓			✓		✓	

Source, Field Data (2019)

The analysis in Table 29 above revealed that 2 board chairs are of the view that the harsh economic environment greatly affects hospital management boards in discharging the good corporate governance mandate. Board chair 3 suggested that the economic turbulence greatly affects hospitals operations as was quoted saying, *“It’s very difficult in this environment as we are speaking right now. Most businesses are struggling so its difficulty for us to approach any business and say we want to partner. We had lots of banks who have been partnering before but i think they are hitting into very difficult times. Actually projects failed to commence due to the economic turbulence”* (Board Chair 3).

Financial resources is a limiting factor which hinder the discharge of good corporate governance mandate as was echoed by Board Chair 4 who was quoted saying, *“Obviously*

*our elephant in the room is the fact that we are being asked to run these hospitals on meagre resources.”* The lack of financial resources was supported by Board Chair 3 who suggested that, *“There is also a limitation in terms of staffing since the government does not have enough resources to employ more staff since the institution is huge and so it needs staff levels which commensurate with the volume of work”*. The institutions cannot employ the much needed staff who are key in health service delivery due to limitation in resources from government.

Lack of experience by board members who are appointed is considered as a limitation in that some board members might be having experience in other sectors that are not health related hence failure to articulate health related issues. This was highlighted by Board chair 4 saying, *“The major limitation is that the people that get appointed on these boards, they are just nice citizens who love their country but are not equipped to run a hospital. You can take the CEO of Delta Corporation or any major company but their knowledge of management does not equip them to run a hospital. So there is need for this board member to be trained on what are the issues that are required to run a hospital, key expenditures of a hospital, how to form a five year strategy of a hospital and how to monitor clinical activities. On average the people that are appointed are not up to the expected standard. Even the people that get appointed as senior managers in hospitals, some of them are just clinicians, nurses, doctors or pharmacists. That doesn't mean they are managers. They need to be taught on what is it like to run a hospital”* (Board Chair 4).

Bad policies are considered a limitation in achieving good corporate governance practices as was proffered by Board Chair 3 who was quoted saying, *“The other challenge is failure to obey the referral chain. We are trying to engage the public and the people who refer patients so that they should not just have people being referred. However, patients just come because the government has got a policy which we have got to honour: Pregnant mothers and children are treated for free. We face challenges of consumables and water to facilitate the delivery of service to our clients”*. It is government policy as provided in the Public Health Act (Chapter 15:17 that every patient should receive medical treatment regardless of gender, social or economic status and political affiliation. It is in this regard that patients are aware of legal instruments available, hence visit health facilities of their choice.

In this regard, the study found that the limitations that affect good corporate governance mandate are bad policies, limited financial resources, staff freeze, staff shortage, unstable economic environment (thus leading to price instability and high rate of inflation), weak referral system, hospital equipment breakdowns and inexperienced board members. The board might have good plans but adversely affected by unfavourable operating or economic environment and this normally leads to derailed achievement of planned performance levels.

#### **6.4.5 Study participants' suggestions for enhancing the functionality of hospital management boards**

The analysis in Table 30 below provides an insight on the strategies that can strengthen the performance of hospital management boards. The broad strategies include resource mobilization, establishment of business or investment models, establishment of effective board members, in-house trainings and community support.

Stakeholder engagement is very key in the enhancement of hospital management boards' performance. Board Chair 1 suggested that, *"I think more interaction between the boards and the government so that the vision of government is fully realized. More stakeholder involvement through workshops is encouraged"*. The concept of community engagement or networking was buttressed by Board Chair 4 who proffered that, *"So their prime responsibility is to pick concerns of society or community and bring them to the notice of the hospital management and as well as the board. We could do better in terms of community outreach and the interactions with community. We need to have good systems that continually make it possible for communities and societies to say this is what we are experiencing at the hospital. That is not being done because in other countries and jurisdictions that has become a very important part of management"* (Board Chair 4). This highlights the importance of community outreach as a way of building the institutional image and stakeholder interface. The citizenry in various capacities need to be engaged in order to foster close interaction.

Table 30: Strategies to strengthen the performance of hospital management boards

Suggest any strategies that can strengthen the performance of hospital management boards		Attributes										
		Central Hospital						Region		Number of Years as board member		
Themes emerged on any strategies that can strengthen the performance of hospital management boards	Number of interview participants who mentioned the same	UBH	MP	HRE	PARI	CHT	INGU	N	S	1 - 5	More than 5	
		Resource mobilization (Fundraising)	3	✓		✓	✓			✓✓	✓	✓
Emerging of business models (farming)	1				✓			✓			✓	
Establishment of effective board members	2	✓			✓			✓	✓		✓✓	
Establishing of In-house trainings	1											
Community support	1	✓							✓		✓	

Source, Field Data (2019)

Monitoring and evaluation mechanisms should be put in place to enhance the performance of hospital management boards. The concept of monitoring and evaluation of hospital boards is very critical in that the approved plans should be closely and regularly monitored to boost accountability and transparency by board members. Board Chair 1 provided that, “*On the ministerial side I suppose we do get to interact quite a bit with our minister. Put in place more constant monitoring and evaluation mechanisms so that boards account more. But in terms of the powers of the hospital management boards the Health Service Act is very clear*”

*so the more evaluation that takes place and how far we have achieved as a board is it in line with the government expectations and our appointing authority” (Board Chair 1).*

The notion of monitoring and evaluation of hospital board performance including the CEOs was reinforced by Board Chair 4 who echoed that, *“There is no tangible effort for assessing the performance of the CEO and its left to the permanent secretary. The bottom line is that there is no tangible process for assessing the CEO and thus a problem”*. It is important to regularly monitor and evaluate the performance of the CEOs as well, since they are part of the executive management. The duty of the hospital management board includes the monitoring and evaluation of the CEO.

Resource mobilization is another strategy that was suggested by both Board chairs and CEOs. CEO 1 suggested that, *“What the management board should do is to create a vision and resource mobilization. The board has come up with business models. So one of the strategies that the hospital management boards can come up with is resource mobilization for government to be sustainable and for hospital management boards to generate revenue streams to complement what they get from the national fiscus”* (CEO 1). The strategy of resource mobilization was supported by CEO 2 who suggested that, *“Resource mobilization concept should be effective through fundraising”*. The strategy should involve the harnessing of resources from diverse revenue streams available for example income generating projects like farming and musical concerts. CEO 1 propped that, *“Therefore, the hospital management board has come up with a model which says that we should not be basket cases, we should not be beggars who will be going to donors. These business models started in 2018. The institution ventured into horticulture such that most of the vegetables that patients eat come from the project. The horticulture is not done commercially as yet but at subsistence level on 7 hectares of land. There is also a dry land plot where maize is grown, which produced in excess of 30 tonnes in 2018 which is used to feed patients. The institution also has 4 hectares of beans which is produced at a subsistence level”* (CEO 1). The resource mobilization strategy is key in assisting to meet the financial demands for hospitals since funding from treasury might be inadequate.

Boosting revenue generation is another strategy that can strengthen the performance of hospital management boards. Board Chair 2 buoyed that, *“Most of the revenue generating*

ventures commenced in 2018. The ventures include farming specializing in horticulture, maize and beans”. In buttressing the concept of boosting revenue generation in health institutions, Board Chair 4 was quoted saying, “For instance in finance, there is need for somebody to test them to say how do you maximize revenue, how do you make sure the financial system that help in revenue generation is in place, cost controls...” In supporting the concept of revenue generation in hospitals CEO 5 suggested that, “Since funds from treasury are inadequate, the hospital board should implement other revenue generation projects for example boosting farming production on the already existing hospital farm. The increase in farming production can be achieved through joint ventures with reputable private farmers who have the necessary inputs like farming equipment, expertise and adequate funding” (CEO 5).

Capacity building is another strategy that was proffered by hospital board members in a bid to enhance the performance of hospital management boards. Board Chair 3 suggested that, “From inception hospital management boards should attend some training courses or induction in order to standardize things. If appointed board members should know what is expected of them. We are coming from different backgrounds so there is need for team building or capacity building exercise. They were being done before but maybe they were discontinued due to certain problems. I am urging the new minister and the new permanent secretary so that people are trained on how to look after a hospital. It is necessary for people to be properly aligned and trained by whoever people from the public or private” (Board Chair 3). In support of training and induction of board members Board Chair 4 suggested that, “So there is need to come up with training program for hospital management boards. Not every board member is a good manager. They need to be taught on what is it like to run a hospital”. Training can be conducted either when commencing duties or during the board’s term of office in an effort to sharpen the managerial skills and close the knowledge gap for non-health professionals as well as some board members drawn from other sectors.

The suggestion for in-house training was propped by CEO 5 as quoted, “Offer in-house trainings for board members to enhance their knowledge on health service delivery”. The notion of in-house training is very critical especially considering that the operating environment in the health sector continuously change due to changes in trends related to disease burden. Even policies at national level can be changed or modified hence the need for

board members to be offered in-house trainings.

Board Chair 4 suggested the holding of meetings as a strategy to enhance the performance of hospital management boards as quoted, *“As far as the management of the hospital is concerned, the management board meets regularly to discuss during the board meetings and during management meetings”*. Holding regular meetings is another strategy that can enhance the performance of hospital management boards in that board members will be kept updated on the new developments in the health sector and solving challenges that might be encountered due to the continuous changing operating environment.

The process of identification and appointment of hospital management board members should be strengthened taking into consideration the good corporate governance best practices. Board Chair 4 echoed proffered that, *“The appointment of board members should be a public event where the minister places an advert in the newspaper. Those names should come from the community not from the ministry of health officials and not from the HSB”*. The strengthening of identification and appointment of board members was reinforced by CEO 4 who was quoted saying, *“One of the strategies that may work is to strengthen the process of identifying and appointing board members. When you appoint board members while there is this principle that if you want your job done don't pick somebody who is less busy or who is idle because he will be idle forever. If you want your job done pick somebody who is busy but sometimes board members may also be so busy that they then don't pay attention to important details and that sometimes you may miss the purpose of some board members”* (CEO 4). In support of competent board members for hospitals, CEO 2 propped that, *“The hospital should have board members who do understand the health systems and the involvement of other executive directors in hospital management boards”*. It is therefore critical to strengthen the appointment process for board members with a view to attract competent and effective board members who can bring the intended benefits to the diverse stakeholders.

The concept of public-private-partnerships (PPPs) is a strategy that can assist in the enhancement of resource mobilization for central hospitals. CEO 5 proffered that, *“There is need to strengthen the public-private-partnerships through engagement of the business community on financing of health services. This can be achieved through the provision of*

*medical equipment, medicines, surgicals and other critical requirements” (CEO 5). Board chair 4 buttressed the importance of PPPs as quoted, “The concept of public-private-partnerships has become very important in the sense that government alone are not in a position to finance health services including hospitals. There is need to reach out to private sector to support some of the activities. We have had a lot of support in the purchase of fairly expensive medical equipment. So you need a very good program for resource mobilization from the private sector” (Board Chair 4). In support of partnering with the private sector, CEO 1 suggested that, “The board has moved a gear up to go commercial and the institution applied for a licence from the Bulawayo City Council to do pan fattening. A plot has been established to do horticulture project commercially which will be funded by donors. Furthermore, the institution is in negotiations with Agribank to secure a loan to start a poultry project. The board is also in talks with the Infrastructure Development Bank of Zimbabwe so that some of the land can be used to build accommodation both for staff and the public” (CEO 1).*

The relevant authorities should come up with a standard operational manual for hospital management boards in an effort to strengthen and standardize their functionality. Board chair 4 was quoted saying, *“There is great need to develop of an operational manual for hospital management boards. The concept of management boards is something that evolved from the past so there is need to modify and modernize. Even now there is lack of clarity between the role of minister, ministry and the HSB” (Board Chair 4).*

#### **6.4.6      Functionality of hospital boards**

The relationship between a board of directors and innovation in not-for-profit organizations is very critical. In practice not only board attribute variables and board process variables were directly related to innovation, but potential to effect innovation and capacity for innovation indirectly through board effectiveness (Jaskyte, 2018a). The functionality of hospital management boards at any time is vital for institutional performance and suitability.

The existence and functionality of hospital management boards was analyzed and the findings are shown in Table 31 below:

Table 31 : Functional hospital board

<b>Binomial Test</b>						
		Category	N	Observed Prop.	Test Prop.	Exact Sig. (1-tailed)
Functional Board	Group 1	Yes	29	.83	.75	.192
	Group 2	No	6	.17		
	Total		35	1.00		

Source, Field Data (2019)

Table 31 above shows a binomial test for dichotomous variable of the availability of a functional board. Since 29 (82.9%) respondents out of 35 participants, this means the observed proportion is  $(29 / 35 =) 0.829$ . The null hypothesis was that this proportion is .75 for the entire sample studied. The p value, denoted by **Exact Sig. (1-tailed)** is .019. If the proportion of respondents was 0.75 in the entire population, then there's only a 19.2% chance of finding 29 or fewer respondents who have a functional board in a sample of 35 respondents in this study. Therefore we reject the null hypothesis since this chance is less than 5% ( $p < 0.000$ ). We conclude that the proportion of finding a functional board in a hospital is 0.75 in the population but probably (much) higher than 0.829.

Therefore, 29 (82.9%) of hospital board members have felt that the hospital boards are functional in their respective institutions. However, 6 (17.1%) have indicated that hospital board are non-functional in their hospitals.

Table 32 : Reasons for non-functionality of hospital boards

If NO, comment					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Currently there is no board, their term of office expired but otherwise has always been there.	1	2.9	2.9	2.9
	N/A	29	82.9	82.9	85.7
	No board currently, thus term expired in 2018	1	2.9	2.9	88.6
	Term expired	1	2.9	2.9	91.4
	Term expired in 2017	1	2.9	2.9	94.3
	Term expired in July 2018	1	2.9	2.9	97.1
	The term of the previous board expired in July 2018	1	2.9	2.9	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

The respondents in Table 32 above highlighted various reasons for the non-functionality of hospital boards. All the six respondents (17%) who said that the boards were non-functional cited some board members' continuation of duty beyond the expiry of their term as the major contributing factor.

#### 6.4.6.1 *Separation of responsibilities between the CEO and chairperson of the board*

The CEO duality is the practice of consolidating the CEO and board chair positions into a single role (Finkelstein and D'Aveni, 1994). However, CEO duality reduces boards' monitoring capacity (Wang et al., 2019a).

Table 33: CEO also chairperson of the board

Binomial Test					
		Category	N	Observed Prop.	Test Prop.
CEO also chairperson of the board	Group 1	No	35	1.00	.75
	Total		35	1.00	

Source, Field Data (2019)

As shown in Table 33 above, the CEO is not the chairperson of the board. All the 35 respondents concurred that there is no duality between the CEO and board chairperson.

#### 6.4.6.2 *Frequency of board meetings*

There is positive association or relationship between board meeting frequency and organizational performance (Eluyela et al., 2018). All the 35 (100%) respondents indicated that meetings are conducted quarterly in their respective institutions and this resonates with Tasfaye (2016) who upholds that frequency of meetings tends to improve organizational governance performance.

#### 6.4.6.3 *Board meeting based on prepared agendas*

The board chairpersons should interact frequently with management, particularly the CEOs. The board chairperson and the CEO may review agendas and materials as well as to follow up on implementation of the board decisions (Shekshnia, 2018).

Table 34: Board meetings based on prepared agendas

<b>Region * Board meetings based on prepared agendas</b>			
Count			
		Board meetings based on prepared agendas	
		Yes	Total
Region	Northern Region	16	16
	Southern Region	19	19
Total		35	35

Source, Field Data (2019)

In Table 34 above reveals that all the 35 respondents agreed that board meetings are conducted based on prepared agendas. The northern region had 16 responses while the southern region had 19 responses.

#### 6.4.6.4 *Setting of agenda for board meeting*

The leadership of the board chair is about setting the board meeting agendas and engaging the other board members to ensure positive firm outcomes (Åberg and Shen, 2019). Hence, it is the responsibility of the board chair to set the agenda of the meetings, however it can be achieved through consultation with other board members to ensure buy in.

Table 35: Setting of agenda for meetings

<b>Setting agenda of meetings</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Chairperson	26	74.3	74.3	74.3
	CEO	2	5.7	5.7	80.0
	Other, Please specify	7	20.0	20.0	100.0
	Total	35	100.0	100.0	

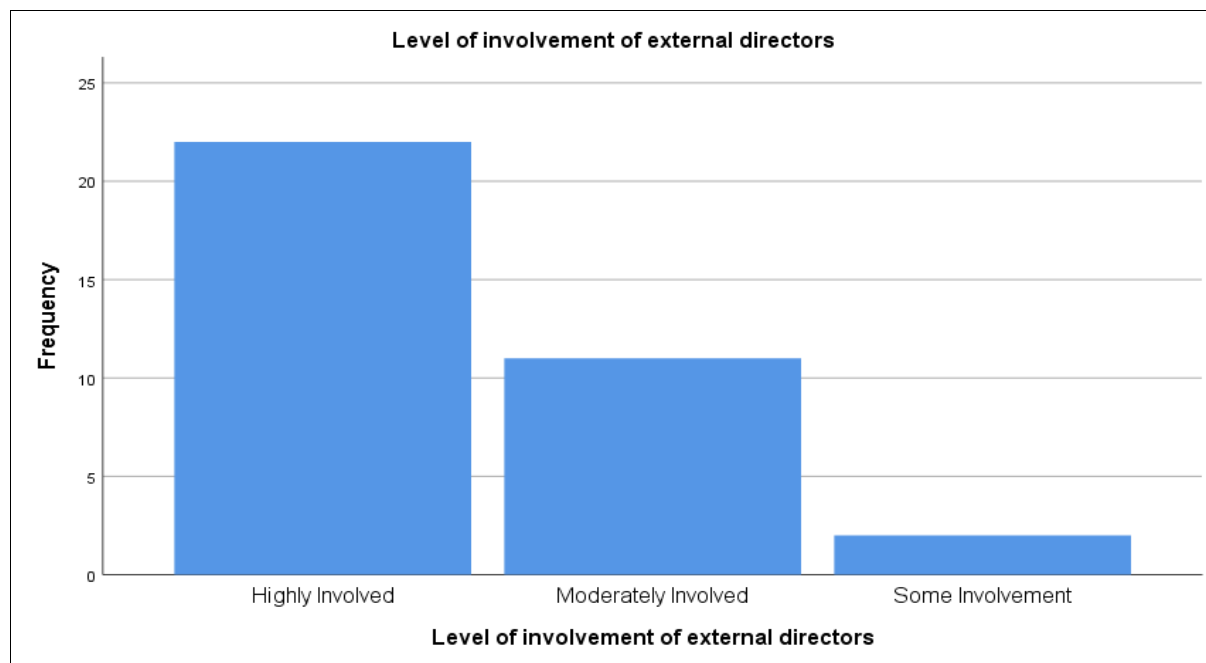
Source, Field Data (2019)

Based on the 35 respondents to the questionnaire administered, Table 35 above denotes that 26 (74.3%) have indicated that the agenda of the meeting is set by the chairperson of the board, 2 (5.7%) is set by the CEO and 7 (20.0%) the agenda is set by other channels apart from either the CEO or the chairperson of the board.

#### 6.4.6.5 *Level of involvement of external directors*

The agency theory posits that, agents to perform assigned duties to the best interest of the principal. The principal in the case of HMBs is the government, whilst the agents are the board members. External directors concentrate more on engaging in technical issues, hence the fusion of different types of experience into board committees provides leverage for a more engaged board (Klarner et al., 2020).

Figure 7 : Level of involvement of external directors



Source, Field Data, 2019

The analysis in Fig 7 provides that of the 35 responses, 22 (62.9%) of the external directors are highly involved, 11(31.4%) are moderately involved and only 2 (5.7%) have indicated some involvement in the decision making of respective institutions. The non-executive directors can interact with both the top managers and executive directors, hence imparting new ideas and innovative practices when they are involved in strategic planning process (Zhu et al., 2016).

#### 6.4.6.6 *Board remuneration*

The Public Entities Corporate Governance Act (10:31), Section 12 provides that the fixed remuneration to non-executive members should be fair, appropriate and reasonable, due regard being given to the members' qualifications, experience and functions performed.

Table 36 : Board Remuneration

Binomial Test						
		Category	N	Observed Prop.	Test Prop.	Exact Sig. (1-tailed)
No remuneration	Group 1	No	35	1.00	.75	.000
	Total		35	1.00		
Set annual fee	Group 1	NO	28	.80	.75	.322
	Group 2	Yes	7	.20		
	Total		35	1.00		
Per meeting fee	Group 1	Yes	21	.60	.75	.036 <sup>a</sup>
	Group 2	No	14	.40		
	Total		35	1.00		
Travel and other reimbursements	Group 1	Yes	11	.31	.75	.000 <sup>a</sup>
	Group 2	No	24	.69		
	Total		35	1.00		

Source, Field Data, 2019

a. Alternative hypothesis states that the proportion of cases in the first group < .75.

Since we have 35 respondents who mentioned that there is *Remuneration* on how the board of remuneration is set, the observed proportion is 35/35, thus 100%. The null hypothesis states that this proportion is 75% for the entire population. The **p** value denoted by the Exact Sig (1 tailed) is 0.00 and it indicates that there is 0% chance of not selecting remuneration when setting the board of remuneration. The analysis has shown that all the 35 (100%) respondents have indicated that board members are getting remuneration for offering their services.

Furthermore, the findings shows that the setting of a board meeting *per annual fee*, 28 respondents says NO out of 35 thus making it 80% the observed proportionality. This Also shows that there is only 32% chance of putting into consideration “Set Annual fee” when setting the Board remuneration. The binomial test indicated that the proportion of Setting Annual fee of **0.80** is greater than the expected **0.75** and the **p** value is 0.322 (1 sided). Therefore we accept the null hypothesis that on setting up remuneration board, there is no need to set annual fee. The remuneration modalities are indicated as follows:

Table 37: Set annual fee

<b>Set annual fee</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	7	20.0	20.0	20.0
	NO	28	80.0	80.0	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

The analysis in Table 37 above entails that out of the 35 responses, 7 (20.0%) are remunerated as per set annual fee. The other 28 (80.0%) are not paid as per set annual fee but through other modalities.

Table 38 : Per meeting fee

<b>Per meeting fee</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	21	60.0	60.0	60.0
	No	14	40.0	40.0	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

The analysis in Table 38 above indicates that of the 35 responses, 21 (60.0%) are paid per meeting fees and the other 14 (40.0%) are paid based on other modalities.

Table 39 : Travel and other reimbursements

<b>Travel and other reimbursements</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	11	31.4	31.4	31.4
	No	24	68.6	68.6	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

The analysis of the 35 responses in Table 39 above entails that, 11 (31.4%) are paid for their

services based on the travel and other reimbursements and the other 24 (68.6%) are remunerated through other payment modalities.

Table 40 : Other payment methods

<b>Other, please specify</b>		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Allowances	6	17.1	17.1	17.1
	Fuel	2	5.7	5.7	22.9
	N/A	23	65.7	65.7	88.6
	No idea	1	2.9	2.9	91.4
	Per sitting fees and reimbursements for fuel	1	2.9	2.9	94.3
	Sitting allowances	2	5.7	5.7	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

The 35 respondents in Table 40 above have indicated more than one payment method, hence 6 (17.1%) have indicated that they are paid allowances, 2 (5.7%) are remunerated in the form of fuel, 2 (5.7%) are paid sitting allowance, 1 (2.9%) is paid per sitting fees and reimbursement for fuel, 1 (2.9%) has indicated a “no idea” on the remuneration set and the other 23 (65.7%) are not in the category of other payments methods therefore not applicable to the option.

#### 6.4.6.7 *Evaluation of board performance*

The board, director and CEO evaluation assists in the implementation of recommendations for evaluation that have been highlighted in corporate governance report or review (Kiel et al., 2004).

Table 41 : Policy to evaluate board performance

Policy to evaluate board performance					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	17	48.6	48.6	48.6
	No	18	51.4	51.4	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

The analysis Table 41 above denotes that of the 35 respondents, 17 (48.6%) are accepting that there is a policy to evaluate performance of the board whilst 18 (51.4%) have indicated the non- existence of policy to evaluate performance of the board.

Table 42 : Board evaluation criteria and frequency

Board evaluation criteria and frequency					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	By the Minister of Health	1	2.9	2.9	2.9
	Conducted through the Health Services Board annually	1	2.9	2.9	5.7
	Done twice per annum by the Health Services Board	1	2.9	2.9	8.6
	Evaluation is done annually through review meetings	1	2.9	2.9	11.4
	Evaluation is done quarterly through review meetings	1	2.9	2.9	14.3
	N/A	15	42.9	42.9	57.1
	No clear policy to evaluate board performance	1	2.9	2.9	60.0
	No idea	1	2.9	2.9	62.9
	Quarterly and annual review meetings	1	2.9	2.9	65.7
	Quarterly performance review meetings	2	5.7	5.7	71.4
	Quarterly performance reviews	2	5.7	5.7	77.1
	Quarterly review meetings	2	5.7	5.7	82.9
	Quarterly reviews	1	2.9	2.9	85.7

Quarterly through progress reports and review meetings	1	2.9	2.9	88.6
Reports are submitted for every meeting	1	2.9	2.9	91.4
Reports discussed in every meeting	1	2.9	2.9	94.3
Review meetings	1	2.9	2.9	97.1
The board evaluates itself during each meeting	1	2.9	2.9	100.0
Total	35	100.0	100.0	

Source, Field Data (2019)

The analysis from Table 42 above entails that of the 35 responses, 15 (42.9%) have strongly denied the existence of policy to evaluate board performance hence their response to the evaluation criteria and frequency is not applicable. However, 1 (2.9%) has indicated that there is no clear policy on the evaluation of the board and furthermore 1 (2.9%) has responded “no idea” to the policy on evaluation of the board. In addition, 1 (2.9%) has highlighted that evaluation is done by the Minister of Health without giving any timelines or frequency. The other 17 board members have indicated different responses to the questionnaire, some highlighting board self-evaluation, review meetings, progress reports and reports submitted during board meetings for discussions. The frequency of the review meetings was pointed out to be either in every meeting, quarterly, bi-annually or annually. Two respondents have proffered that the Health Services Board is involved in the evaluation of the hospital board annually.

Table 43 : Board involvement on the appointment of the CEO

Board involvement on the appointment of the CEO					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	7	20.0	20.0	20.0
	No	28	80.0	80.0	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

The analysis in Table 43 above of the 35 respondents has indicated that the majority, thus 28 (80.0%) have indicated non-involvement of the board on the appointment of the CEO, whilst

only 7 (20.0%) have accepted that the board is involved on the appointment of the CEO.

#### 6.4.6.8 Policy to evaluate performance of the CEO

The leadership in the public sector is critical to good public governance, hence transforming the country into a high growth and inclusive economy. Therefore, the performance of a CEO can be strengthened through advocating for a fixed tenure, mentoring, training and recommends performance metrics or agreed targets (Dash et al., 2018).

Table 44 : Policy to evaluate performance of the CEO

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	25	71.4	71.4	71.4
	No	10	28.6	28.6	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

The analysis of the 35 responses in Table 44 above to the questionnaire has entails that, 25 (71.4%) are accepting the existence of a policy to evaluate the performance of the CEO, whilst 10 (28.6%) have denied the existence of policy on evaluation of the CEO.

Table 45 : Evaluation criteria of the CEO and frequency

#### CEO evaluation criteria and frequency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Annual review meetings	1	2.9	2.9	2.9
	Annually	2	5.7	5.7	8.6
	Annually in board meetings	1	2.9	2.9	11.4
	Annually through evaluation of level achieved in meeting set targets	1	2.9	2.9	14.3
	Annually through performance reviews	1	2.9	2.9	17.1
	Done quarterly through performance appraisal by the Health Services Board	1	2.9	2.9	20.0

Has got performance agreement appraised annually	1	2.9	2.9	22.9
N/A	10	28.6	28.6	51.4
Performance appraisal done annually	2	5.7	5.7	57.1
Performance appraisal done quarterly and then annually	1	2.9	2.9	60.0
Performance appraisals are done quarterly and annually through the Health Services Board	1	2.9	2.9	62.9
Performance appraisals done quarterly and annually	1	2.9	2.9	65.7
Performance reports and progress review meetings	1	2.9	2.9	68.6
Performance review	1	2.9	2.9	71.4
Policy in place but extremely immature	1	2.9	2.9	74.3
Progress review	1	2.9	2.9	77.1
Quarterly and annual performance appraisal	1	2.9	2.9	80.0
Quarterly and annually which is done by the Permanent Secretary and the Health Services Board	1	2.9	2.9	82.9
Quarterly performance appraisal	1	2.9	2.9	85.7
Quarterly performance reviews	1	2.9	2.9	88.6
Quarterly review meetings	2	5.7	5.7	94.3
Through performance appraisals done quarterly	1	2.9	2.9	97.1
Through reports in board meetings	1	2.9	2.9	100.0
Total	35	100.0	100.0	

Source, Field Data (2019)

The analysis of the 35 responses in Table 45 above have highlighted that, 10 (28.6%) have indicated their response as not applicable to the questionnaire. The other 25 (71.4%) respondents have highlighted various evaluation criteria of the CEO. The evaluation is done

through performance appraisals, review meetings, reports in board meetings and the evaluation is done either in every meeting, quarterly or annually. At least 3 respondents out of the 17 have mentioned the appraisal of the CEO being done through the Permanent Secretary and the Health Services Board and the evaluation is done quarterly and annually.

#### 6.4.6.9 Policy on succession planning

Public sector managers are widely realizing the importance of succession planning, hence the need for spreading it across different government levels and types. However, most public sector institutions lack succession plans, while those that do have succession plans often react to turnover instead of having a permanent solution (Gallardo, 2018). The ideal succession planning may help state health agencies to deal with turnover and preserve institutional memory (Harper et al., 2018).

Table 46 : Policy on succession planning

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	13	37.1	37.1	37.1
	No	22	62.9	62.9	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

The analysis of the 35 respondents in Table 46 above to the questionnaire have indicated that, 22 (62.9%) of the responses denied the existence of a policy on succession planning whilst 13 (37.1%) have accepted the existence of a policy on succession planning.

#### 6.4.6.10 The internal audit department

Generally, companies that have established internal audit departments have strong corporate governance mechanisms which will subsequently improve firm performance (Hay and Cordery, 2018). However, the internal audit department should maintain a high level of objectivity and independence, during the execution of their core function of evaluating and providing management with assurance on risk management (Ojo, 2019).

Table 47 : Existence of internal audit department

Existence of an internal audit department					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	32	91.4	91.4	91.4
	No	3	8.6	8.6	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

The analysis of the 35 responses in Table 47 above have indicated that, 32 (91.4%) accepted the internal audit department do exist in various institutions. Only 3 (8.6%) have denied the existence of an internal audit department.

#### 6.4.6.11 *Sub-committees of hospital management boards*

The analysis of the 35 respondents to the questionnaire has indicated that institutions have various sub-committees in place. All the 35 (100%) respondents have indicated that the finance and clinical audit sub-committees are in place. For risk management, 32 (91.4%) have indicated the existence of the sub-committee whilst 3 (8.6%) highlighted the non-existence. Under the human resources sub-committee, 20 (57.1%) have proffered the existence of the committee whilst 15 (42.9%) have denied the existence of the sub-committee. Furthermore, the analysis of the 35 responses under the sub-committee on social or ethical committee has indicated that 32 (91.4%) denied the existence of such a committee, whilst only 3 (8.6%) have concurred with its existence.

The 35 respondents have specified the existence of other sub-committees apart from the sub-committees indicated on the questionnaire.

Table 48 : Other board sub-committees

<b>Other, please specify</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Audit	1	2.9	2.9	2.9
	Audit and Operations	1	2.9	2.9	5.7
	Audit and Resource mobilization	1	2.9	2.9	8.6
	Audit and Resource mobilization committee	1	2.9	2.9	11.4
	Fund Raising	1	2.9	2.9	14.3
	Fundraising, Projects and Security	1	2.9	2.9	17.1
	Housing and Amenities	1	2.9	2.9	20.0
	Infrastructure and Audit	1	2.9	2.9	22.9
	N/A	11	31.4	31.4	54.3
	Operations	6	17.1	17.1	71.4
	Resource Mobilization	9	25.7	25.7	97.1
	Security and Resource mobilization	1	2.9	2.9	100.0
	Total	35	100.0	100.0	

Source, Field Data (2019)

The analysis of the respondents in Table 48 above has highlighted the existence of 8 other sub-committees that is the fundraising had 11 responses, operations 7 responses, audit 5 responses, resource mobilization 4 responses, security 2 responses, projects 1 response, housing and amenities 1 response and infrastructure 1 response.

Table 49: Relationship between policy to evaluate performance of the board and the CEO

<b>Correlations</b>			
		Policy to evaluate board performance	Policy to evaluate performance of the CEO
Policy to evaluate board performance	Pearson Correlation	1	.362
	Sig. (2-tailed)		.033
	N	35	35
Policy to evaluate performance of the CEO	Pearson Correlation	.362	1
	Sig. (2-tailed)	.033	
	N	35	35

Source, Field Data (2019)

\*. Correlation is significant at the 0.05 level (2-tailed).

The analysis of Table 49 above illustrates that there is a positive co-relation between the policy to evaluate the hospital management board and the CEO.

### 6.3.6.12 *Multivariate Analysis*

<b>Between-Subjects Factors</b>			
		Value Label	N
Region	1	Northern Region	16
	2	Southern Region	19
Gender	1	Male	29
	2	Female	6

Source, Field Data (2019)

## Between-Subjects Factors

		Value Label	N
CEO also chairperson of the board	2	No	35
Frequency of meetings within a year	2	Quarterly	35
Board meetings based on prepared agendas	1	Yes	35
Setting agenda of meetings	1	Chairperson	26
	2	CEO	2
	3	Other, Please specify	7
Board Remuneration : No remuneration	2	No	35
Policy to evaluate board performance	1	Yes	17
	2	No	18
Board involvement on the appointment of the CEO	1	Yes	7
	2	No	28
Policy to evaluate performance of the CEO	1	Yes	25
	2	No	10
Policy on succession planning	1	Yes	13
	2	No	22
Existence of an internal audit department	1	Yes	32
	2	No	3
Board Committees : Risk management	1	Yes	32
	2	No	3
Building organizational reputation	1	Not important	1
	2	Not sure	1
	3	Moderately important	2
	4	Important	14
	5	Very important	17

Source, Field Data (2019)

### Tests of Between-Subjects Effects

Dependent Variable: Functional Board

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	3.368 <sup>a</sup>	12	.281	3.852	.003
	7.729	1	7.729	106.071	.000
Q3	.000	0	.	.	.
Q4	.000	0	.	.	.
Q5	.000	0	.	.	.
Q7	.050	2	.025	.344	.713
Q9a	.000	0	.	.	.
Q10	.049	1	.049	.669	.422
Q12	.303	1	.303	4.153	.054
Q13	.031	1	.031	.428	.520
Q15	.336	1	.336	4.617	.043
Q16	.281	1	.281	3.853	.062
Q17a	3.204E-5	1	3.204E-5	.000	.983
Q18a	.046	4	.011	.156	.958
Error	1.603	22	.073		
Total	53.000	35			
Corrected Total	4.971	34			

Source, Field Data (2019)

a. R Squared = .678 (Adjusted R Squared = .502)

A multivariate Anova was conducted that examined the effect of variables on Functionality of Board. There was statistically no significant interaction between the effect *who sets the agenda of meetings* on the availability of a functional board with  $F = 0.344$ ,  $p = 0.713$ .

Furthermore the findings shows that there is a statistically significant interaction between the variable “*Is the board involved in the appointment of the CEO?*” On the availability of a functional board,  $F = 4.153$  and the  $p$  value of 0.054 which is slightly greater than the 0.05 tested at 95% confidence interval.

The Pillai’s trace is the most preferred approach for the F value as this is the least sensitive to the violation of the assumption of the covariance of matrices. In this case for the first

independent variable Q7 (Who sets the agenda of the meetings) the Pillai's Trace value is 0.512 with F value of 2.624b. This is not significant at 5% level as the p value is 0.166. So we accept the null hypothesis that the IV1 are at same level for all the dependent variables. This is concluded on the basis of the MANOVA derived by combined dependent variable. For Region the Pillai's Trace is 0.690 with F value of 5.315. This is also not significant as the p value is greater than 0.05. So for Region also we reject the null hypothesis. In other words, Regions are at the same level for all the dependent variables.

#### 6.4.6.13 Exploratory Factor Analysis

Exploratory factor analysis is another multivariate statistical correlation analyses that can be used to examine the validity of variable items (Ong and Puteh, 2017). It is a statistical tool used for refinement, reconstruction and confirmation of variable structures' structures that share a common variance (Sakaluk and Short, 2016).

<b>KMO and Bartlett's Test</b>		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.685
Bartlett's Test of Sphericity	Approx. Chi-Square	248.608
	Df	66
	Sig.	.000

The KMO test measures the sampling adequacy, that is determining if the response given is adequate or not. It states that if the measure is close to 0.5 for satisfactory factor analysis, then it should proceed. Kaiser (1974) recommend 0.5 as barely accepted, 0.7 to 0.8 as acceptable and 0.9 as super or best.

The KMO and Bartlett's Test of 0.685 shown above indicates that there are enough items predicated by each factor in this research question which are fairly adequate. This is because any score above greater than 0.70 is considered adequate. Furthermore, the Bartlett's Test of Sphericity significance score indicated here of 0.000 means that the variables tabulated below are correlated highly enough to provide a reasonable basis for factor analysis for this research question.

#### 6.4.6.14 Descriptive Statistics

Descriptives is a commonly used SPSS procedure, designed to provide information about distribution of variables for example the mean, median and mode (George and Mallery, 2016). Descriptive statistics are used to organize and summarize large amounts of data that needs to be interpreted (Holcomb, 2016). The contribution of the hospital board of directors in central hospitals of Zimbabwe was analysed using the descriptive statistics as follows:

Table 50 : Contribution of the board of directors

	Mean	Std. Deviation	Analysis N
Building organizational reputation	4.29	.926	35
Strategic planning process	4.14	1.033	35
Control organizational resources	3.60	.946	35
Finance expertise	3.66	.968	35
Legal expertise	3.40	.946	35
Operational expertise	3.89	1.105	35
Recruitment	3.03	.747	35
Providing strategic advice	4.43	.917	35
Networking	4.31	.832	35
Determining salary and remuneration	1.80	.797	35
Evaluating management	3.40	1.241	35
Directing succession challenges	2.06	1.083	35

Source, Field Data (2019)

#### 6.4.6.15 Principal component analysis (PCA)

The principal component analysis is widely used in dimensionality reduction (Yi et al., 2017). The PCA is the technique for reducing the dimensionality of datasets, increasing interpretability and reducing or minimizing data loss (Jolliffe and Cadima, 2016).

Table 51 : Principal component analysis of hospital board contribution

	Initial	Extraction
Building organizational reputation	1.000	.817
Strategic planning process	1.000	.776
Control organizational resources	1.000	.723
Finance expertise	1.000	.754
Legal expertise	1.000	.347
Operational expertise	1.000	.784
Recruitment	1.000	.907
Providing strategic advice	1.000	.923
Networking	1.000	.855
Determining salary and remuneration	1.000	.858
Evaluating management	1.000	.686
Directing succession challenges	1.000	.803

Source, Field Data (2019)

Table 52 : Contribution of board of directors to hospital governance

<b>Question : Contribution of board of directors</b>	
	Component 1
Providing strategic advice	.873
Building organizational reputation	.850
Control organizational resources	.773
Strategic planning process	.765
Operational expertise	.753
Finance expertise	.716
Evaluating management	.570
Legal expertise	.411
Directing succession challenges	.375
Determining salary and remuneration	.326
Recruitment	.332
Networking	.616

Source, Field Data (2019)

As shown in Tables 51 and 52 above, twelve factors were considered for this research question and two, thus providing strategic advice and building organizational reputation had the highest number of respondents who expressed strongly agree or agree viewpoint with a factor analysis score of 0.873 and 0.850 respectively. The finding suggests that respondents have a strong view that the board of directors has a major contribution on providing the strategic advice and also building organizational reputation. There were also other five factors (highlighted above) which were viewed moderately by the respondents as being pushing factors to the contribution of directors. The rest of the factors are viewed with lesser influence. The factors with a score of 0.30 and 0.60 were neglected in the analysis.

## 6.5 Chapter summary

The analysis of data above gave rise to the key issues and conclusions being drawn. Hospital management boards in existence have sub-committees which suite their needs and expectations. However, there are some board committees which are very common in all institutions like for example the clinical audit, finance and internal audit committees. All hospital boards thrive to have robust internal control systems and be centres of excellence in terms of service delivery. The accolades or awards won by different institutions signify the board and management commitment in the fulfilment of the expectations of various stakeholders.

The analysis to measure the scale reliability and validity was conducted through the use of the SPSS Version 25. The Cronbach's Alpha test was at an acceptable level of 0.716. Furthermore, the validity and reliability were also confirmed by the KMO and Bartlett's factor analysis test, whilst KMO measure the sample adequacy and the Bartlett's measures the significance values. The sampling adequacy test score of 0.685 was derived from the test. Hence, based on the reliability analysis using the KMO, Cronbach's Alpha test and Bartlett's test, all factors or components in this study are reliable.

Finally, this chapter states that the hospital management boards should be standardized and strengthened through the implementation of good governance principles. The effectiveness of hospital management boards in discharging their mandate should be based on the adherence to good corporate governance practices. The next chapter report the results or findings of the study based on the scales highlighted above.

## **CHAPTER SEVEN**

### **INTERPRETATION AND PRESENTATION OF RESEARCH FINDINGS**

#### **7.1 Introduction**

The previous chapter was an analysis and presentation of the research results of data gathered through research questionnaires and interviews. This current chapter is the interpretation of the study findings. It is from the interpretation of the study findings in this chapter that conclusions are drawn and models related to the statement of the problem are developed and presented in the final chapter.

In chapter 1, section 1.4, the following research objectives were stressed presented: (i) To determine standard functional structures of hospital management boards in central hospitals of Zimbabwe; (ii) To examine the processes for appointing hospital management board members in central hospitals of Zimbabwe, and (iii) To establish the challenges faced by hospital management boards in carrying out their mandate and finally to recommend strategies for enhancing functionality of hospital management boards in central hospitals of Zimbabwe. Therefore, the results of this study will be interpreted and presented with a view to ascertain the extent to which the set objectives were addressed through the data obtained and analysed. .

#### **7.2 DETERMINATION OF STANDARD FUNCTIONAL STRUCTURES OF HOSPITAL MANAGEMENT BOARDS IN CENTRAL HOSPITALS OF ZIMBABWE**

From the findings presented, it is evident that 12 dimensions emerged with regard to standard functional structures of hospital management boards in central hospitals. These are as follows: (i) Functional hospital management board; (ii) Number of board members in hospital management boards; (iii) Board committees; (iv) Board's term of office and duration as a board member; (v) Policy to evaluate performance of the CEO; (vi) Frequency of board meetings and setting of agendas; (vii) Policy to evaluate performance of the hospital management board; (viii) Board remuneration; (ix) Succession planning; (x) Involvement of external or independent non-executive directors; (xi) Existence of an internal audit

department (xii) Contribution of hospital boards to governance of hospitals. Each one of these is discussed in the next sections respectively.

### **7.2.1 Functional hospital management board**

The study results revealed that out of the 6 hospital management boards only 4 have functional hospital management boards. The accountability assessment framework stipulates that, accountability is achieved through the existence of such arms like watchdog agencies, hospital boards, civil society organizations and others. Hospitals with functional boards are Parirenyatwa Group of Hospitals, Harare central hospital, Ingutsheni central hospital and Mpilo central hospital. UBH and Chitungwiza central hospitals do not have functional hospital management boards since their terms of office expired in October 2017 and July 2018 respectively. The board function as coach, sensor, diplomat, shock absorber and conscience, hence the importance of having a functional board to steer the ship towards the achievement of the desired goals of the hospital (Chambers et al., 2020). As can be seen, absence of a functional board for such a long period of time is undoubtedly an indication of weak governance practice. Hospital management boards are there to offer strategic advice on hospital operations, but without a functional board for such a long time, this reduces the chance for failure to achieve the objectives of both the hospital and the nation. In practice, the hospital boards support management in terms of financial management, monitoring, resource mobilization, stakeholder interfacing and strategic decision making (Thiel et al., 2018). The relevant authorities, thus the Minister of Health and Child Care and Health Service Board should come up with a clear policy on hospital management board's functions and term of office.

### **7.2.2 Number of board members in hospital management boards**

The Health Service Act (Chapter 15:16) provides that a hospital management board should have not more than seven members, that is, including the superintendent or CEO. In terms of good corporate governance, the CEO or any member of the executive should not be a board member but should rather be accountable to the board. The CEO duality is considered highly undesirable since the firm performance is significantly affected by such an arrangement. However the impact of duality can be moderated by ensuring board independence (Duru et

al., 2016). The managerialism theory supports the inclusion of executive management in the HMBs, due to the fact that they render technical or expert advice to board members. The finding in this study revealed that the CEOs are also board members suggests that the Act needs to be re-aligned to the good corporate governance practices as highlighted in the Zimbabwe Code on Corporate Governance (2014). If the Act is amended, it means that the seven hospital board members should comprise independent non-executive professionals in order to foster the independence of the hospital management board in its functions. The presence of internal directors, external chair, independent board members and ownership concentration has positive effect on firm performance. CEO duality is not highly recommended since it was discovered to have negative effect on firm performance (Shahrier et al., 2020).

### **7.2.3 Board committees**

A functional hospital board should have relevant sub-committees accountable to the main board. The board committees make important decisions (Kesner, 1988). The resource dependence theory proffers that, relevant skills, knowledge and expertise enhance organizational capacity to achieve desired goals and objectives. The harnessing of contributions by non-executive directors can be achieved through delegation of tasks from the main board to sub-committees, hence their establishment is highly recommended to improve corporate governance (Vig and Datta, 2020). The study results revealed that the sub-committees vary according to the vision of each institution. The common sub-committees that are found across most institutions are the clinical audit, finance, fundraising, human resources, internal audit and risk management. Other sub-committees like social amenities, housing, technical and operations are formed in line with the institutional vision and targets of each institution. The fusion of external board members and internal directors is quite commendable considering that external directors in sub-committees handle agency issues like compensation and audit, whilst insiders use their acumen on such matters like investment and financial management (Chen and Wu, 2016).

### **7.2.4 Board's term of office and duration as a board member**

The study results revealed that there is no clear policy to regulate the operations of hospital

management boards, hence the boards' term of office vary across the institutions studied. The principal-agent theory stipulates that, agents in this case board members or management should be given contracts and performance agreements or targets by the government. The government which is the principal rely on the agents to make informed decisions. The term of office ranged from three to five years and renewable subject to the Minister's discretion who can renew for one more term. The results have also revealed that the CEOs have terms of office which are indefinite, for example CEO 2 and CEO 3 have been in office for 12 and 17 years respectively. This is in contradiction with the Public Entities Corporate Governance Act (Chapter 10:31) which stipulates that the CEO can only be in office for 10 years, thus 2 terms of 5 years each. Specifying the term of office for board members and senior managers in state-funded health institutions result in improvement of organization's performance (Shalev and Prodan, 2016). This finding also means that there is need to align the Health Service Act (Chapter 15:16) to some provisions of the Public Entities Corporate Governance Act (Chapter 10:31), which is very comprehensive and in tandem to the good corporate governance best practices. The CEO's long term of office has a negative impact on the discretionary accruals level, hence the shorter the term of office the better the results derived from management practices (Dal Magro et al., 2018).

#### **7.2.5 Policy to evaluate performance of the CEO**

The policy to evaluate performance of a CEO is an important tool to allow for achievement of the goals of an organization. The stewardship theory states that, staff motivation, safeguarding of organizational resources and achievement of both bold and specific objectives are fundamental to the success of the entity. The effectiveness of the board to monitor the top management including the CEO is decreased in the event that the chairperson of the board of directors is also the CEO (Firth et al., 2007). Financial performance is the baseline for the overall CEO's evaluation, thus poor financial performance increase the likelihood of CEO dismissal and reduce the likelihood when financial performance is good (Hubbard et al., 2017). As already understood, the board members are necessary to set long term strategic plans for an organization whilst the executive management including the CEO streamlines the long term plans into medium and short term plans. The Zimbabwe Code on Corporate Governance of 2014, Section 131 (e) propounds that the CEO has the mandate of monitoring and reporting to the board on the performance of the company and its

conformance and compliance imperatives to laws, policies and other regulatory frameworks.

The study results revealed that there is a policy to evaluate performance of the CEO. The entity's board has the prerogative to evaluate the CEO, however the stakeholders like investors, society and employees are central to the evaluation process. Generally, it is the board's prerogative to either hire or fire the CEO (Wiersema and Weber, 2017). The results of the 35 respondents indicated that 25 (71.4%) confirmed the existence of policy to evaluate performance of the CEOs, whilst 10 (28.6%) did not know the policy existed. The study findings also indicated that the performance evaluation of the CEOs was done quarterly and annually through board meetings, reports and performance appraisals conducted by the HSB and Permanent Secretary. From the findings, it appears that the boards are not quite committed to evaluate themselves. This aspect is emphasized by Board Chair 4 who highlighted that *“There is no tangible effort for assessing the performance of the CEO and it's left to the permanent secretary. The bottom line is that there is no tangible process for assessing the CEO and thus a problem”*. The CEO performance evaluation is considered an indicator of good corporate governance practice and it actually shows board commitment and effectiveness in carrying out their mandate. However, since the CEO is considered an active board member, this limits the independence and objectivity of the evaluation by the board. The greater the board independence, the higher the quality of accounting information (Abdoli and Royae, 2012). This resonates with the earlier assertion that in a bid to guarantee independence and impartiality in the hospital governance, the CEO should be an ex-officio member of the board.

#### **7.2.6 Frequency of board meetings and setting of agendas**

The results have revealed that all the 35 (100%) respondents confirmed that board meetings are conducted on a quarterly basis and the proceedings are guided by prepared agendas. This is quite a positive aspect in that the board should be well acquainted with progress in the institution. The firm should hold at least four board meetings per year in a bid to comply with good governance (Eluyela et al., 2018). The study finding also showed that even board committees regularly report to the main board on their performance progress in line with the broader vision of the entity. The higher the percentage of board meetings the greater the

board awareness on the organizational activities and monitor the implementation of strategies (Kamardin and Haron, 2011). The agendas were confirmed to be set by the board chairperson and in some instances after consultation with other board members. This practice is in compliance with Zimbabwe Code on Corporate Governance of 2014, Section 119 (g).

#### **7.2.7 Policy to evaluate performance of the hospital management board**

The results from the study revealed the non-existence of policy to evaluate performance of the board. Performance accountability is for health provider and hospital board performance in accordance with the agreed performance indicators. The performance agreements and targets should be aligned to financial allocations, hence the close relationship between financial and performance accountability. Strengths and weaknesses in the performance of the board are scrutinized through board evaluations (Rebeiz, 2016). The 18 (51.4%) expressed that they did not know if a policy to evaluate performance of the hospital management board existed, whilst 17 (48.6%) confirmed its existence and use. Of the 35, only 2 respondents revealed that the evaluation is done by the HSB and only 1 expressed that it is done by the Minister of Health and Child Care. The results from the 17 respondents who confirmed the existence of policy to evaluate performance of hospital management. Furthermore, it was stated that self-evaluations are conducted through regular board quarterly meetings. The board evaluation might be conducted by the board itself being facilitated by external evaluators, internally or externally (Osborne, 2008). The individual director evaluations should be conducted to expose better and immediate performance results, with respect to the BOD competencies (HUMPHRIES, 2014). Self-evaluation of the board can be considered an ineffective approach because of its nature of self-reporting. Therefore, it can be concluded that the policy on board evaluation in place requires strengthening and consistent enforcement to bring about objective evaluation results of the board performance. This aspect was stressed by Board Chair 4 who proposed that *“There is great need to develop an operational manual for hospital management boards.”* This shows that the reportedly existing policy has limitations and, without a clear policy to evaluate board performance, its effectiveness in carrying out its roles and responsibilities in line with good corporate governance is clearly compromised.

### **7.2.8 Board remuneration**

From the study findings, it is apparent that different remuneration modalities are applied across the six central hospitals studied. It furthermore emerged from all the 35 (100%) respondents that board members are paid allowances for attending board meetings. The remuneration of state-owned enterprises ought to be reviewed in line with financial performance, hence perks should be based on the pay-for-performance system (Marimuthu and Kwenda, 2019). The principal-agent theory is of the view that, the remuneration of board members should be administered transparently and information should be disclosed pertaining to decision making. In a bid to buttress the performance based remuneration for board members, a study was conducted in Malaysia on 118 state-owned enterprises and the results revealed that there is a positive relationship between directors' remuneration and firm performance, hence directors' remuneration is considered as an incentive to perform their monitoring task effectively (Marzuki and Shukri, 2020). The allowances are paid per meeting actually attended and to verify such, everyone in attendance is required to sign in the register. The allowance includes the stipulated amount for meeting attendance and reimbursement of travel allowances and fuel. Seven (7) of the respondents indicated that payment is administered as per the institutional set annual fee for board members. This therefore translates to a static fee being paid whatever the number of meetings attended. Other respondents indicated existence of more than one reimbursement modality, that is, a possibility of one getting both per meeting fees or sitting allowances plus travel and other reimbursements like fuel or similar out of pocket expenses. From this finding reveal a need for the hospitals to develop standard manuals on the operation of hospital management boards which would spell out and standardize the board remuneration.

### **7.2.9 Succession planning**

Board succession planning is pivotal in ensuring board effectiveness. Civil service reforms are earmarked to achieve professionalization of government ministries or agencies, hence the importance of succession planning. In other words, succession planning prepares the board to maintain the knowledge and skills it requires even when the term of a board member expires or board member dies or terminates service. In terms of succession planning, correct

people should occupy key positions, hence succession plans ought to guarantee knowledge retention. Generally, when long serving employees retire, they take along with them years of experience and institutional knowledge (Avalos, 2020). The Zimbabwe Code on Corporate Governance of 2014, Section 56 (h) provides for the establishment of an institutional proper succession plan for its board members. The study results revealed that, out of the 35 respondents 22 (62.9%) expressed that they did not know if a policy on succession planning existed in their organizations. The term of office for hospital management boards for UBH and Chitungwiza central hospitals expired in October 2017 and July 2018 respectively but remain unconstituted. Obviously, this affects the smooth running of institutions due to the vacuum in hospital governance. Furthermore, the CEO for Chitungwiza central hospital was appointed Minister of Health and Child Care in September 2018 but the post remain unfilled for eight months. This means that Chitungwiza central hospital was run without both a substantive CEO and hospital management board during that period. The organizational growth and business sustainability in the public sector is based on proper succession planning. However, few organizations have attempted to introduce the concept and practice. In the case of the United Arab Emirates, succession planning strategy, organizational culture and leadership development opportunities were linked to succession planning in the public sector (Al Suwaidi et al., 2020). The finding clearly shows that effective policy on succession planning should be in place and effectively enforced to avoid intermittent governance void in organizations. The void in governance structures has a negative impact on the achievement of good corporate governance mandate.

#### **7.2.10 Involvement of external or independent non-executive directors**

The external or independent non-executive directors are critical to serve in boards and board committees so that effective good corporate governance is achieved and sustained. The principal-agency theory postulates that, agents should be endowed with vast information as compared to the principals who rely more on the agents for decision making. Furthermore, the stakeholder theory posits that the HMBs should involve the interests of different stakeholders in order to integrate and balance various stakeholder interests in relation to the goals and expectations of the organization. The Zimbabwe Code on Corporate Governance of 2014, states that independent non-executive directors are appointed to serve the board and board committees, to balance corporate power and to protect the interest of the organization,

minority shareholders and other stakeholders. The study results revealed that external directors are highly involved in the affairs of their respective health institutions, as reflected by the 33 (94.3%) respondents and 11 (31.4%) who indicated that their involvement is moderate to high. Only 2 (5.7%) respondents revealed some involvement. The independent non-executive directors have been incorporated as an antidote to corruption and poor governance in the non-profit organizations, hence increasing the quality of governance and provision of assurance to stakeholders (Nelson, 2017). It is likely that the involvement of external and non-executive directors bring in good corporate image, expertise and resources because of their possible networking with the external stakeholders. The non-executive directors are custodians of governance processes achieved through bringing independent judgment and reduction in conflict of interest between shareholders and management. They monitor the executive activities and bring independence to the board (Imade, 2019). Thus external directors enhance the effectiveness of good corporate governance practice.

#### **7.2.11 Existence of an internal audit department**

The internal audit function is an internal control tool aimed at creating robust systems to manage the organization's resources. Financial accountability is concerned with internal control systems, which include budget controls, cashflow management, record keeping and other systems that ensure transparency in financial management. The internal audit function is designed to ensure compliance with internal control systems. In the public sector, robust internal checks should be instituted in a bid to provide assurance that government funds are utilized for the intended purpose, hence the existence of an internal audit function (Udeh and Nwadiakor, 2016). The study results confirmed the existence of an internal audit department in every institution studied as evidenced by the 32 (91.4%) respondents. The results further indicate the importance of the internal audit function as perceived by the hospital management boards. The sentiments to support the importance of the audit function were echoed by the CEO 4 who said, "...but the audit committee has no one in the executive but what they do is that they then invite the internal auditor to come and make presentations". During the conducting of their duties, internal auditors in the public sector lack proper independence, therefore not very effective tool of the governance system as was revealed in study findings in Accra, Ghana (Collins Frimpong OFORI, 2018).

In addition, the results on the existence of sub-committees of the board revealed the existence

of a board committee on internal audit. The internal audit committee analyse and make recommendations on findings from the internal audit. However, the audit function does not prevent fraud, rather it is established to evaluate existing processes and identify any weaknesses that might lead to undetected fraud (Sorunke, 2016). From these findings, it can be argued that one of the main functions of a hospital management board is to manage the organization's resources in an efficient, effective and responsible manner.

## **7.2.12 Contribution of hospital boards to governance in hospitals**

### **7.2.12.1 Significant contribution**

The respondents expressed a high contribution in the provision of strategic advice and building organizational reputation, with a factor analysis score of 0.873 and 0.850 respectively. Public sector boards have a multi-pronged portfolio in terms of strategic advice, employment, external linkage or networking and critical scrutiny (Schillemans and Bovens, 2019). Hospital boards are critical in rendering strategic advice to executive management in central hospitals. Boards develop a vision and strategic plan which would be cascaded to the executive management for implementation. The study results further revealed that hospital boards and sub-committees hold meetings quarterly to evaluate progress, hence the importance of strategic advice to respective institutions. Strategic advice is an important tool in strengthening the effectiveness of hospital management boards and executive management. Valuable advice would definitely influence quality service delivery to the patients, who are considered to be the biggest stakeholder.

Building of organizational reputation was considered a major contribution by hospital management boards and this was attributed to its effect on protecting the institutional image. Research on corporate reputation has generally shown that reputational risk or risk of reputational loss has emanated from all company risks (Pérez-Cornejo et al., 2019). In hospital management systems, reputational risk can be managed through either a risk management or internal audit committee or function. Results from the 35 respondents indicated that 32 (91.4%) existence of an internal audit department in all respective central hospitals. Furthermore, the 10 (83.3%) of responses from interviews conducted affirmed the existence of internal audit committee. It can be implied that all the six central hospitals in

Zimbabwe are concerned with the building of organizational reputation through robust internal control systems and procedures. Generally, not-for-profit organizations are consciously aware of building organizational reputation and this is necessitated by the public scrutiny and need for financing in a competitive environment (Santos et al., 2019).

#### **7.2.12.2      *Moderate contribution***

Hospital boards contribute moderately to hospital governance, with a factor analysis score of 0.773 on controlling organizational resources, 0.765 on strategic planning process, 0.753 on operational expertise, 0.716 on finance expertise and 0.616 on networking.

The controlling of organizational resources is a critical function of a hospital management board. The Zimbabwe Code on Corporate Governance of 2014, Section 63 provides that the directors or board members have an obligation to perform their duties with the degree of care expected of a reasonable person in resource stewardship of an entity and honestly apply their minds in decision making. Hence, it is the duty of every hospital board member to serve the interests of stakeholders in safeguarding the assets or resources of the organization. The board member should not have conflict of interest in the carrying out the work in line with the organizational mandate. This aspect is supported by the study results that revealed the importance given to the management of organizational resources.

A strategic planning process entails having a clear broad perspective to planning, thus having a broader stakeholder involvement and stakeholder collaboration. The broad participation means having many ideas and suggestions that have to be considered against each other which may lead to conflicting ideas (Gustafsson et al., 2019). The hospital boards contribute greatly to the strategic planning process. For example, the study results revealed that Parirenyatwa Group of Hospitals and Ingutsheni central hospital developed their 2018-2020 and 2019-2023 strategic plans respectively. Furthermore, at the time of this study, Harare central hospital was about to launch its strategic plan to guide achievement of the targets towards quality and efficient health service delivery. Without a doubt, the board members have a mandate in the strategic planning process of their respective institutions.

In terms of the operational expertise, hospital board members also play an important role to

ensure responsive service delivery. The study results revealed that patients are the most important stakeholder in a hospital set up and this emphasizes the imperative for quality service delivery. The study results revealed that all the respondents (35 = 100%) confirmed the existence of a clinical audit committee which indicates the important role clinicians play hospital management boards discourse. Furthermore, in terms of board member professions, out of the 35 respondents 15 (42.9%) had a medical background. Again, this shows that board members have a crucial role to ensure the achievement of quality service in their respective institutions.

The finance expertise is another important component in hospital governance as the study results revealed that board members have a central role to design and implement governance frameworks that help to ensure effective financial management. The study results also indicated that all the 35 (100%) respondents to the questionnaire had a finance sub-committee in their respective boards. Furthermore, the resource mobilization or fundraising committee was in place and reportedly functional in all the central hospitals studied. This suggests that board members contribute greatly to matters of resource mobilization and financial management.

There is a significant increase in the use of diversity networks, in the form of diversity management instruments (Dennissen et al., 2018). External networking by board members is regarded as a competitive edge in public health institutions and this why it is encouraged that the recruitment and selection of board members should target individuals with different but complementing professional backgrounds and experience. The study results have revealed that board members are identified from different backgrounds like the private sector, public sector, different professions and gender diversity. Stakeholder interfacing is an important responsibility for board members, hence, networking becomes significant in bridging the gap between public health institutions and the various stakeholders in a country.

### **7.2.12.3      *Less contribution***

The study found that hospital boards have less influence or contribution in evaluating management with a factor analysis score of 0.570, legal expertise with 0.411, directing succession challenges with 0.375, determining salary and remuneration with 0.326 and

recruitment with 0.332.

Board evaluations are done to identify, address issues and potential problems or challenges. However, it should be noted that there is no single correct method to the evaluation process (Hanks Jr et al., 2018). The study results revealed the absence of clear procedure to ensure the evaluation of performance of both the CEO and executive management by the board. The Public Entities Corporate Governance Act (Chapter 10:31), Sections 23 and 24 provides that the CEO and staff members of state entities are subjected to annual performance reviews and monitoring, through performance appraisals. The performance appraisal of the CEO should be conducted by the board. In the case of a central hospital, hospital management boards should do performance appraisals for the CEO and then the CEO appraises the executive management who include the directors of finance, clinical and operations.

Factor analysis revealed that boards of directors should have diversity in skill sets (Adams et al., 2018). Board structures across firms should be consistent with models of monitoring and advising roles. Furthermore, it should be generally understood that board members should possess the requisite legal expertise (Linck et al., 2008). The Health Service Act (Chapter 15:16), Section 18 provides that every central, provincial, district or general hospital is mandated to operate as a corporate body, hence the importance of having a legal expertise in the hospital management board. Generally, directors with legal and consulting experience render unique advice and expertise (Fedaseyeu et al., 2018). The study results revealed that board members have less contribution on legal expertise as evidenced by only 2 (5.7%) respondents who mentioned that their board members had legal expertise.

As generally understood in governance practice, the planning for executive succession or leadership is an important component in the success of non-profit organizations. Despite the replacement of long serving leaders or managers being deemed to be acknowledged difficult, most organizations are not proactive in taking steps to close the void (Froelich et al., 2011). The shortages of chief executives within a growing economic and social importance in non-profit organizations highlight the need for executive succession planning since the operating environment is complex and sometimes uncertain (McKee and Froelich, 2016). As pointed out earlier, the CEO for Chitungwiza central hospital has not been recruited for eight months from the time the position fell vacant. Furthermore, the hospital management boards for UBH

and Chitungwiza central hospitals have not been filled since October 2017 and July 2018 respectively. The study results of the 35 respondents revealed that 22 (62.9%) affirmed that there is no clear policy on succession planning. This scenario of not filling critical leadership and managerial posts is not ideal for organizational performance and continuity. For this reason, it is critical to have a clear succession policy on directing succession challenges in central hospitals.

The management played no role in determining the directors' remuneration. However, there is a significant and positive association between the directors' influence and the directors' remuneration (NELSON and RAHIM, 2018). The study results revealed that hospital board members are not involved or do not have any contribution in determining salary and remuneration. The salary scales and remuneration for hospital staff or employees are determined by the Ministry of Finance and Economic Development in consultation with the Public Service Commission and HSB, hence the non-involvement of the hospital management boards. The remuneration for employees of public entities are regulated by the Minister of Finance as provided in the Public Entities Corporate Governance Act (Chapter 10:31), Section 20 (1). However, the Zimbabwe Code on Corporate Governance of 2014, Section 161 and 163 provides that based on the person's calibre, experience and appropriate skills, the remuneration for board members and senior management should be fair in order to attract, retain and motivate employees.

The Zimbabwe Code on Corporate Governance of 2014, Section 123 provides that the CEO and the entire executive management of the state enterprise ought to be appointed by the board and be accountable to it. The 35 respondents, 28 (80.0%) expressed non-involvement of the board in the appointment of the CEO. This study finding is contrary to the provisions of the good corporate governance practices where boards are responsible for the recruitment of all senior managers including the CEO.

#### **7.2.13 Alignment of organizational goals with interest of stakeholders**

Stakeholders of an organization can be classified as both the internal and external stakeholders. The agency theory is anchored on the interests of both internal and external

stakeholders. The internal stakeholders are the staff, who include the executive management, medium level management or heads of departments and low level staff who are the operatives. External stakeholders involve various interested parties like the patients, auditors, suppliers, ministry or HSB, community leaders, donors and partners. The social accountability theory advances that government officials are answerable to the citizens, civil society organizations and various stakeholders. Stakeholder engagement proactively responds to the desires of multiple stakeholders through enhanced organizational commitment in the provision of goods and services (Franklin, 2020). In case of misalignment of goals, decision makers at all levels ought to evaluate choices to identify conflicting outcomes amongst a host of stakeholders (Samson et al., 2018). Hence, the hospital management board should be very consultative in ensuring that the interests of various stakeholders are achieved.

#### **7.2.14 Formulating and implementing business and corporate strategies**

The general consensus by hospital management boards is to align their goals with those of the government. The common pool resources theory postulates that the three levels, thus the operation, collective and constitutional levels should be aligned to the achievement of organizational goals. Most organizations' strategic plans are aligned to the Zimbabwe's Vision 2030 and the country's mantra of Zimbabwe is open for business. In the case of health care organizations in Iran, the study results revealed that strategic planning was positively associated with organizational performance inclusive of the satisfaction of patients and employees as well as organizational productivity (Esfahani et al., 2018). The study results also revealed that hospital management boards strive to link their strategic plans to the corporate world. For instance, the involvement of the Bulawayo Residents Association and the Buy-A-Brick concept as mentioned by Board Chair 1 during the interview. One of the functions of the hospital management board is to mobilize resources and this resonates with the notion that it is key to approach the business and donor community through networking. All hospitals realized that they could not rely solely on funding from the national fiscus but the need to think outside the box on other models to boost revenue streams for organizational capacity and sustainability to provide services.

#### **7.2.15 Major successes in achieving good corporate governance mandate**

The study results revealed some successes or achievements in the practice of good corporate governance. The study found that Parirenyatwa Group of Hospitals, Ingutsheni and Mpilo central hospitals, received awards in best innovative institution in financial management, budgeting and financial planning, financial turnaround, debt management, auditing and financial reporting during the period ending 2018. The institutions are legally compliant with regulations, procedures and statutory instruments that govern how they conduct business. Furthermore, the CEO of UBH was awarded the first runner of the year 2018, being the best CEO in Matebeleland Region. These awards show that despite the financial challenges being encountered, all central hospitals have some resilience towards ensuring transparency, accountability, robust internal control systems, fighting corruption and excellent performance.

In terms of excellence in service delivery, Harare central hospital surgeons successfully conducted a major operation, thus the separation of Siamese twins. Such procedures are usually conducted in developed countries through utilization of the state-of-the art equipment. This is one of the reasons that have made Harare central hospital rated as one of the best managed institutions in the country.

In terms of strategic planning, Parirenyatwa Group of Hospitals and Mpilo central hospital managed to craft strategic plans, thus 2018-2020 and 2019-2023 respectively. Harare central hospital has confirmed to be in the process of launching its vision or strategic plan. The crafting of strategic plans is an indicator which shows board commitment in offering best services. The Zimbabwe Code on Corporate Governance of 2014, Section 56 (a) propounds the board's prerogative in the determination of the entity's purpose, vision, mission and values. Therefore, hospital management boards are obliged to come up with clear visions and long term strategic plans for their institutions.

The study results indicated that Ingutsheni, Mpilo and Parirenyatwa Group of Hospitals submit financial statements to the Auditor General's office every year as required. Furthermore, these three institutions received unqualified audit reports. This clearly shows that the institutions are compliant with financial procedures and statutes as outlined in the

Public Finance Management Act (Chapter 22:19). This further confirms the effectiveness of the internal audit function or department in respective institutions.

### **7.3 EXAMINATION OF THE PROCESS OF APPOINTING HOSPITAL MANAGEMENT BOARD MEMBERS IN CENTRAL HOSPITALS OF ZIMBABWE**

From the findings presented, it is evident that 5 dimensions emerged with regard to the process of appointing hospital management board members in central hospitals. These are as follows: (i) Appointing authority for board members, (ii) Selection criteria for board members (iii) Gender balance of the board (iv) Board composition and educational requirements (v) Board involvement on the appointment of the CEO. Each one of these is discussed in the next sections respectively.

#### **7.3.1 Appointing Authority for board members**

The Health Service Act (Chapter 15:16), Section 19 provides for the establishment or appointment of hospital management boards. The Minister of Health and Child Care as guided by the Health Service Board has the mandate to appoint board members.

The analysis of research results shows that the majority of board members are duly appointed by the Minister of Health and Child Care. The four board chairs revealed that the Honourable Minister is responsible for the identification and engagement of board members. The appointment of hospital management board members by the President and Head of State was also revealed in the research results. This situation might cause challenges in terms of good corporate governance practices. The results further indicate three sources from which board members are appointed, thus the Minister of Health and Child Care, Health Service Board and the President and Head of State.

The National Code on Corporate Governance of Zimbabwe, Chapter 3 provides insights to the board of directors' appointment, thus, "*All directors should be appointed through a formal, robust and transparent process that reflects broadly the diversity of shareholders*". The most important stakeholder in public health institutions is the general public or citizenry which suggests that their interests should be reflected in a transparent manner. Generally,

once the President and Head of State is involved in the appointment of board members, then the appointments become political or in other words board members would be considered as political appointees. Political appointees serve the interests of the ruling elite, thus in the case of board members they would lack independence in their good corporate governance practice.

The Minister of Health and Child Care is the one responsible for the appointment of HSB board members, thus in accordance with the Health Service Act (Chapter 15:16). Furthermore, the HSB board members are selected under unclear selection criteria and this probably because the Act is silent on the selection process. Then the Minister as well in consultation with the HSB is responsible for appointment of hospital management boards. The Minister is a political appointee, hence the President and Head of State is obliged to make such appointments. Thus, the individuals who are appointed as board members in both the HSB and hospital management boards might not be in line with the good corporate governance practice, highlighting compliance with the principles of transparency and accountability.

### **7.3.2 Selection criteria for board members**

The research results have indicated that the identification and selection of board members vary by institution, which is an indication that there is no clear policy framework on the selection criteria for board members. In fact, the Health Service Act (Chapter 15:16) is silent on the process involved in the selection of hospital management board members. The Minister of Health and Child Care has the prerogative to identify, select and appoint board members. However, some respondents revealed that, board members are solicited from both the public and private sector based on their experience, skills, expertise and influence in the community. The Health Service Act (Chapter 15:16), Section 19 stipulates that, “*The Minister shall establish a hospital management board for each Government hospital which shall be the responsible authority for the hospital concerned. One shall be the superintendent or chief executive officer of the hospital, who shall be the chairperson of the board. The remaining members shall be appointed by the Minister; through the Board for their professional or managerial skills*”. The provisions of the Act are not in tandem with the requirements outlined in the Zimbabwe Code on Corporate Governance of 2014, which stipulates that, “*All directors should be appointed through a formal, robust and transparent process that reflects*

*broadly the diversity of the shareholders. Where appropriate, the nomination committee should be established with clear terms of reference on how to invite and recommend the nomination of new directors by the Board and the election and re-election by shareholders”.*

The study results have exhumed that there is no clear policy on the selection criteria or process. Board Chair 1 is not clear on how board members are identified or selected, as quoted, *“The Minister of Health did his own search I suppose through his offices of people in the private sector and also in the medical fraternity who could comprise the board”*. Furthermore, sentiments to proffer ignorance on the selection criteria were echoed by Board Chair 3, as quoted, *“Well I don't know, I was approached by the then Minister that he intended me to go and help the management board of .....”*. Due to lack of clarity on the selection criteria and process, then the selection procedure will be prone to corruption and nepotism which results in compromised good governance practice in which transparency, fairness, independence and openness are highly likely to be limited.

The study results further revealed that hospital management board members are not subjected to any interviews or thorough scrutiny by an independent committee to identify their suitability to occupy the public office as board members. The opaque selection criteria and process leaves the Minister to make his/her personal decision which might not be to the best interest of stakeholders. CEO 3 proffered that, *“The identification I am not so sure because that is the responsibility of the Minister. We were not consulted. The Minister is the one who identifies them. He asks for their CVs to then enable him to make his decision”*. Respondents from both executive and non-executive board members denote that no adverts are circulated in the media to invite prospective board members. Again this goes against the corporate governance concepts of transparency, fairness and openness.

### **7.3.3 Gender balance of the board**

The study results have revealed that hospital boards composition are not gender balanced. The Constitution of Zimbabwe, Amendment (No 20) Act 2013, Sub Section 245 advocate for gender equality. This finding shows that public and private institutions should ensure gender quality in their governance structure. For the 45 respondents to the questionnaire and interviews, 36 (80.0%) are male whilst 9 (20.0%) are female. Public sector institutions should

be the advocates and lead national policies and programmes.

#### **7.3.4 Board composition and educational requirements**

In terms of board composition, the results revealed that the majority of board members have a medical background. Other professions with a fair representation are administration and finance, whilst the least represented is legal. The Health Service Act (Chapter 15:16), Section 5, only refer to the composition of the HSB in that one of the board members should be a person registered as a legal practitioner in terms of the Legal Practitioners Act (Chapter 27:07). Since hospital management boards are considered to be an extension of the HSB, then the terms should apply. However, for the four hospitals with functional boards, the legal representation can be said to be 50% since they are two legal practitioners from different institutions. In terms of hospital management the board representation, considering the skills mix, it can be concluded that it is satisfactory since the majority of board members have a medical background. Board members with medical background can be deemed to articulate hospital or medically related matters better compared to non-medical, although other professions are vital to contribute in areas of their expertise. A hospital set up is a complex system, hence all professions matter to ensure good health service delivery. Furthermore, most of the board members are holders of post graduate degrees in their respective professions, as evidenced by a 94.3% of them who fall under this category. The selection and appointment of board members with higher degrees actually fulfil the requirement outlined in the Health Service Act (Chapter 15:16), Section 19, subsection 2 (c).

#### **7.3.5 Board involvement on the appointment of the CEO**

The study results revealed that hospital management boards are not involved in the appointment of the CEO. Rather the CEO is considered as an active member of the board, who is included among the seven board members. The inclusion of the CEO and recommendation for a chairperson of the same board is clearly against the dictates of good corporate governance principles. The Zimbabwe Code on Corporate Governance of 2014, Section 123 stipulates that, "*The chief executive officer and other senior executive officers of the company should be appointed by the Board and accountable to it*". Furthermore, the Public Entities Corporate Governance Act (Chapter 10:31), Section 17 provides terms and conditions for appointment and accountability of the CEO of a state entity. This further

clarifies that the Health Services Act (Chapter 15:16) is not in tandem with good corporate governance practices. It is quite certain that this situation can bring conflicts in the carrying out of good governance practice in the respective health institutions. While the CEOs are part of hospital management boards, the study results discovered that they were not the chairpersons but rather, the boards are chaired by independent non-executive board members. This might be an issue that authorities have identified as a flaw in the Act pertaining to the functionality of the hospital management boards. Nevertheless, this discretionary governance practice that CEOs are not chairpersons of the boards is something that is yet to be re-aligned at law through necessary legal amendments.

#### **7.4 ESTABLISHMENT OF CHALLENGES FACED BY HOSPITAL MANAGEMENT BOARDS IN DISCHARGING THEIR MANDATE**

From the findings presented, it is evident that 5 dimensions emerged with regard to challenges faced by hospital boards in discharging their mandate. These are as follows: (i) Unstable economic environment (ii) Current staff establishment (iii) Staff freeze (iv) Board composition and educational requirements (v) Shortage of foreign currency. Each one of these is discussed in the next sections respectively.

##### **7.4.1 Major challenges in achieving good corporate governance mandate**

The study results have revealed some unique limitations which actually hinder the achievement of good corporate governance mandate or practice. The general consensus across the central hospitals is that the unstable economic environment is adversely affecting the smooth running of institutions. For example, the negative impact of inflation on prices of basic goods and services. The hospitals might be having the best and well-articulated plans, but due to limitation or diminished purchasing power of financial resources, the plans may not be fully implemented thereby reducing the level of attainment of goals or objectives. Thus, the challenge is beyond the aspect of good corporate governance mandate.

The current staff establishment is not commensurate with the volume of work in hospitals. Most central hospital management boards are keen to offer the best service to their stakeholders, but the staff complement in terms of specialist services is always not adequate

for the required services. This actually results in clients seeking services in other expensive private hospitals in Zimbabwe or even outside the country. ,

Staff freeze was identified as a major stumbling block in the achievement of good corporate governance mandate. Institutions have to seek Treasury Concurrence from the Ministry of Finance and Economic Development in the filling of vacant posts and this often causes delay in getting the required employees. This automatically affects the smooth flow of operations in hospitals, which is beyond the control of hospital management boards.

The study results have also revealed a weak referral system as a major limitation in central hospitals. Central hospitals are supposed to be the highest level of care in the referral health service chain but quite a number of patients seek services at this level without proper referral and this leads to over-burden of resources. The government policy is that patients should not be turned away once they approach a hospital. Central hospitals are then obliged to attend to such patients or clients using the limited resources.

Shortage of foreign currency is another limitation that is beyond the hospital management board's control. Most medicines and hospital equipment are procured from outside the country and they require foreign currency. The study results revealed that, often, the shortage of foreign currency negatively affects the procurement process, due to price variations. Hospitals might be in need of such equipment urgently but can take long before delivery, hence the service provision is certainly compromised.

## **7.5 RECOMMENDATION OF STRATEGIES FOR ENHANCING THE FUNCTIONALITY OF HOSPITAL MANAGEMENT BOARDS IN ZIMBABWE**

From the findings presented, it is evident that 6 dimensions emerged with regard to strategies for enhancing the functionality of hospital management boards. These are as follows: (i) Networking (ii) Monitoring and evaluation (iii) Revenue generation (iv) Public-Private-Partnerships (v) Hospital management board operational plan (vi) Transparency in the selection and appointment of board members. Each one of these is discussed in the next sections respectively.

### **7.5.1 Strategies that can strengthen the performance of hospital management boards**

Although some of the strategies are not directly linked to the governance practice, the study results indicated that they can strengthen the performance of hospital management boards. However, hospital management boards significantly interface with the corporate world, hence the success in hospital service delivery should be attributed to the board as well.

Networking is vital in hospital management boards, thus stakeholder interface role, for example more interaction between the boards' various stakeholders such as the community, business people, the government, donors and partners so that the vision is fully realized. Board Chair 1 suggested more stakeholder involvement through workshops. So the hospital management board's prime responsibility should be that of gathering concerns of society or community and bring them to the notice of the hospital management. The study findings have shown an imperative need to do more in terms of community outreach and interaction. Stakeholder involvement or buy-in is quite key in unlocking the much needed support in terms of resources like finances, material and other essentials. Board members are drawn from different backgrounds and there is need to tap into their professional and social networks. This emphasizes the need for hospital boards to interact or network with stakeholders within Zimbabwe and even abroad.

Monitoring and evaluation of the performance of hospital management boards should be strengthened, through relevant policy formulation. The study results have revealed the absence of a clear policy on the evaluation of performance for hospital boards and even the CEO. The CEO and the board itself should be monitored and evaluated continuously, to identify any gaps or short falls in their implementation process. Hence, the need to come up with a policy to assist on monitoring and evaluating of board performance, putting into consideration their visions, missions and values.

The study results have revealed that all hospital management boards have fundraising committees, hence more emphasis is put on revenue generation. Hospitals should come up with business ventures or models that would sustain hospital operations and not rely solely on resources from the government. The government mantra is "*Zimbabwe is open for business*"

which means that hospital management boards should tap into the vast business opportunities available. A good example is that of Ingutsheni central hospital which has come up with business models to generate revenue in the form of farming specializing in horticulture, maize and beans.

The strengthening of the Public-Private-Partnerships is another way of strengthening the performance of hospital management boards. A good example is that of Ingutsheni central hospital board which has approached the Infrastructure Development Bank of Zimbabwe with a view to source funds to finance the provision of accommodation for staff. Furthermore, Mpilo central hospital has approached the Bulawayo Residents Association with a view to finance the construction of a perimeter wall at the institution and was successfully conducted. These projects can only be a success if hospital management boards are able to interface with key stakeholders. At Harare central hospital, the National Social Security Authority is one organization which has adopted one of the wards and Mimosa Mine which painted the nursing rooms. This is evident that HMBs should strengthen the interface with the business community in order to harness the much needed opportunities and resources.

The development of a hospital management board operational manual would be a commendable initiative towards strengthening the performance of the boards. From inception, hospital management boards should attend some training courses or induction in order to standardize operations. Regardless of their backgrounds, the appointed members of the board should have acumen in running a hospital. In practice board members come from different backgrounds, hence there is need for team building or capacity building exercise to bring them to a common agenda in line with the goals and aspirations of the specific health institution.

Transparency in the recruitment and selection of board members is another strategy that should be strengthened in achieving the best out of hospital boards. The appointment of board members ought to be a public event where the relevant authorities place adverts in the relevant media. The names of prospective board members should come from the community not from the ministry of health officials or the HSB. The concept of HMBs is something that evolved from the past, hence there is need to modify and modernize it.

The findings lead to the following models:-

## **7.5.2 Hospital management boards governance models**

### ***7.5.2.1 Independent appointing authority***

The Health Service Board which is mandated under the Health Service Act (Chapter 15:16), is the sole monitor and supervisor of hospital management boards. However, the same Act gives the Minister of Health and Child Care powers to appoint both the Health Service Board and the hospital management boards. Therefore, independence of the both the Health Service Board and hospital management boards should start from the appointment of its members, thus to ensure transparency and accountability. The study results revealed three centres of power on the appointment of the hospital management boards as revealed in the 10 interviews conducted inclusive of the 4 Board Chairs and 6 CEOs. The results indicated that 8 (80.0%) had the view that board members are appointed by the Minister of Health and Child Care, 1 (10.0%) indicated appointment by the Health Service Board and 1 (10.0%) revealed appointment through the Ministry and the President and Head of State.

In order to ensure separation of powers, the appointing authority for hospital management boards should only be the Minister of Health and Child Care as enunciated in Health Service Act (Chapter 15:16). However, the HSB should remain with the mandate to offer supervision, advisory and monitoring roles to the hospital management boards on technical performance. The Health Service Board and the President and Head of State should not be the appointing authority for hospital management boards.

### ***7.5.2.2 Selection criteria for hospital management boards***

An advert should be circulated in local newspapers inviting prospective members of the board, thus through normal recruitment procedures. The requirements for board members should be well articulated to include requisite qualifications, experience, skills or competencies. Interviews should be conducted to select the best candidates who are capable and worthy to deliver the expectations of various stakeholders. Members of the hospital management boards should be apolitical and be technocrats in various fields who shall

independently enhance health service delivery. The Health Service Act (Chapter 15:16) should be re-aligned with good corporate governance's best practises. For instance, to repeal the clause which mandates that either the superintendent or the CEO to be the chairperson of the hospital management board. The study results from the 10 interviews conducted inclusive of 6 CEOs and 4 Board Chairs did not reveal transparency in the recruitment and selection of board members which is normally problematic. The CEO is considered an active board member, but the study results from the 35 respondents on the board involvement in the appointment of the CEO indicated that 28 (80.0%) expressed non-involvement.

The Parliament of Zimbabwe through the portfolio committee on Health and Child Care should be involved in the recruitment and selection of hospital management board members to ensure independence, transparency and accountability. During the selection process the parliamentary portfolio on Health and Child Care should play an oversight role to minimise incidences of corruption or nepotism. The names of suitable candidates should then be forwarded to the Minister of Health and Child Care for appointment. Technocrats or professionals of relevant fields to health service delivery should be hired to deliver the best in their respective institutions. The process of recruitment, selection and appointment of hospital board members should be done within a reasonable period not exceeding at least three months from the date the board would have expired.

### ***7.5.2.3 Evaluation of hospital management boards performance***

Hospital management boards are not evaluated on a regular basis to ascertain whether they are achieving the set goals of their respective institutions. The study results revealed that of the 35 respondents, 18 (51.4%) expressed that a policy to evaluate the performance of hospital management boards did not exist whilst 17 (48.6%) indicated its existence. The other 2 respondents confirmed evaluation of boards quarterly through the Health Service Board and the Minister of Health and Child Care. Therefore, the Health Services Board should develop a clear policy that ensures standardization of performance and operations of all hospital management boards in Zimbabwe. The Government of Zimbabwe has enacted the Public Entities Corporate Governance Act (Chapter 10:31) which regulates the operations of all state enterprises and parastatals. Accordingly, the policy on the performance of hospital management boards should be aligned to the Public Entities Corporate Governance Act (Chapter 10:31). Most of the board performance indicators are detailed in the Act but they

only require re-alignment to meet the needs of hospital management boards. Therefore, hospital management boards should be accountable to the Health Services Board, with a mandate to report quarterly unless ad hoc circumstances arise.

## **7.6 Chapter summary**

In the chapter, interpretation and discussion of the research findings were presented. The study results revealed three centres of power for the appointing of hospital board members, this being the Minister of Health and Child Care, the HSB and the President and Head of State. The selection criteria for hospital board members is not quite transparent, the process lacks checks and balances in terms of procedures followed. The operations of hospital boards are not guided by clear policies. Despite the challenges encountered by the existing hospital boards in their operations, some successes were realized which shows the boards' commitment in their good corporate governance mandate. Models to strengthen the appointment, selection criteria and performance of hospital boards in Zimbabwe were stated and explained. The next chapter provide the conclusion and recommendations of the study.

## CHAPTER EIGHT

### CONCLUSIONS AND RECOMMENDATIONS

#### 8.1 Introduction

In the previous chapter, data interpretation and presentation of research findings were provided. In this chapter, summary, conclusions and recommendations based on the research results are presented.

It should be noted that, the background to the study entails the governance reforms that are initiated at different contextual levels, thus globally, regionally and nationally. The reforms have an effect on the governance structures that are implemented in central hospitals in Zimbabwe.

The problem to the study is hinged on the fact that autonomy on the governance of central hospitals was granted but still there are some limitations or bottlenecks that impinge on the achievement of desired outcomes. Therefore, the purpose of the study was to explore governance aspect towards the standardization and strengthening the performance of hospital boards in central hospitals in Zimbabwe. The study focused on protecting the interests of multiple stakeholders, strengthening effective use and safeguarding hospital resources.

The sequence of the presentation in this chapter is the summary of research objectives and questions, then conclusions and recommendations of the study based on the data analysis and presentations in previous chapters. The proposed models are also presented and discussed. The study contributions to theory, policy and practice are highlighted. The limitations to the study are provided followed by the suggestions for future research.

#### 8.2 Summary of research findings

The general purpose of this study was to explore ways of how performance of hospital management boards in Zimbabwe could be standardized and strengthened in line with corporate governance practice. Furthermore, the study sought to enable development of

models that could be used for strengthening the appointment and performance of hospital boards.

### **8.2.1 Determination of standard functional structures of hospital management boards in central hospitals of Zimbabwe**

The standard functional structures for hospital management boards can be identified through various indicators like functional board, existence of board sub-committees, policy to evaluate performance of CEO and the board itself, frequency of board meetings and setting of agendas, succession planning, alignment of goals with interests of stakeholders, formulation of business, corporate strategies and any best practices.

The study results have revealed that Parirenyatwa Group of Hospitals, Harare central hospital, Mpilo central hospital and Ingutsheni central hospital have functional hospital management boards. However, UBH and Chitungwiza central hospital do not have functional boards and the terms of office expired in October 2017 and July 2018 respectively. Furthermore, Chitungwiza central hospital did not have a substantive CEO for eight months. This scenario of having some non-functional boards and no substantive chief executive officer for such a long time clearly indicates limited good corporate governance practice.

All central hospitals studied do not have a policy to evaluate the performance of either the CEO or the board itself. Without policy on monitoring and evaluation of the top management of public hospitals, it is difficult to enforce performance management in the central hospitals. The study results revealed that most central hospitals are having self- evaluations quarterly.

Despite, the various challenges faced by the hospital management boards in the performance of their good corporate governance mandate, the study results revealed some major successes or emerging good practices. Parirenyatwa Group of Hospitals, Mpilo and Ingutsheni central hospitals won some awards in various portfolios, like the best innovative institutions in financial management, debt management, financial planning and budgeting, financial turnaround, auditing and reporting during the year ended 2018. This is attributed to the effectiveness of hospital management boards in carrying out their mandate, enabled through robust internal control systems, compliance with laid down statutes and procedures.

In terms of strategic planning, hospital management boards strive to attain the set vision and goals through the alignment of goals to the interests of stakeholders. Furthermore, the business and corporate strategies are formulated and implemented based on the national goals like the “*Zimbabwe is open for business mantra and Vision 2030*”. All strategic plans are set towards achieving the national goals as demonstrated by Parirenyatwa Group of Hospitals and Mpilo central hospital who developed the 2018-2020 and 2019-2023 plans respectively. The crafting of strategic plans by hospital management boards indicates board commitment and determination for the success of their respective institutions.

### **8.2.2 Examination of the process of appointing hospital management board members in central hospitals of Zimbabwe**

The research has established that the hospital board members are appointed by three authorities, thus the Minister of Health and Child Care, the Health Service Board and the President and Head of State. In terms of the Health Service Act (Chapter 15:16), Section 19 (1), the Minister of Health and Child Care is responsible for establishing and appointing hospital management boards for all Government hospitals. From this provision, it means that the Health Service Board and the President and Head of State should not be the appointing authorities and this will help to ensure independence and separation of powers in state institutions.

The analysis of the selection criteria in all central hospitals was discovered to have flaws on how the identification and recruitment process should be conducted. All board members in central hospitals were selected without transparent procedures, like dissemination of adverts in newspapers, shortlisting and interviews to choose the best cadres to recommend for appointment by the Minister of Health and Child Care. Additionally, the study results have indicated that there is no independent committee involved in the selection of board members, an aspect which exposes the process to corruption and nepotism. A situation without independent committee increases the high possibility of appointing board members who are incompetent and unethical leading to a scenario where board members’ commitment and knowledge limited for guiding provision of health services.

In terms of the Zimbabwe Code on Corporate Governance of 2014, in Section 123, the CEO and other senior executives of the company should be appointed by the Board and be accountable to it. Furthermore, the Public Entities Corporate Governance Act (Chapter 10:31), Section 17 (3) provides that the CEO should be appointed by the board of an entity after circulating adverts in national newspaper, conduct interviews and then appoint. However, the study results revealed that hospital management boards are not involved in the appointment of the CEO, rather the CEO is an active member of the board, whom surprisingly according to the Health Service Act (Chapter 15:16) should be chairperson of the board. At operational level, all functional hospital management boards are chaired by an independent non-executive board member, however the Act has not yet been amended.

### **8.2.3 Establishment of challenges faced by hospital management boards in discharging their mandate**

Hospital management boards are faced with a number of challenges in carrying out their good corporate governance mandate. While they had sound professional backgrounds and with the level of commitment required, the study found that some of the drawbacks they faced were beyond their control like the economic stress in the country. Specifically, the study results revealed that the unstable economic environment impacts negatively on rate of inflation and pricing of goods and services, staff freeze by the government, weak referral system, shortage of foreign currency and the lean staff establishment. These aspects are the major challenges which hinder effectiveness of good corporate governance practice in organizations. Hospital boards might have clear visions and detailed strategic plans but without the necessary resources, it is less likely that the desired level of performance will be achieved.

### **8.2.4 Recommendation of strategies for enhancing the functionality of hospital management boards in central hospitals of Zimbabwe**

The strategies proffered and models developed hinges on the appointing authority for hospital management boards, the selection criteria for board members and evaluation of performance for hospital management boards. The study results revealed three centres power who appointed hospital board members, thus the Minister of Health and Child Care, the HSB and the President and Head of State. However, the majority of the respondents indicated the Minister of Health and Child Care as the appointing authority for hospital board members.

The Health Service Act (Chapter 15:16) mandates the Minister of Health and Child Care to be the appointing authority for all hospital boards in Government hospitals.

The selection criteria for hospital management boards is not clear in terms of the identification and selection process, hence it can be considered to be prone to corruption and nepotism. The study results revealed that no adverts are circulated in national newspapers and no interviews are conducted to choose suitable candidates for appointment into hospital management boards. In terms of the Zimbabwe Code on Corporate Governance of 2014 and the Public Entities Corporate Governance Act (Chapter 10:13) the process of selecting board members should be transparent. Hence, the selection process for board members in central hospitals has huge gaps in achieving good corporate governance best practices.

The evaluation of performance for hospital management boards is not clearly regulated by policy. Therefore, there are no laid down performance indicators to monitor and evaluate performance of hospital management boards. In addition, the study results revealed that boards often carry out self-evaluations on a quarterly basis. The CEO is not formally evaluated by the board and is considered as an active board member and this makes the monitoring and evaluation ineffective.

### **8.3 Conclusions**

The conclusions of this study are interpreted and discussed based on the research objectives. Fundamentally, the general aim of the study was to standardize and strengthen the performance of hospital management boards through the development of a model that can be implemented in the selection criteria and evaluation of performance for hospital management boards in Zimbabwe. The structures of the proposed model were presented and discussed in chapter two. The study results revealed some gaps in terms of the current governance systems and procedures. In light of this finding, the proposed model is designed to strengthen the appointment and performance of hospital management boards. Essentially, the study conclusions are presented guided by its objectives as follows:

#### **8.3.1 Determination of standard functional structures of hospital management boards in central hospitals of Zimbabwe**

The functional structures of hospital management boards are identified through various performance indicators during the discharge of good corporate governance mandate, for example board committees, the substantive CEO, succession planning, the executive management and internal audit functions.

### **8.3.2 Examination of the process of appointing hospital management board members in central hospital of Zimbabwe**

It is clear from the study that the appointing authority for hospital board members is the Minister of Health and Child Care. The Health Service Board is mandated through the Health Service Act (Chapter 15:16) to ensure supervision, monitoring and evaluation of hospital management boards. There is need to ensure separation of powers between the appointing authority and the monitoring and evaluation.

The study established that the selection criteria for hospital management boards is not in compliance with the best practices of good corporate governance. This clearly shows the need for a robust and transparent system of identifying and selecting the best candidates through circulation of adverts in national newspapers and formal interviews.

### **8.3.3 Establishment of the challenges faced by hospital management boards in discharging their mandate**

In the course of carrying out the corporate governance mandated by the hospital boards, there are various challenges that are encountered. It was noted in the study that some of the challenges are beyond the control of the boards and require interventions of relevant authorities. Despite the challenges, hospitals are still committed to the achievements of their mandate and have made some successes as illustrated by awards received by some hospitals, reported high quality service, robust internal control systems and performance reporting.

#### **8.3.4 Recommendation of strategies for enhancing the functionality of hospital management boards in central hospitals of Zimbabwe**

The study results have revealed some gaps in the implementation of good corporate governance in central hospitals of Zimbabwe. In light of this finding, some strategies and models are recommended which are aimed at ensuring a framework of one centre of power in appointing hospital management boards. The proposed framework, if implemented properly, is likely to strengthen transparency in the selection criteria for hospital board members. One key strength of the framework is its explicit monitoring and evaluation mechanism proposed for all hospital management boards in Zimbabwe.

### **8.4 Recommendations**

In order to standardize and strengthen the performance of hospital management boards in Zimbabwe, the study results revealed some shortcomings in the governance systems that adversely impact on the implementation of good corporate governance practices. Based on the literature reviewed and data analyzed and presented, the following recommendations are proffered towards improving and strengthening the governance practice in the central hospitals in the country:

#### **8.4.1 Recommendations to strengthen the functionality of hospital management boards in discharging the good corporate governance mandate**

- The HSB should develop an operational manual to formalize the performance indicators for all hospital management boards in Zimbabwe.
- Standard monitoring and evaluation policy for all hospital management boards should be developed.
- Succession planning policy should be developed and implemented in respect of both hospital management board members and the CEOs.
- The CEO should be an ex-officio board member and this will mean all the seven board members become non-executive.
- The CEO's contract and performance agreement should be approved and be accountable to the hospital management board.

- The CEO's term of office should be on a contract basis, maximum should be ten years, which is five year term renewable for another term subject to satisfactory performance.
- The remuneration policy for all hospital management boards should be standardized.
- Standardize the hospital management board's term of office to five years renewable for another term subject to performance.
- The hospital management board should be accountable to the HSB.
- The Health Service Act (Chapter 15:16) should be amended to comply with good corporate governance best practices.
- Hospital management boards to comply and implement the provisions of the Public Entities Corporate Governance Act (Chapter 10:31)

#### **8.4.2 Recommendations on the process for appointing hospital management board members in central hospitals of Zimbabwe**

- There should be separation of powers and when this happens it will mean that the Office of the President and Cabinet and HSB should not be the appointing authority for hospital management boards. Rather, the Minister of Health and Child Care should be the sole appointing authority for hospital management boards as enunciated in the Health Service Act (Chapter 15:16).
- The hospital management boards for all central hospitals should be involved in the appointment of the CEO and other senior executive directors, like the director of finance, director of operations and director of clinical services.
- An advert should be circulated in the national newspaper inviting prospective hospital board members.
- The requirements for prospective board members should be clearly stated in the advert, such as qualifications, knowledge and experience in the health sector and any other attributes.
- The selection process should consider the issue of gender balance as stated in the Constitution of Zimbabwe (No.20) Act 2013, Section 246.
- Board members should be selected through a panel of independent committee, like the involvement of the Parliamentary Portfolio Committee on Health and Child Care to ensure transparency of the process.

- Public interviews should be conducted in order to come up with the best candidates to be recommended for appointment to hospital management boards.

## **8.5 Contributions to theory, policy and practice**

The literature reviewed and the study results presented have implications to policy and practice in hospital management boards in Zimbabwe. Training needs and orientations of new board members are some of the key issues that emerged which are currently not consistently practiced and there is no standard framework to guide the practice. The major identified gap is in the legal frameworks that regulate governance practice in the health sector including contradictions in the related policies and procedures. It is without a doubt that the study attempted to make some contributions to academia through this thesis and journal articles to be developed out of this study.

### **8.5.1 Theoretical contributions**

The study has added value to the body of knowledge through journal articles that are health management related, hence literature available for other researchers. The scarcity in academic literature in public sector corporate governance in Zimbabwe require further research to investigate complexities faced by public entities' boards in discharging their mandate (Moyo, 2016). To the best of my knowledge and literature extant, the current study contribute immensely to the healthcare governance since it is the first one to explore the standardization and strengthening the functionality of hospital management boards in Zimbabwe. One of the objectives is anchored on the challenges faced by hospital management boards in discharging their good corporate governance mandate, hence vital to the body of knowledge.

The study has made some additions to the current literature in corporate governance, which is specifically in the public sector. Abor (2014) recommended research on healthcare governance especially in Africa with a focus on the appointment and performance of both board members and management. The current study addressed the gaps on appointment modalities and board performance evaluation by recommending models to strengthen the appointment of board members. The aforesaid models are a huge

milestone in the academic field, thus in Zimbabwe, Southern African Development Countries, Africa and beyond.

#### **8.5.2 Policy contributions**

- Providing training needs for newly recruited board members, in both the public and private hospitals.
- Capacity strengthening through in-house trainings and orientation for the already existing board members.
- Develop operational manual for hospital management boards.

#### **8.5.3 Contribution to practice**

- The study has revealed gaps that, when considered, can influence the legislature to amend the Health Service Act (Chapter 15:16) to be in compliance with good corporate governance best practices.
- It is quite certain that the study can influence both internal and external auditors on how best to audit corporate governance matters.

#### **8.5.4 Limitations**

The CEOs are active members of the hospital management boards, hence the anticipation of having six non-executive directors as respondents to the questionnaire was reduced to five per institution. However, the board chairs and CEOs participated in the interviews in their respective institutions as scheduled.

UBH and Chitungwiza central hospitals did not have HMBs during the time of the study, since their terms expired in October 2017 and July 2018 respectively. This impacted negatively on the number of research participants or sample size. However, the available executive directors participated in the study, despite the unavailability of non-executive board members.

One of the executive directors at Parirenyatwa Group of hospitals declined to participate in the study citing that: *“I regret to advise that I cannot participate in your research. I might have the information but I cannot divulge”*. However, this was despite the

permission granted by the CEO of the institution allowing the participation of all executive directors.

Regardless of this, a fair sample (68%) of the entire board members inclusive of executive and non-executive directors in all central hospitals of Zimbabwe for the period January to June 2019 was obtained.

## **8.6 Areas for future research**

The existing literature on hospital governance in Zimbabwe is quite limited, further research could be carried out on the implementation of the proposed governance models. The independence of the appointing authority, selection criteria for board members and evaluation of performance for hospital management boards are crucial in ensuring the effectiveness of boards, hence the need for research on these factors.

Furthermore, hospital management boards alone cannot guarantee the success of quality service delivery in hospitals, but the commitment and implementation by the executive management who are the implementers. The study results from the current research have revealed that most central hospitals have comprehensive strategic plans. On this aspect, future studies could focus on the implementation of the strategic plans by the executive management.

## **8.7 Conclusion**

The study was arranged into eight chapters. Chapter one gave an overview on the expectations of the study. Chapter two provided literature on hospital governance models and frameworks. Chapter three gave an overview of the nature of functionality of central hospitals in Zimbabwe, covering the background of the establishment of hospital management boards, the structure, financial management, resource mobilization, the mandate of hospital management boards in terms of policy formulation and implementation and compliance with statutory requirements. Chapter four covered literature review on healthcare governance, good healthcare governance, components and its benefits, models of hospital governance, healthcare governance structure, healthcare strategic management and its benefits, governing structures and delegation and strategies that strengthen hospital board performance. Chapter

five presented the research methodology, thus it detailed the instruments used to collect data, the institutions and the respondents involved. Chapter six presented the results from data collected from both executive and non-executive hospital board members. Chapter seven provided the interpretation of the results. Chapter eight provided a blend covering each chapter, the study results and conclusion with reference to the objectives of the study. The proposed models and several recommendations were also presented to be implemented in all central hospitals in Zimbabwe. Contributions to the theory, policy and practice were also highlighted. The final conclusion is that, if the proposed recommendations and models are implemented, then the health institutions studied and similar would have standard functional structures. Furthermore, the effectiveness or performance of hospital management boards would greatly improve to achieve quality health service in the country.

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## Appendix 1: Questionnaire

### **Research Information**

I am Webster Funhiro undertaking a Doctor of Business Administration Degree with the University of KwaZulu-Natal, South Africa. My research title: Standardization and strengthening the functionality of hospital management boards in central hospitals of Zimbabwe. This research questionnaire is part of my PhD research at the University of KwaZulu-Natal Graduate School of Business and Leadership and its purpose is for my academic research use only.

This questionnaire is strictly confidential and anonymous. Please do not indicate your personal details (your name and surname) and contact details. Your participation in this research is voluntary.

You may refuse to participate or withdraw from the project at any time with no negative consequences. There will be no monetary gain from participating in this survey. Please attempt to answer all questions as **honestly as possible**.

There are no correct or wrong answers. Please answer all questions to the best of your ability. Please mark only one answer per question.

**SECTION A: CHARACTERISTICS DATA**

<b>Name of Hospital</b>	
<b>Region</b>	

**I am:**

Male

Female

**Your Age:**

18 to 30 Years

31 to 43 Years

44 to 56 Years

57 Years and above

**Number of years as a board member in this organization.....**

**Level of Education:**

Primary Education

Secondary Education

College (Diploma/Certificate)

Technical (Diploma/Certificate)

University Undergraduate Degree

Postgraduate Degree

**Your Profession**

Medical

Administration

Legal

Accounting or Finance

Other, Please specify.....

**SECTION B: HOSPITAL GOVERNANCE PRACTICES**

1. Do you have a functional board of directors?

Yes  No

2. If NO, comment?.....

3. Is the CEO also the chairman of the board?

Yes  No

4. How often do you hold board meetings within a year?

Monthly

Quarterly

Bi-annually

Other, Please specify.....

5. Are board meetings based on prepared agendas?

Yes  No

6. If NO, comment?.....

7. Who sets the agenda of the meetings?

Chairperson

CEO

Other, Please Specify.....

8. What is the level of involvement of external directors?

Highly Involved

Moderately Involved

Some Involvement

Hardly Involved

Not Involved

9. How is board remuneration set?

No remuneration

Set annual fee

Per meeting fee

Travel and other reimbursements

Other, please specify.....

**SECTION B: HOSPITAL BOARD PERFORMANCE**

10. Is there a policy to evaluate the performance of the board?

Yes  No

11. How is the evaluation done and how often is it done?

.....

.....

.....

12. Is the board involved in the appointment of the CEO?

Yes  No

13. Is there a policy of evaluating the performance of the CEO?

Yes  No

14. How is the evaluation of the CEO done and how often is it done?

.....

.....

.....

15. Do you have a policy on succession planning?

Yes  No

16. Do you have an internal audit department?

Yes  No

17. Which sub-committees of the board do you have?

Risk management

Finance

Human resources

Social/Ethical

Clinical audit

Others, please specify.....

18.

On the scale of 1 - 5 Rank the contribution of the board of directors

1. Not important
2. Not sure
3. Moderately important
4. Important
5. Very important

	1	2	3	4	5
Building organizational reputation	[ ]	[ ]	[ ]	[ ]	[ ]
Strategic planning process	[ ]	[ ]	[ ]	[ ]	[ ]
Control organizational resources	[ ]	[ ]	[ ]	[ ]	[ ]
Finance expertise	[ ]	[ ]	[ ]	[ ]	[ ]
Legal expertise	[ ]	[ ]	[ ]	[ ]	[ ]
Operational expertise	[ ]	[ ]	[ ]	[ ]	[ ]
Recruitment	[ ]	[ ]	[ ]	[ ]	[ ]
Providing strategic advise	[ ]	[ ]	[ ]	[ ]	[ ]
Networking	[ ]	[ ]	[ ]	[ ]	[ ]

Determining salary and remuneration [ ] [ ] [ ] [ ] [ ]

Evaluating management [ ] [ ] [ ] [ ] [ ]

Directing succession challenges [ ] [ ] [ ] [ ] [ ]

## Appendix 2: Interview Schedule

I am Webster Funhiro undertaking a Doctor of Business Administration Degree at the University of KwaZulu-Natal, South Africa. My research title: Standardization and strengthening the functionality of hospital management boards in central hospitals of Zimbabwe.

This interview is part of my PhD research at the University of KwaZulu-Natal, South Africa, Graduate School of Business and Leadership and its purpose is for my academic research use only.

Your participation in this research is voluntary. There will be no monetary gain from participating in this survey. Please attempt to answer all questions as **honestly as possible**. There are no correct or wrong answers.

<b>Name of Hospital</b>	
<b>Region</b>	

1. How long have you been with your organization?.....

2. How many directors are there in your organization?.....

3. How many of these are non-executive directors?.....

4. Explain how each non-executive director (Including the Chairperson) was identified and

engaged?.....  
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5. How many governance committees are there in your organization?.....

6. State the name of each committee, the composition of each and the number of non-executive and executive directors?.....

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7. What is the term of office of directors?

2 years and renewable for another.....years

3 years and renewable for another.....years

4 years and renewable for another.....years

5 years and renewable for another.....years

No limit to term

Other, please specify.....

8. Explain how the board of directors has aligned the goals of the organization with those of its stakeholders, which are namely the government, employees, patients or clients, donors and partners and suppliers of goods and services and the public?.....

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9. Briefly describe how the business and corporate strategies of your organization are formulated and implemented.....

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10. Briefly explain any major limitations or best practices that your hospital board experience in the discharge of good corporate governance mandate.....

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11. Suggest any strategies that can strengthen the performance of hospital management boards.....

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## Appendix 3 : Multivariate Analysis Tables

### Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	Board meetings based on prepared agendas	.000 <sup>a</sup>	1	.000	.	.
	Setting agenda of meetings	.013 <sup>b</sup>	1	.013	.019	.890
	Board Remuneration : No remuneration	.000 <sup>a</sup>	1	.000	.	.
	Level of involvement of external directors	.066 <sup>c</sup>	1	.066	.173	.680
	CEO also chairperson of the board	.000 <sup>a</sup>	1	.000	.	.
	Frequency of meetings within a year	.000 <sup>a</sup>	1	.000	.	.
	Set annual fee	.290 <sup>d</sup>	1	.290	1.800	.189
	Per meeting fee	.394 <sup>e</sup>	1	.394	1.625	.211
	Travel and other reimbursements	.003 <sup>f</sup>	1	.003	.011	.915
	Policy to evaluate board performance	.001 <sup>g</sup>	1	.001	.006	.941
	Board involvement on the appointment of the CEO	.652 <sup>h</sup>	1	.652	4.346	.045
	Policy to evaluate performance of the CEO	.016 <sup>i</sup>	1	.016	.076	.784
	Policy on succession planning	.120 <sup>j</sup>	1	.120	.491	.489
	Existence of an internal audit department	1.243 <sup>k</sup>	1	1.243	27.343	.000
	Board Committees : Risk management	.444 <sup>l</sup>	1	.444	6.374	.017
	Finance	.000 <sup>a</sup>	1	.000	.	.
	Human Resources	.066 <sup>m</sup>	1	.066	.255	.617
	Social/Ethical	.444 <sup>l</sup>	1	.444	6.374	.017
	Clinical	.000 <sup>a</sup>	1	.000	.	.
	Building organizational reputation	.591 <sup>n</sup>	1	.591	.683	.414
Strategic planning process	1.642 <sup>o</sup>	1	1.642	1.564	.220	

Control organizational resources	2.607 <sup>p</sup>	1	2.607	3.095	.088
Finance expertise	1.742 <sup>q</sup>	1	1.742	1.907	.177
Legal expertise	1.360 <sup>f</sup>	1	1.360	1.545	.223
Operational expertise	1.077 <sup>s</sup>	1	1.077	.879	.355
Recruitment	.948 <sup>l</sup>	1	.948	1.737	.197
Providing strategic advice	1.330 <sup>u</sup>	1	1.330	1.611	.213
Networking	.715 <sup>v</sup>	1	.715	1.034	.317
Determining salary and remuneration	.129 <sup>w</sup>	1	.129	.198	.659
Evaluating management	1.159 <sup>x</sup>	1	1.159	.746	.394
Directing succession challenges	.552 <sup>y</sup>	1	.552	.463	.501
Board meetings based on prepared agendas	19.886	1	19.886	.	.
Setting agenda of meetings	43.213	1	43.213	62.898	.000
Board Remuneration : No remuneration	79.543	1	79.543	.	.
Level of involvement of external directors	38.466	1	38.466	101.503	.000
CEO also chairperson of the board	79.543	1	79.543	.	.
Frequency of meetings within a year	79.543	1	79.543	.	.
Set annual fee	70.233	1	70.233	436.445	.000
Per meeting fee	33.994	1	33.994	140.126	.000
Travel and other reimbursements	56.003	1	56.003	245.097	.000
Policy to evaluate board performance	45.259	1	45.259	170.858	.000
Board involvement on the appointment of the CEO	56.195	1	56.195	374.761	.000
Policy to evaluate performance of the CEO	33.845	1	33.845	156.724	.000
Policy on succession planning	49.491	1	49.491	202.839	.000
Existence of an internal audit department	31.071	1	31.071	683.571	.000
Board Committees : Risk management	27.873	1	27.873	400.111	.000
Finance	19.886	1	19.886	.	.

	Human Resources	38.466	1	38.466	149.236	.000
	Social/Ethical	65.587	1	65.587	941.499	.000
	Clinical	19.886	1	19.886	.	.
	Building organizational reputation	346.191	1	346.191	400.127	.000
	Strategic planning process	310.899	1	310.899	296.148	.000
	Control organizational resources	224.778	1	224.778	266.889	.000
	Finance expertise	238.428	1	238.428	261.020	.000
	Legal expertise	253.703	1	253.703	288.296	.000
	Operational expertise	277.077	1	277.077	225.959	.000
	Recruitment	165.520	1	165.520	303.066	.000
	Providing strategic advice	360.644	1	360.644	436.882	.000
	Networking	349.058	1	349.058	504.605	.000
	Determining salary and remuneration	60.700	1	60.700	93.292	.000
	Evaluating management	208.930	1	208.930	134.553	.000
	Directing succession challenges	93.352	1	93.352	78.321	.000
Q1	Board meetings based on prepared agendas	.000	1	.000	.	.
	Setting agenda of meetings	.013	1	.013	.019	.890
	Board Remuneration : No remuneration	.000	1	.000	.	.
	Level of involvement of external directors	.066	1	.066	.173	.680
	CEO also chairperson of the board	.000	1	.000	.	.
	Frequency of meetings within a year	.000	1	.000	.	.
	Set annual fee	.290	1	.290	1.800	.189
	Per meeting fee	.394	1	.394	1.625	.211
	Travel and other reimbursements	.003	1	.003	.011	.915
	Policy to evaluate board performance	.001	1	.001	.006	.941
	Board involvement on the appointment of the CEO	.652	1	.652	4.346	.045
	Policy to evaluate performance of the CEO	.016	1	.016	.076	.784

	Policy on succession planning	.120	1	.120	.491	.489
	Existence of an internal audit department	1.243	1	1.243	27.343	.000
	Board Committees : Risk management	.444	1	.444	6.374	.017
	Finance	.000	1	.000	.	.
	Human Resources	.066	1	.066	.255	.617
	Social/Ethical	.444	1	.444	6.374	.017
	Clinical	.000	1	.000	.	.
	Building organizational reputation	.591	1	.591	.683	.414
	Strategic planning process	1.642	1	1.642	1.564	.220
	Control organizational resources	2.607	1	2.607	3.095	.088
	Finance expertise	1.742	1	1.742	1.907	.177
	Legal expertise	1.360	1	1.360	1.545	.223
	Operational expertise	1.077	1	1.077	.879	.355
	Recruitment	.948	1	.948	1.737	.197
	Providing strategic advice	1.330	1	1.330	1.611	.213
	Networking	.715	1	.715	1.034	.317
	Determining salary and remuneration	.129	1	.129	.198	.659
	Evaluating management	1.159	1	1.159	.746	.394
	Directing succession challenges	.552	1	.552	.463	.501
Error	Board meetings based on prepared agendas	.000	33	.000		
	Setting agenda of meetings	22.672	33	.687		
	Board Remuneration : No remuneration	.000	33	.000		
	Level of involvement of external directors	12.506	33	.379		
	CEO also chairperson of the board	.000	33	.000		
	Frequency of meetings within a year	.000	33	.000		
	Set annual fee	5.310	33	.161		
	Per meeting fee	8.006	33	.243		

	Travel and other reimbursements	7.540	33	.228		
	Policy to evaluate board performance	8.741	33	.265		
	Board involvement on the appointment of the CEO	4.948	33	.150		
	Policy to evaluate performance of the CEO	7.126	33	.216		
	Policy on succession planning	8.052	33	.244		
	Existence of an internal audit department	1.500	33	.045		
	Board Committees : Risk management	2.299	33	.070		
	Finance	.000	33	.000		
	Human Resources	8.506	33	.258		
	Social/Ethical	2.299	33	.070		
	Clinical	.000	33	.000		
	Building organizational reputation	28.552	33	.865		
	Strategic planning process	34.644	33	1.050		
	Control organizational resources	27.793	33	.842		
	Finance expertise	30.144	33	.913		
	Legal expertise	29.040	33	.880		
	Operational expertise	40.466	33	1.226		
	Recruitment	18.023	33	.546		
	Providing strategic advice	27.241	33	.825		
	Networking	22.828	33	.692		
	Determining salary and remuneration	21.471	33	.651		
	Evaluating management	51.241	33	1.553		
	Directing succession challenges	39.333	33	1.192		
Total	Board meetings based on prepared agendas	35.000	35			
	Setting agenda of meetings	97.000	35			

Board Remuneration : No remuneration	140.000	35			
Level of involvement of external directors	84.000	35			
CEO also chairperson of the board	140.000	35			
Frequency of meetings within a year	140.000	35			
Set annual fee	119.000	35			
Per meeting fee	77.000	35			
Travel and other reimbursements	107.000	35			
Policy to evaluate board performance	89.000	35			
Board involvement on the appointment of the CEO	119.000	35			
Policy to evaluate performance of the CEO	65.000	35			
Policy on succession planning	101.000	35			
Existence of an internal audit department	44.000	35			
Board Committees : Risk management	44.000	35			
Finance	35.000	35			
Human Resources	80.000	35			
Social/Ethical	131.000	35			
Clinical	35.000	35			
Building organizational reputation	672.000	35			
Strategic planning process	637.000	35			
Control organizational resources	484.000	35			
Finance expertise	500.000	35			
Legal expertise	435.000	35			
Operational expertise	570.000	35			
Recruitment	340.000	35			
Providing strategic advice	715.000	35			

	Networking	675.000	35			
	Determining salary and remuneration	135.000	35			
	Evaluating management	457.000	35			
	Directing succession challenges	188.000	35			
Corrected Total	Board meetings based on prepared agendas	.000	34			
	Setting agenda of meetings	22.686	34			
	Board Remuneration : No remuneration	.000	34			
	Level of involvement of external directors	12.571	34			
	CEO also chairperson of the board	.000	34			
	Frequency of meetings within a year	.000	34			
	Set annual fee	5.600	34			
	Per meeting fee	8.400	34			
	Travel and other reimbursements	7.543	34			
	Policy to evaluate board performance	8.743	34			
	Board involvement on the appointment of the CEO	5.600	34			
	Policy to evaluate performance of the CEO	7.143	34			
	Policy on succession planning	8.171	34			
	Existence of an internal audit department	2.743	34			
	Board Committees : Risk management	2.743	34			
	Finance	.000	34			
	Human Resources	8.571	34			
	Social/Ethical	2.743	34			
	Clinical	.000	34			

Building organizational reputation	29.143	34		
Strategic planning process	36.286	34		
Control organizational resources	30.400	34		
Finance expertise	31.886	34		
Legal expertise	30.400	34		
Operational expertise	41.543	34		
Recruitment	18.971	34		
Providing strategic advice	28.571	34		
Networking	23.543	34		
Determining salary and remuneration	21.600	34		
Evaluating management	52.400	34		
Directing succession challenges	39.886	34		

- a. R Squared = . (Adjusted R Squared = .)
- b. R Squared = .001 (Adjusted R Squared = -.030)
- c. R Squared = .005 (Adjusted R Squared = -.025)
- d. R Squared = .052 (Adjusted R Squared = .023)
- e. R Squared = .047 (Adjusted R Squared = .018)
- f. R Squared = .000 (Adjusted R Squared = -.030)
- g. R Squared = .000 (Adjusted R Squared = -.030)
- h. R Squared = .116 (Adjusted R Squared = .090)
- i. R Squared = .002 (Adjusted R Squared = -.028)
- j. R Squared = .015 (Adjusted R Squared = -.015)
- k. R Squared = .453 (Adjusted R Squared = .437)
- l. R Squared = .162 (Adjusted R Squared = .136)
- m. R Squared = .008 (Adjusted R Squared = -.022)
- n. R Squared = .020 (Adjusted R Squared = -.009)
- o. R Squared = .045 (Adjusted R Squared = .016)
- p. R Squared = .086 (Adjusted R Squared = .058)
- q. R Squared = .055 (Adjusted R Squared = .026)
- r. R Squared = .045 (Adjusted R Squared = .016)
- s. R Squared = .026 (Adjusted R Squared = -.004)
- t. R Squared = .050 (Adjusted R Squared = .021)
- u. R Squared = .047 (Adjusted R Squared = .018)
- v. R Squared = .030 (Adjusted R Squared = .001)
- w. R Squared = .006 (Adjusted R Squared = -.024)

x. R Squared = .022 (Adjusted R Squared = -.008)

y. R Squared = .014 (Adjusted R Squared = -.016)

### Multivariate Tests<sup>a</sup>

Effect		Value	F	Hypothesis df	Error df	Sig.
	Pillai's Trace	.000	. <sup>b</sup>	.000	.000	.
	Wilks' Lambda	1.000	. <sup>b</sup>	.000	5.500	.
	Hotelling's Trace	.000	. <sup>b</sup>	.000	2.000	.
	Roy's Largest Root	.000	.000 <sup>b</sup>	2.000	4.000	1.000
Q3	Pillai's Trace	.000	. <sup>b</sup>	.000	.000	.
	Wilks' Lambda	1.000	. <sup>b</sup>	.000	5.500	.
	Hotelling's Trace	.000	. <sup>b</sup>	.000	2.000	.
	Roy's Largest Root	.000	.000 <sup>b</sup>	2.000	4.000	1.000
Q4	Pillai's Trace	.000	. <sup>b</sup>	.000	.000	.
	Wilks' Lambda	1.000	. <sup>b</sup>	.000	5.500	.
	Hotelling's Trace	.000	. <sup>b</sup>	.000	2.000	.
	Roy's Largest Root	.000	.000 <sup>b</sup>	2.000	4.000	1.000
Q5	Pillai's Trace	.000	. <sup>b</sup>	.000	.000	.
	Wilks' Lambda	1.000	. <sup>b</sup>	.000	5.500	.
	Hotelling's Trace	.000	. <sup>b</sup>	.000	2.000	.
	Roy's Largest Root	.000	.000 <sup>b</sup>	2.000	4.000	1.000
Q7	Pillai's Trace	.512	2.624 <sup>b</sup>	2.000	5.000	.166
	Wilks' Lambda	.488	2.624 <sup>b</sup>	2.000	5.000	.166
	Hotelling's Trace	1.050	2.624 <sup>b</sup>	2.000	5.000	.166
	Roy's Largest Root	1.050	2.624 <sup>b</sup>	2.000	5.000	.166
Q8	Pillai's Trace	.311	1.129 <sup>b</sup>	2.000	5.000	.394
	Wilks' Lambda	.689	1.129 <sup>b</sup>	2.000	5.000	.394
	Hotelling's Trace	.452	1.129 <sup>b</sup>	2.000	5.000	.394
	Roy's Largest Root	.452	1.129 <sup>b</sup>	2.000	5.000	.394
Q9a	Pillai's Trace	.000	. <sup>b</sup>	.000	.000	.
	Wilks' Lambda	1.000	. <sup>b</sup>	.000	5.500	.
	Hotelling's Trace	.000	. <sup>b</sup>	.000	2.000	.
	Roy's Largest Root	.000	.000 <sup>b</sup>	2.000	4.000	1.000
Q9b	Pillai's Trace	.408	1.725 <sup>b</sup>	2.000	5.000	.269
	Wilks' Lambda	.592	1.725 <sup>b</sup>	2.000	5.000	.269
	Hotelling's Trace	.690	1.725 <sup>b</sup>	2.000	5.000	.269
	Roy's Largest Root	.690	1.725 <sup>b</sup>	2.000	5.000	.269
Q9c	Pillai's Trace	.028	.072 <sup>b</sup>	2.000	5.000	.931
	Wilks' Lambda	.972	.072 <sup>b</sup>	2.000	5.000	.931
	Hotelling's Trace	.029	.072 <sup>b</sup>	2.000	5.000	.931
	Roy's Largest Root	.029	.072 <sup>b</sup>	2.000	5.000	.931

Q9d	Pillai's Trace	.478	2.286 <sup>b</sup>	2.000	5.000	.197
	Wilks' Lambda	.522	2.286 <sup>b</sup>	2.000	5.000	.197
	Hotelling's Trace	.914	2.286 <sup>b</sup>	2.000	5.000	.197
	Roy's Largest Root	.914	2.286 <sup>b</sup>	2.000	5.000	.197
Q10	Pillai's Trace	.460	2.131 <sup>b</sup>	2.000	5.000	.214
	Wilks' Lambda	.540	2.131 <sup>b</sup>	2.000	5.000	.214
	Hotelling's Trace	.852	2.131 <sup>b</sup>	2.000	5.000	.214
	Roy's Largest Root	.852	2.131 <sup>b</sup>	2.000	5.000	.214
Q12	Pillai's Trace	.019	.050 <sup>b</sup>	2.000	5.000	.952
	Wilks' Lambda	.981	.050 <sup>b</sup>	2.000	5.000	.952
	Hotelling's Trace	.020	.050 <sup>b</sup>	2.000	5.000	.952
	Roy's Largest Root	.020	.050 <sup>b</sup>	2.000	5.000	.952
Q13	Pillai's Trace	.015	.038 <sup>b</sup>	2.000	5.000	.963
	Wilks' Lambda	.985	.038 <sup>b</sup>	2.000	5.000	.963
	Hotelling's Trace	.015	.038 <sup>b</sup>	2.000	5.000	.963
	Roy's Largest Root	.015	.038 <sup>b</sup>	2.000	5.000	.963
Q15	Pillai's Trace	.451	2.051 <sup>b</sup>	2.000	5.000	.224
	Wilks' Lambda	.549	2.051 <sup>b</sup>	2.000	5.000	.224
	Hotelling's Trace	.820	2.051 <sup>b</sup>	2.000	5.000	.224
	Roy's Largest Root	.820	2.051 <sup>b</sup>	2.000	5.000	.224
Q16	Pillai's Trace	.094	.258 <sup>b</sup>	2.000	5.000	.782
	Wilks' Lambda	.906	.258 <sup>b</sup>	2.000	5.000	.782
	Hotelling's Trace	.103	.258 <sup>b</sup>	2.000	5.000	.782
	Roy's Largest Root	.103	.258 <sup>b</sup>	2.000	5.000	.782
Q17a	Pillai's Trace	.183	.559 <sup>b</sup>	2.000	5.000	.604
	Wilks' Lambda	.817	.559 <sup>b</sup>	2.000	5.000	.604
	Hotelling's Trace	.224	.559 <sup>b</sup>	2.000	5.000	.604
	Roy's Largest Root	.224	.559 <sup>b</sup>	2.000	5.000	.604
Q17b	Pillai's Trace	.000	. <sup>b</sup>	.000	.000	.
	Wilks' Lambda	1.000	. <sup>b</sup>	.000	5.500	.
	Hotelling's Trace	.000	. <sup>b</sup>	.000	2.000	.
	Roy's Largest Root	.000	.000 <sup>b</sup>	2.000	4.000	1.000
Q17c	Pillai's Trace	.287	1.007 <sup>b</sup>	2.000	5.000	.429
	Wilks' Lambda	.713	1.007 <sup>b</sup>	2.000	5.000	.429
	Hotelling's Trace	.403	1.007 <sup>b</sup>	2.000	5.000	.429
	Roy's Largest Root	.403	1.007 <sup>b</sup>	2.000	5.000	.429
Q17d	Pillai's Trace	.466	2.182 <sup>b</sup>	2.000	5.000	.208
	Wilks' Lambda	.534	2.182 <sup>b</sup>	2.000	5.000	.208
	Hotelling's Trace	.873	2.182 <sup>b</sup>	2.000	5.000	.208
	Roy's Largest Root	.873	2.182 <sup>b</sup>	2.000	5.000	.208
Q17e	Pillai's Trace	.000	. <sup>b</sup>	.000	.000	.

	Wilks' Lambda	1.000	. <sup>b</sup>	.000	5.500	.
	Hotelling's Trace	.000	. <sup>b</sup>	.000	2.000	.
	Roy's Largest Root	.000	.000 <sup>b</sup>	2.000	4.000	1.000
Q18a	Pillai's Trace	.118	.335 <sup>b</sup>	2.000	5.000	.730
	Wilks' Lambda	.882	.335 <sup>b</sup>	2.000	5.000	.730
	Hotelling's Trace	.134	.335 <sup>b</sup>	2.000	5.000	.730
	Roy's Largest Root	.134	.335 <sup>b</sup>	2.000	5.000	.730
Q18b	Pillai's Trace	.406	1.708 <sup>b</sup>	2.000	5.000	.272
	Wilks' Lambda	.594	1.708 <sup>b</sup>	2.000	5.000	.272
	Hotelling's Trace	.683	1.708 <sup>b</sup>	2.000	5.000	.272
	Roy's Largest Root	.683	1.708 <sup>b</sup>	2.000	5.000	.272
Q18c	Pillai's Trace	.178	.542 <sup>b</sup>	2.000	5.000	.612
	Wilks' Lambda	.822	.542 <sup>b</sup>	2.000	5.000	.612
	Hotelling's Trace	.217	.542 <sup>b</sup>	2.000	5.000	.612
	Roy's Largest Root	.217	.542 <sup>b</sup>	2.000	5.000	.612
Q18d	Pillai's Trace	.004	.009 <sup>b</sup>	2.000	5.000	.991
	Wilks' Lambda	.996	.009 <sup>b</sup>	2.000	5.000	.991
	Hotelling's Trace	.004	.009 <sup>b</sup>	2.000	5.000	.991
	Roy's Largest Root	.004	.009 <sup>b</sup>	2.000	5.000	.991
Q18e	Pillai's Trace	.327	1.215 <sup>b</sup>	2.000	5.000	.372
	Wilks' Lambda	.673	1.215 <sup>b</sup>	2.000	5.000	.372
	Hotelling's Trace	.486	1.215 <sup>b</sup>	2.000	5.000	.372
	Roy's Largest Root	.486	1.215 <sup>b</sup>	2.000	5.000	.372
Q18f	Pillai's Trace	.465	2.173 <sup>b</sup>	2.000	5.000	.209
	Wilks' Lambda	.535	2.173 <sup>b</sup>	2.000	5.000	.209
	Hotelling's Trace	.869	2.173 <sup>b</sup>	2.000	5.000	.209
	Roy's Largest Root	.869	2.173 <sup>b</sup>	2.000	5.000	.209
Q18g	Pillai's Trace	.186	.571 <sup>b</sup>	2.000	5.000	.598
	Wilks' Lambda	.814	.571 <sup>b</sup>	2.000	5.000	.598
	Hotelling's Trace	.228	.571 <sup>b</sup>	2.000	5.000	.598
	Roy's Largest Root	.228	.571 <sup>b</sup>	2.000	5.000	.598
Q18h	Pillai's Trace	.111	.313 <sup>b</sup>	2.000	5.000	.745
	Wilks' Lambda	.889	.313 <sup>b</sup>	2.000	5.000	.745
	Hotelling's Trace	.125	.313 <sup>b</sup>	2.000	5.000	.745
	Roy's Largest Root	.125	.313 <sup>b</sup>	2.000	5.000	.745
Q18i	Pillai's Trace	.149	.438 <sup>b</sup>	2.000	5.000	.668
	Wilks' Lambda	.851	.438 <sup>b</sup>	2.000	5.000	.668
	Hotelling's Trace	.175	.438 <sup>b</sup>	2.000	5.000	.668
	Roy's Largest Root	.175	.438 <sup>b</sup>	2.000	5.000	.668
Q18j	Pillai's Trace	.248	.824 <sup>b</sup>	2.000	5.000	.490
	Wilks' Lambda	.752	.824 <sup>b</sup>	2.000	5.000	.490

	Hotelling's Trace	.330	.824 <sup>b</sup>	2.000	5.000	.490
	Roy's Largest Root	.330	.824 <sup>b</sup>	2.000	5.000	.490
Q18k	Pillai's Trace	.486	2.359 <sup>b</sup>	2.000	5.000	.190
	Wilks' Lambda	.514	2.359 <sup>b</sup>	2.000	5.000	.190
	Hotelling's Trace	.944	2.359 <sup>b</sup>	2.000	5.000	.190
	Roy's Largest Root	.944	2.359 <sup>b</sup>	2.000	5.000	.190
Q18l	Pillai's Trace	.146	.429 <sup>b</sup>	2.000	5.000	.673
	Wilks' Lambda	.854	.429 <sup>b</sup>	2.000	5.000	.673
	Hotelling's Trace	.171	.429 <sup>b</sup>	2.000	5.000	.673
	Roy's Largest Root	.171	.429 <sup>b</sup>	2.000	5.000	.673
Region	Pillai's Trace	.680	5.315 <sup>b</sup>	2.000	5.000	.058
	Wilks' Lambda	.320	5.315 <sup>b</sup>	2.000	5.000	.058
	Hotelling's Trace	2.126	5.315 <sup>b</sup>	2.000	5.000	.058
	Roy's Largest Root	2.126	5.315 <sup>b</sup>	2.000	5.000	.058
Gender	Pillai's Trace	.220	.706 <sup>b</sup>	2.000	5.000	.537
	Wilks' Lambda	.780	.706 <sup>b</sup>	2.000	5.000	.537
	Hotelling's Trace	.282	.706 <sup>b</sup>	2.000	5.000	.537
	Roy's Largest Root	.282	.706 <sup>b</sup>	2.000	5.000	.537
Region * Gender	Pillai's Trace	.043	.112 <sup>b</sup>	2.000	5.000	.896
	Wilks' Lambda	.957	.112 <sup>b</sup>	2.000	5.000	.896
	Hotelling's Trace	.045	.112 <sup>b</sup>	2.000	5.000	.896
	Roy's Largest Root	.045	.112 <sup>b</sup>	2.000	5.000	.896

a. Design: + Q3 + Q4 + Q5 + Q7 + Q8 + Q9a + Q9b + Q9c + Q9d + Q10 + Q12 + Q13 + Q15 + Q16 + Q17a + Q17b + Q17c + Q17d + Q17e + Q18a + Q18b + Q18c + Q18d + Q18e + Q18f + Q18g + Q18h + Q18i + Q18j + Q18k + Q18l + Region + Gender + Region \* Gender

b. Exact statistic

## Correlation Matrix

		Building organizational reputation	Strategic planning process	Control organizational resources	Finance expertise
Correlation	Building organizational reputation	1.000	.756	.605	.605
	Strategic planning process	.756	1.000	.572	.462
	Control organizational resources	.605	.572	1.000	.617
	Finance expertise	.605	.462	.617	1.000
	Legal expertise	.437	.301	.250	.379
	Operational expertise	.493	.401	.630	.539
	Recruitment	.158	-.005	.433	.339

	Providing strategic advice	.822	.772	.645	.601
	Networking	.567	.425	.426	.247
	Determining salary and remuneration	.279	.250	.320	.023
	Evaluating management	.409	.550	.416	.533
	Directing succession challenges	.277	.255	.195	.356
Sig. (1-tailed)	Building organizational reputation		.000	.000	.000
	Strategic planning process	.000		.000	.003
	Control organizational resources	.000	.000		.000
	Finance expertise	.000	.003	.000	
	Legal expertise	.004	.039	.074	.012
	Operational expertise	.001	.008	.000	.000
	Recruitment	.182	.488	.005	.023
	Providing strategic advice	.000	.000	.000	.000
	Networking	.000	.005	.005	.076
	Determining salary and remuneration	.052	.074	.030	.448
	Evaluating management	.007	.000	.006	.000
	Directing succession challenges	.054	.069	.130	.018

### Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	Functional Board	4.600 <sup>a</sup>	28	.164	2.654	.112
	Name of hospital	117.902 <sup>b</sup>	28	4.211	32.252	.000
	Functional Board	.000	0	.	.	.
	Name of hospital	.000	0	.	.	.
Q3	Functional Board	.000	0	.	.	.
	Name of hospital	.000	0	.	.	.
Q4	Functional Board	.000	0	.	.	.
	Name of hospital	.000	0	.	.	.
Q5	Functional Board	.000	0	.	.	.
	Name of hospital	.000	0	.	.	.
Q7	Functional Board	.239	1	.239	3.868	.097
	Name of hospital	.657	1	.657	5.029	.066

Q8	Functional Board	.037	1	.037	.599	.468
	Name of hospital	.353	1	.353	2.701	.151
Q9a	Functional Board	.000	0	.	.	.
	Name of hospital	.000	0	.	.	.
Q9b	Functional Board	.255	1	.255	4.120	.089
	Name of hospital	.069	1	.069	.526	.496
Q9c	Functional Board	.011	1	.011	.173	.692
	Name of hospital	.004	1	.004	.028	.872
Q9d	Functional Board	.273	1	.273	4.412	.080
	Name of hospital	.000	1	.000	.003	.958
Q10	Functional Board	.250	1	.250	4.033	.091
	Name of hospital	.418	1	.418	3.199	.124
Q12	Functional Board	.002	1	.002	.030	.869
	Name of hospital	.015	1	.015	.118	.743
Q13	Functional Board	.004	1	.004	.068	.802
	Name of hospital	.008	1	.008	.061	.813
Q15	Functional Board	.295	1	.295	4.773	.072
	Name of hospital	.042	1	.042	.325	.589
Q16	Functional Board	.013	1	.013	.218	.657
	Name of hospital	.019	1	.019	.143	.719
Q17a	Functional Board	.045	1	.045	.720	.429
	Name of hospital	.150	1	.150	1.150	.325
Q17b	Functional Board	.000	0	.	.	.
	Name of hospital	.000	0	.	.	.
Q17c	Functional Board	.081	1	.081	1.302	.297
	Name of hospital	.270	1	.270	2.069	.200
Q17d	Functional Board	.237	1	.237	3.832	.098
	Name of hospital	.008	1	.008	.063	.811
Q17e	Functional Board	.000	0	.	.	.
	Name of hospital	.000	0	.	.	.
Q18a	Functional Board	.002	1	.002	.035	.859
	Name of hospital	.100	1	.100	.764	.416
Q18b	Functional Board	.029	1	.029	.470	.518
	Name of hospital	.531	1	.531	4.067	.090
Q18c	Functional Board	.080	1	.080	1.299	.298
	Name of hospital	.036	1	.036	.274	.620
Q18d	Functional Board	.001	1	.001	.010	.925
	Name of hospital	.003	1	.003	.019	.894
Q18e	Functional Board	.001	1	.001	.010	.923
	Name of hospital	.295	1	.295	2.260	.183
Q18f	Functional Board	.001	1	.001	.016	.904

## Correlation Matrix

	Name of hospital	.587	1	.587	4.499	.078
Q18g	Functional Board	.002	1	.002	.025	.879
	Name of hospital	.126	1	.126	.969	.363
Q18h	Functional Board	.046	1	.046	.750	.420
	Name of hospital	.018	1	.018	.135	.726
Q18i	Functional Board	.013	1	.013	.217	.658
	Name of hospital	.052	1	.052	.399	.551
Q18j	Functional Board	.000	1	.000	.002	.967
	Name of hospital	.218	1	.218	1.673	.243
Q18k	Functional Board	.011	1	.011	.173	.692
	Name of hospital	.691	1	.691	5.290	.061
Q18l	Functional Board	.016	1	.016	.265	.625
	Name of hospital	.133	1	.133	1.019	.352
Region	Functional Board	.001	1	.001	.018	.899
	Name of hospital	1.415	1	1.415	10.842	.017
Gender	Functional Board	6.496E-5	1	6.496E-5	.001	.975
	Name of hospital	.186	1	.186	1.424	.278
Region * Gender	Functional Board	.001	1	.001	.011	.920
	Name of hospital	.033	1	.033	.256	.631
Error	Functional Board	.371	6	.062		
	Name of hospital	.783	6	.131		
Total	Functional Board	53.000	35			
	Name of hospital	609.000	35			
Corrected Total	Functional Board	4.971	34			
	Name of hospital	118.686	34			

a. R Squared = .925 (Adjusted R Squared = .577)

b. R Squared = .993 (Adjusted R Squared = .963)

			Legal expertise	Operational expertise	Recruitment	Providing strategic advice
Correlation	Building organizational reputation		.437	.493	.158	.822
	Strategic planning process		.301	.401	-.005	.772
	Control organizational resources		.250	.630	.433	.645
	Finance expertise		.379	.539	.339	.601
	Legal expertise		1.000	.383	.067	.238
	Operational expertise		.383	1.000	.574	.572
	Recruitment		.067	.574	1.000	.067
	Providing strategic advice		.238	.572	.067	1.000
	Networking		.172	.488	.080	.705
	Determining salary and remuneration		.070	.274	.158	.161
	Evaluating management		.236	.442	.114	.439
	Directing succession challenges		.322	.325	-.038	.212
Sig. (1-tailed)	Building organizational reputation		.004	.001	.182	.000
	Strategic planning process		.039	.008	.488	.000
	Control organizational resources		.074	.000	.005	.000
	Finance expertise		.012	.000	.023	.000
	Legal expertise			.012	.352	.085
	Operational expertise		.012		.000	.000
	Recruitment		.352	.000		.350
	Providing strategic advice		.085	.000	.350	
	Networking		.162	.001	.324	.000
	Determining salary and remuneration		.344	.056	.182	.178
	Evaluating management		.087	.004	.257	.004
	Directing succession challenges		.030	.028	.413	.111

### Correlation Matrix

		Networking	Determining salary and remuneration	Evaluating management	Directing succession challenges
Correlation	Building organizational reputation	.567	.279	.409	.277
	Strategic planning process	.425	.250	.550	.255
	Control organizational resources	.426	.320	.416	.195
	Finance expertise	.247	.023	.533	.356
	Legal expertise	.172	.070	.236	.322
	Operational expertise	.488	.274	.442	.325
	Recruitment	.080	.158	.114	-.038
	Providing strategic advice	.705	.161	.439	.212
	Networking	1.000	.319	-.040	.077
	Determining salary and remuneration	.319	1.000	.172	.457
	Evaluating management	-.040	.172	1.000	.354
	Directing succession challenges	.077	.457	.354	1.000
Sig. (1-tailed)	Building organizational reputation	.000	.052	.007	.054
	Strategic planning process	.005	.074	.000	.069
	Control organizational resources	.005	.030	.006	.130
	Finance expertise	.076	.448	.000	.018
	Legal expertise	.162	.344	.087	.030
	Operational expertise	.001	.056	.004	.028
	Recruitment	.324	.182	.257	.413
	Providing strategic advice	.000	.178	.004	.111
	Networking		.031	.410	.329
	Determining salary and remuneration	.031		.161	.003
	Evaluating management	.410	.161		.018
	Directing succession challenges	.329	.003	.018	

### Component Matrix<sup>a</sup>

		Component			
		1	2	3	4
Building	organizational	.860	-.263	-.068	-.059
reputation					
Strategic planning process		.783	-.376	.066	-.128
Control	organizational	.803	.194	-.200	-.002
resources					
Finance expertise		.753	.216	.102	-.360
Legal expertise		.473	.040	.322	-.133
Operational expertise		.773	.399	-.139	.091
Recruitment		.333	.816	-.356	.060
Providing strategic advice		.861	-.348	-.217	-.112
Networking		.599	-.355	-.501	.345
Determining	salary and	.382	.045	.192	.821
remuneration					
Evaluating management		.602	.125	.462	-.308
Directing	succession	.435	.054	.692	.362
challenges					

Source: Field Data (2019)

## Appendix 4: Thesis editing confirmation letter

### Thesis Editorial Review Report for Webster Funhiro

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12 June 2020

**University of KwaZulu Natal**  
Graduate School of Business and Leadership  
South Africa

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### **TO WHOM IT MAY CONCERN**

#### **1 Introduction**

This thesis editorial review report is made to the Graduate School of Business and Leadership at the University of KwaZulu Natal (UKZN) following a editorial work of Mr. Webster Funhiro's thesis entitled "*Standardization and strengthening the functionality of hospital management boards in central hospitals of Zimbabwe*". This is in line with UKZN's requirement that a student's thesis has to be subjected to an independent academic editorial scrutiny. Thus, the objective of this report is to highlight the shortcomings of the thesis to which appropriate corrections and suggestions were made through track-changes in the document for the convenience of the candidate as presented in Section 2 below.

#### **2 Editorial findings**

The shortcomings/limitations observed and corrections/suggestions made for the candidate's consideration are categorized into eleven (11) themes here outlined.

##### **2.1 *Sentence constructions***

- a) Over use of certain words and phrases in sentence construction.
- b) Use of an inappropriate word to express an idea (choice of words was quite problematic)
- c) Widespread instances of incomplete sentences.
- d) Sentence construction was largely passive instead of active for clarity and flow of thought
- e) Some mechanics (full stop, comma, semi-colon, colon, double quotation marks, single quotation marks, hyphenation, etc.) were improperly used in the sentence constructions and presentation of direct quotations.

##### **2.2 *Literature and citation***

- a) Referencing style is not consistent. Harvard referencing should be used as required by UKZN
- b) There were widespread instances of inappropriate use of phrases to articulate what the author(s) discussed. For example, to say an author argued when in fact the author noted or proposed.
- c) Old literature is quite evident and some authors are over-used in the thesis
- d) Citation of qualitative findings (verbalism) were improperly and inconsistently done.
- e) Flow of presentation and discussions required strengthening through use of proper paragraphing, transitions and good choice of words.
- f) There were quite a number of repetitions of discussions and interpretations of issues that emerged from the study which resulted synchronization and coherence of the narrative.

Editorial work by: Dr. Pindai Sithole ([sitholepindai@gmail.com](mailto:sitholepindai@gmail.com)): 12 June 2020

1

### 2.3 *Paragraphing*

Some paragraphs needed to be joined together because the main ideas discussed were the same while other paragraphs required splitting because they contained two or more different main ideas.

### 2.4 *Section introductions*

Some sections had inappropriate introductory statements while others did not have them at all. This situation reduced flow of presentation and discussion in the thesis.

### 2.5 *Line spacing*

- a) Double-spacing was widespread between diagrams and their captions as well as in tables to which single-spacing is recommended.
- b) The caption numbers of Figures and Tables should reflect the chapter number. For example, **Table 4.3: Study population**; which denotes the third table in the fourth chapter.

### 2.6 *Phrasing of headings*

Some headings were not self-explanatory while others were too long. Such a situation contributed to some level of detachment between the heading and the narrative that followed.

### 2.7 *Text colour*

Main headings, sub-headings and diagrams (tables, graphs, etc.) were in blue colour to the normal black colour in conformance to writing of academic documents.

### 2.8 *Transitions*

Transitions were quite limited and sometimes a few applied were inappropriately used or over used. This limited interconnection and flow of issues presented and discussed in the thesis.

### 2.9 *Presentation of findings*

It is important to indicate how many respondents answered/responded a particular question under consideration/discussion so that one can make relative sense of the percentages presented. This observation applied to all graphs, tables and charts. In other words, the sample size of the data presented had to be indicated through writing the sample size (n) at the top left corner of the diagram, graph or table concerned.

### 2.10 *Limited in the use of cautious language*

Where an issue or study findings were not quite conclusive, the candidate tended to make absolute or sweeping expressions/conclusions. For example, the candidate would use phrases like *very critical* instead of just say *critical*, *highly likely* instead of *likely*, etc. Generally, absolute expressions were quite prevalent in the thesis.

### 2.11 *Crafting of a chapter summary*

Instead of providing just a summary at the end of each chapter, the candidate tended to repeat discussion of the issues already presented and discussed earlier in the chapter or section concerned.

## 3 **Conclusion**

If the candidate considers the suggestions/corrections made in the thesis to address the above-mentioned gaps and also makes proper adjustments, it is highly likely that the final document would meet the required quality level for doctorate studies.

Signed:



Dr. Pindai Sithole, PhD

## Appendix 5: MOHCC Approval

Telephone: +263-4-798537-80

All correspondences should be  
Addressed to the Permanent  
Secretary for Health and  
Child Care



Reference:

Ministry of Health and Child Care  
P.O. Box CY1122  
Causeway  
Zimbabwe

17 May 2017

Provincial Medical Director  
Mashonaland West Province  
P.O. Box 139  
**Chinhoyi**

**Attention:** Mr Webster Funhiro

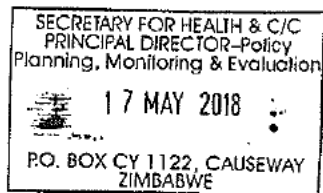
**RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH IN CENTRAL  
HOSPITALS OF ZIMBABWE**

Your request on the above refers.

Ministry of Health and Child Care has no objection on your request for permission to  
conduct a research and interviews in six (6) central hospitals of Zimbabwe.

You are therefore requested to submit a final copy of the report.

Thanking you.



**Dr R. F. Mudyiradima**  
**Acting Secretary for Health and Child Care**

/pm

## Appendix 6 : Ethical Clearance Approval Letter



25 May 2020

**Mr Webster Funhiro (217080065)**  
Graduate School of Business & Leadership  
Westville Campus

Dear Mr Funhiro,

**Protocol reference number:** HSS/1091/018D

**Project title:** Standardization and strengthening the functionality of Hospital Management Boards in central hospitals of Zimbabwe

### Approval Notification – Amendment Application

This letter serves to notify you that your application and request for an amendment received on 22 May 2020 has now been approved as follows:

- Change in Supervisor

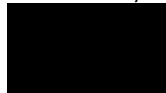
**Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.**

**PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.**

**All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.**

Best wishes for the successful completion of your research protocol.

Yours faithfully








.....  
**Professor Dipane Hlalele (Chair)**  
/dd

Cc Supervisor: Dr. Bhaso Yalezo & Prof Cecile N. Gerwel Proches  
cc Academic Leader Research: Professor Muhammad Hoque  
cc School Administrator: Ms Zarina Bullyraj

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Humanities & Social Sciences Research Ethics Committee  
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building  
Postal Address: Private Bag X54001, Durban 4000  
Tel: +27 31 260 8350 / 4557 / 3587

Website: <http://research.ukzn.ac.za/Research-Ethics/>

Founding Campuses:  Edgewood  Howard College  Medical School  Pietermaritzburg  Westville

INSPIRING GREATNESS

## Appendix 7 : Turnitin Report

Standardization and strengthening the functionality of hospital management boards in central hospitals of Zimbabwe

### ORIGINALITY REPORT

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