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Health Care Financing and Health Service Delivery in Public Hospitals during Covid-19 Lock down: A Case of Lyantonde Hospital

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Abstract: *The study examined the effect of health financing on health service delivery in public hospitals, a case of Lyantonde Hospital study the above general objective, the following specific objectives were adopted; to determine the effect of government financing on health service delivery in public hospitals; to examine the effect of donor financing on health service delivery in public hospitals; to find out the effect of out-of-pocket financing on health service delivery in public hospitals.The study employed a correlation design to establish the underlying effect/relationship among study variables and a case study design to obtain information, and opinions from a large group of people in order to describe some characteristics of a phenomenon. Both qualitative and quantitative methods will be used in order to reduce bias. Quantitative approaches were adopted when sampling, collecting data, Controlling data quality and in analysing data. Qualitative approach will be helpful in interpreting people's thoughts, opinions and perceptions about Health sector financing and health service delivery. The qualitative data gave a narrative and descriptive information that will explain and give deeper understanding and insight into a problem .The study used both primary data sources and secondary data sources to enable the researcher meet the study objectives. Qualitative data was obtained from open ended questionnaires and by conducting interviews with other respondents to provide additional information to study problem. Quantitative data dealt with numbers and anything that was measurable in a systematic way of investigation of phenomena and their relationships. It answered questions on relationships within measurable variables with an intention to explain, predict and control phenomena*

Keywords ; Health Care ; Health Service Delivery ; Public Hospitals ; Lyantonde Hospital ; Health Care Financing

1. Introduction

According to Anton & Onofre (2013) a common feature of all health systems from emerging economies is the shortage of financial resources. Mukasa (2012) established the challenges of Ugandan public hospitals, his study never ascertained the exact effect of the available financing strategies on health service delivery which data analysis gap will be addressed by running regression analysis to establish whether financing strategies have any significant effect on health service delivery in Lyantonde hospital. The study aimed at investigating the effect of healthcare financing on health service delivery at Lyantonde Hospital.
There is a convergence in opinion that adequate public financing as a health intervention affects the quality and uptake of health services which ultimately insures citizens against catastrophic health expenditures (Verguet, Olson, Babigumira, Desalegn, Johansson, Kruk, Levin, Nugent, Pecenka, Shrime, Memirie, Watkins, & Jamison, 2015). Indeed, public health sector financing for many countries comes from tax revenues, donor funds, and out-of-pocket expenditure (Verguet et al., 2015). But despite such anticipation, many countries are yet to harness the above significance. Like in India, their health care system is punctuated by low levels and uneven spread of public spending on health care hence poor quality of health care services as the system over-depends on poor population's out of pocket funding (Govinda & Mita, 2012). While in Brazil, Massuda, Hone, Leles, de Castro, and Atun (2018) established that structural problems persisted in terms of low public funding and suboptimal resource allocation which was consequently illuminating large regional disparities in access to healthcare services.

Such challenges in both public financing and health service delivery have not spared the African continent as inadequate funding sources was earmarked to be curtailing financing health care delivery in Ghana (Addae-Korankye, 2013). This is not too different from the Malawian perspective where Donor sources accounts for 74% of funds, 19% from Government, and 7% from out of pocket which distribution has benefited mostly urban citizens (Borghi, Munthali, Million, & Martinez-Alvarez, 2018). In East Africa,

Tanzanian hospitals face insufficient public funding and untimely disbursement of funds from the central government (Magaka&Swere, 2016),while most hospital services in Kenya are being funded by out of pocket payments that are being interpreted as regressive (Munge& Briggs, 2014). As for Burundi, acute shortage of health service providers like including skilled birth attendants because of low public funding, traditional birth attendants have become the first point of call for many pregnant women (Che-Chi &Urdal, 2018).

Uganda has not been exceptional either. This is because despite the enactment of a number of public finance management reforms since the 1990s to strengthen the country's health system, various cases of inefficiencies in health care such as drug stock-outs, increase of out-of-pocket payments and decrease of government spending in Ugandan hospitals which continued to contribute towards high incidences of catastrophic health expenditures (Okech, 2014). In fact, the country's health sector has remained significantly under-funded, mainly relying on private sources of finance, especially out-of-pocket spending that has reduced employee morale, drug stock outs, and worsened the state of medical facilities, and increased costs of services breeding corruption-related tendencies in government hospitals (Nabukeera, 2016).

Though there exists eye-catching evidence that the state of service delivery in Ugandan hospitals requires immediate attention, Lyantonde hospital deserves priority. This is because though citizens continue to demand for timely, quality, accessible and sustainable services, the apparent financing challenges coupled with evidence of poor performance on core parameters of service delivery at the hospital created urgent need for a study to establish the effect of health care financing on health service delivery at Lyantonde Hospital.

Literature Review

2.1 Theoretical review

2.1.1 Goal setting theory by Latham and Locke (2002)

This study was guided by the goal-setting theory by Latham and Locke (2002. The goal-setting theory by Latham and Locke (2002), as cited in Kyakulumbye (2013), highlights mechanisms that connect goals to performance outcomes, direct attention to priorities, and focused mind and efforts to achieve health sector service delivery. Goals challenge employees to bring their knowledge and skills to bear and to increase their chances of success. The more challenging the goal, the more people will draw on their full repertoire of skills (Locke & Latham, 2002). The theory emphasizes goal setting and encouragement of decision rights as a basis for service delivery. The theory observes that taking responsibility for results requires that organizational members are given the opportunity to influence their results favourably and have the freedom to take action.

In relation to health sector financing, the above theory implies that workers have a say in defining the right Key Performance Indicators and the mandate to establish Critical Success Factors in relation to their job responsibilities (Armstrong, 2006). Therefore, for health sector financing to have the desired effect, clear goals must be set by the entities implying that the service delivery in the health sector will also improve. Entities may thus attain the desired health services, timeliness of services and accessibility of health services if clear goals for healthcare financing through government funding, donor funding and out of pocket are set. However, the existing healthcare financing in public hospitals appear to be problematic or unsatisfactory, where some employees perceive health sector financing as a relegated human resource function that is not done in good faith and that the exercise rarely improves health service delivery (MOPS 2008).

2.2 Review of the study concepts

2.2.1 The Concept of Healthcare Financing

A common feature of all health systems from emerging economies is the shortage of financial resources (Anton & Onofre, 2013). This is because of population growth and increase of elderly people which will strongly affect health financing needs as well as its ability to meet those needs as the burden of disease would then shift from communicable diseases to non-communicable diseases and injuries (Schieber, Cashin, Saleh,&Lavado, 2012). However, despite such caution, Verguet et al. (2015)opined that public health sector financing for many countries comes from tax revenues, donor funds, and out-of-pocket expenditure.

Though Verguet et al. (2015) avails the three (3) sources of public funding, some countries like Malawi, Donor sources accounts for 74% of funds, 19% from Government, and 7% from out of pocket (Borghi, et al., 2018). For Uganda, increase of out-of-pocket payments and decrease of government spending in Ugandan hospitals has continued to contribute towards high incidences of health expenditures (Okech, 2014). This has been because of mainly relying on private sources of finance (out-of-pocket) that has reduced employee morale, drug stock outs, and worsened the state of medical facilities, and increased costs of services breeding corruption-related tendencies in government hospitals (Nabukeera, 2016).

Despite the fact that the above studies illustrated the availability and challenges in public financing in the health sector, none of them clearly spells out the exact effect amongst them which summons another related study to bridge such conceptual gap.

2.2.2 Health Service Delivery in Public Hospitals

World Health Organization (WHO, 2013) defined health service delivery as the immediate output of the health system that leads to improved service delivery and access to such services. This definition was operationalized by Ministry of Health (2016) to refer to all efforts aimed at improving health service delivery like; Timeliness, Quality of Services, Accessibility and Sustainable specialized health services as adopted performance indicators (Ministry of Health, 2016). This was in line with earlier scholars who hypothesized that the major objectives of health financing were to make sure that funding for the health system was made available, ensure cost-effective interventions, set appropriate financial incentives for health care providers, and ensure that all individuals accessed effective public health and personal health care (Fretheim et al., 2014).

Nyongesa, Onyango, and Kakai (2014) sought to identify factors which determined patients' satisfaction with health care services at Pumwani Maternity Hospital in Nairobi Kenya using purposive sampling to select sample of 280 of postnatal mothers from a population of 1000 using Fisher's method. They found that despite the high cost services, inadequate staffing and poor sanitation, the hospital managed to offer quality services that satisfied the majority of clients. They lastly found that factors that determined patient satisfaction were patient waiting time, attitude of the providers, availability of drugs and services, affordability of the services, level of staffing and level of cleanliness. Despite the fact that Nyongesa et al. (2014) established the factors that led to patient satisfaction, their study was only descriptive and never collected any qualitative feedback to support such descriptive observations. This data collection gap in their methodology will be filled by this current study that will also collect qualitative data through face to face interviews.

On the contrary, Korir (2010) had used an exploratory approach and found that though after independence in 1963, Kenya pledged to fight diseases, ignorance and poverty but the country later experienced lapses in the health status trend evident in the souring child mortality rates despite the massive expansion of health infrastructure after independence, the inability of the government to effectively provide health services leading to a sharp increase in demand for health services. He also observed the growing lack of resources in the public health sector that resulted in a decline in efficiency and quality of government hospitals and health services at large.

In Uganda, Mukasa (2012) established the country's health system was one of the best in the region by 1960's but got worse in the 1970's during the military turmoil and civil strife. Service delivery in most public hospitals in the country are threatened with communicable diseases such as malaria, limited access to quality healthcare, health policy loopholes and the low physician to patient ratio despite support from the international community and NGOs to various health programs and planning.
Also, Ondoa, Basheka, and Basaasa (2013) examined the institutional dynamics affecting health service delivery at Jinja Regional Referral Hospital in Eastern Uganda. Their study population comprised of referral hospital top management, healthcare workers, and a few purposively selected patients. They found that medical supplies were not a significant predictor of government health facilities' service delivery but were seriously affected by inadequate facilities. They therefore suggested that the Ministry of Health should budget more funds for infrastructural development and emphasise more support supervision and monitoring strategies to ensure full utilisation of lower level health centre facilities so that referral hospitals were decongested and left to handle only referrals and emergency cases by specialists. Since the above conclusions of Ondoa et al. (2013) were only explorational aimed at establishing factors that affected service delivery in Jinja regional referral hospital, there is need to carry out a correlational study to avail the real effect among study variables.

2.3Actual review of the literature

2.3.1 Government Financing and Health Service Delivery

Dulal, Magar, Dulal, Khatiwada, and Hamal (2014) examined the effect of health sector budget allocation (financing) and outcome. They established that budget requirements to meet the population's needs were still limited in Nepal because the health sector budget (financing) could not achieve even gainful results due to mismatch in policy and policy implementation despite of political commitment. Though the conclusions of Dulal et al. (2014) were significant in addressing health sector performance in Nepal, they based their findings on only quantitative data which neglected qualitative opinions that left out other reasons as to why respondents thought so. This methodological gap will be addressed by this current study by also collecting qualitative data using face to face interviews.

Relatedly, Seitio-Kgokgwe, Gauld, Hill, & Barnett (2014) evaluated the performance of Botswana public hospital system using document analysis and 54 key informants comprising senior managers and staff of the Ministry of Health (N= 40) and senior officers from stakeholder organizations (N= 14), and surveys of 42 hospital managers and 389 health workers. They found that though

physical access to health services had increased, insufficient government funding yielded into challenges in the distribution of facilities and inpatient beds created inequities and inefficiencies which ultimately affected the quality of health care as the available meagre resources were being over-stretched.Seitio-Kgokgwe et al. (2014) did not consider patients who would have been cardinal in assessing performance of hospitals since they were the real service recipients. This sampling gap will be filled by including patients to assess service delivery at Mbale regional referral hospital.

In Kenya, Wanjau, Muiruri, and Ayodo (2012) explored the factors affecting provision of service quality in the public health sector by reviewing existing literature and experiences. They found that minimal government financing led to a decrease in provision of service quality by a factor of 0.917 coupled by the ineffective communication channels, low employees' capacity, low technology adoption affected delivery of service quality to patients in public health sector affecting health service quality perceptions, patient satisfaction and loyalty. However, despite fact that the conclusions of Wanjau et al. (2012) were far reaching, they never measured the actual effect of government funding on given parameters of health service delivery like general, curative, preventive, rehabilitative, promotive, and specialized health services as adopted performance indicators by the Ministry of Health (2016) hence calling for another study to bridge the above conceptual gap.

Also, Ojakaa, Olango, and Jarvis (2014) further investigated factors influencing motivation and retention of Health Care Workers in the remote area of Turkana (Kenya). They established that due to the low government funding to such health facilities, 20% indicated that they could leave their current job within the next two years due to ill-financed work environment, inadequate access to electricity, equipment, transport, housing, and the physical state of the health facilities in Turkana. Ojakaa et al. (2014) established the willingness of health workers to leave their jobs as a result of inadequate funding from government but their study didn't elaborate how such funding affected the overall health service delivery in such health facilities. This conceptual gap will be bridged by this current study by assessing the effect of government financing strategies on health service delivery at Lyantonde hospital.

Lastly, Rudasingwa and Uwizeye (2017) explored physicians' and nurses' experiences and views on how performance-based financing (PBF) influenced and helped them in healthcare delivery in Burundi. They employed face-to-face, in-depth, semi-structured interviews with 6 physicians and 30 nurses in three hospitals in Gitega Province. They found that the interviewees felt that the PBF scheme had provided positive motivation to improve the quality of care. They further found that the utilization of health services and the relationship between health practitioners and patients also improved because salary top-ups were recognized as the most significant impetus to increase effort in improving the quality of care. Since Rudasingwa and Uwizeye (2017) left a sampling gap as they never included patients who would have assessed the state of service delivery better, there is need to bridge that gap by also including both outpatients and inpatients in the current study in Lyantonde hospital.

2.3.2 Donor Financing and Health Service Delivery

Aid came to the developing countries under the theme "health for all" as well as concerted efforts to uplift the general livelihood of the general public (Bonfrer, 2015). Donor financing strategies refers to the means of financing health care by external agencies and nongovernmental organization such as the World Health Organization, World Bank, and United Nations Children Fund (Yunusa et al., 2014).

From the background that the signing of the United Nations millennium development goals led to for the injection of billions of dollars of donor funds into countries with great need, Ejughemre (2013) found that the impact of donor support in Sub-Saharan region was fairly remarkable where major health problems reached unprecedented levels with improvements on certain fronts. He noted however that there were reports besides where donor funds were allocated but the problem of corruption and mismanagement of these funds in many countries were bothering issues warranting urgent solutions. He also found that there were no sustainable policies for gradually exiting from donor funding for health, without which these countries dependent on humanitarian actors, would continue to cripple their ability to be self-sufficient and self-reliant. Given that the conclusions of Ejughemre (2013) were based on secondary data after reviewing literature of different publications, there is need to bridge this methodological gap by collecting current data from to address the prevailing research problem in Lyantonde hospital.

Shaw, Wang, Kress, and Hovig (2015) evaluated resource commitments to primary health care (PHC) by donors and selected governments between 1990–2011 in Nigeria and Ethiopia and established that though donor funding for health among Low in Countries had mushroomed over the last decade, it had remained a minimal failing to fulfil their spending targets prescribed by international forums to attain universal access to basic/essential PHC services. They further found that at country level, there were allocative inefficiency of donor where domestic spending on health was highly conditional on contextual factors to specific diseases and areas. Since Shaw et al. (2015) concentrated on only donor funds and primary health care yet there are other services demanded from health systems like hospitals, there is need to fill the above conceptual gap by also establishing the effect of donor funding on general, curative, preventive, rehabilitative, promotive, and specialized health services as adopted performance indicators (Ministry of Health, 2016) using Lyantonde hospital as a case study.

Recently, Verbeke, Kaze, Ajeneza, Nkurunziza, Sindatuma, Asmini, Bastelaere, and Mugisho (2017) found that donor financing was driven by unequal distribution of hardware equipment across health administration components and health facilities which was challenging overall health service delivery in Burundi. The study by Verbeke et al. (2017) was based on policy documents published, field visits, and semi-structured interviews with administrators of the health system in Burundi. This left a sampling gap since patients of different health facilities were not consulted that might have limited the comprehensiveness of their conclusions which gap ought to be filled by this current study in Lyantonde hospital that will also collect data from both inpatients and outpatients especially about specific aspects of service delivery.

Mutopo (2017) assessed how performance-based financing embraced by donors performed in terms of efficiency, effectiveness, equity and governance in the Zimbabwean context. She used both qualitative and quantitative dimensions and found that the performance-based approaches adopted by most donors were characterized by poor primary health outcomes, unsound governance and a lack of confidence in the public health delivery system. She further observed that access to health care by marginalized groups had increased explained by the slight increases in post-natal care visits in rural health care centres. Mutopo (2017) concentrated on only performance-based financing by donors which might have left other types of donations unstudied, this conceptual gap will be addressed by this current study in Lyantonde hospital which will study the effect of donor financing on health service delivery at the hospital.

Lastly, Paul, Albert, and Bisala (2018) also questioned the view that performance-based financing (PBF) in the health sector is an effective, efficient and equitable approach to improving the performance of health systems in low-income and middle-income countries as adopted by donor partners? They found that PBF implementation was rushed despite insufficient evidence of its effectiveness coupled with lack of domestic ownership considering the amounts of time and money it absorbs and lack of evidence of effectiveness and efficiency which actually damages health services and systems. Given that the conclusions of Paul et al. (2018) were general and broad on low-income and middle-income countries, there is need to obtain specific recommendations that be used to address the prevailing problem in Lyantonde hospital by bridging the above contextual gap.

2.3.3 Out-Of-Pocket Financing and Health Service Delivery

Out-of-pocket payments (financing) are contributions made directly by a patient to a health service institution without reimbursement (Yunusa et al., 2014).

On the basis that donor agencies in Ghana were confronted with rethinking how the health sector can be funded and sustained, Adisah-Atta (2017) examined whether Ghanaians would support or oppose paying higher taxes or user fees (out-of-pocket) in order to increase funding of public health care. He used cross tabulation, correlation, and multiple linear regression analysis and found that only (35%) of respondents supported the payment of higher taxes or user fees even though many Ghanaians had difficulties in accessing better health and medical care. More importantly, he used a multiple linear regression analysis found that Ghanaians opposition to higher taxes/fees were highly influenced by perceptions of government's performance and trustworthiness. She also found that corruption public officials showed negative association with paying of higher taxes. Since Adisah-Atta (2017) only assessed the willingness of patients to pay for health services, this current study hopes to bridge the above conceptual gap by also ascertaining whether out-of-pocket financing affected health service delivery in Lyantonde hospital.

Lee and Shaw (2014) came from the global financial crisis of 2008 that led to the reinforcement of patient cost sharing in health care policy and studied the impact of direct out-of-pocket payments (OOPs) on health care utilization in South Korea using national data from 2007, 2008, and 2009. They found that the average unit OOPs of the poorest quintile was approximately 75% and 60% of each counterpart in the richest quintile in the outpatient and inpatient services. Substantial OOPs under the National Health Insurance were disadvantageous, particularly for the lowest income group in terms of health care quality and financial burden . Since Lee and Shaw (2014) used secondary data that was collected from 2007-2009, this left a time gap calling for fresh data to collected in 2019 to arrest the current situation at Lyantonde hospital. Also, they used on only quantitative data which neglected qualitative opinions like underlying reasons behind such statistical trends. This methodological gap will also be filled by this current study as it will also employ interviews in data collection.

Aregbeshola and Khan (2018) on the background that there was high reliance on out-of-pocket (OOP) health payments as a means of financing health system in Nigeria which were making households face catastrophe and become impoverished. They examined the financial burden of OOP health payments among households in Nigeria using secondary data from the Harmonized Nigeria Living Standard Survey (HNLSS) of 2009/2010. They found that a total of 16.4% of households incurred catastrophic health payments at 10% threshold of total consumption expenditure while 13.7% of households incurred catastrophic health payments at 40% threshold of non-food expenditure. They conclusively observed that OOP health payments led to an 0.8% rise in poverty headcount which meant that about 1.3 million Nigerians were being pushed below the poverty line. Though the conclusions of Aregbeshola and Khan (2018) established that OOP financing impoverishes citizens, they never found the exact effect of such a

financing model on health service delivery which conceptual gap will be addressed in thus current study through regression analysis. Also, primary data to be collected on questionnaires and interview guides will be used to bridge the data collection gap left by the methodology of Aregbeshola and Khan (2018).

Further, Palasca and Jaba (2015) found that there was a consistent tendency of European governments to diminish spending on healthcare during crisis which led to increase in out of pocket payments in most countries which do not have robust health insurance policies and a decrease in the number of people accessing healthcare services. These findings were generated from data collected from 34 countries during 2006-2012. The conclusions of Palasca and Jaba (2015) considered economic crisis repercussions on European healthcare systems and left a contextual gap since the plight of LDCs like Uganda was not studied. To fill this gap, there is need to establish the effect of out-of-pocket expenditures on health service delivery in Lyantonde hospital whose recommendations may also be generalizable in Uganda.

Yunusa et al. (2014) reviewed relevant literatures related to public health care financing in Nigeria and found that public health care services in Nigeria is financed through; out-of-pocket payments, tax revenue, donor funding and through health insurance. They however established that the bulk of public health care is financed by households through out-of-pocket payments and government was contributing just 25% of the total health expenditure which caused major challenges of health care financing and led to high out of pocket payment and inadequate implementation of health care financing policy and corruption. Yunusa et al. (2014) used only journals published about financing of the health care sector in Nigeria and left other countries unstudied which left a contextual gap worth filling with another study. Also, Yunusa et al. used secondary data from earlier publications and yet there might have been new trends in the field of healthcare financing which calls for a fresh study that will consider both current data on questionnaires and interviews to generate latest recommendations. All these gaps will be filled using this current study in Lyanonde hospital.

From Papua Guinea, Australian Aid (2016) found that there was high out-of-pocket healthcare spending accounting for 59% despite the poor population complaining about the cost of treatment as the second major barrier to accessing medical care as their families reported distance and transportation barriers as the main reasons for not seeking medical treatment when their children were sick. It was also found that the cost of visits was greatest at private hospitals, while visits to public facilities were comparatively cheaper, and non-hospital public facilities were cheaper to access for most people than public hospitals. Though Australian Aid (2016) established the high rates of out-of-pocket expenditures in Papua Guinea, their report failed to exactly state the effect of such financing on overall health service delivery which conceptual gap will be filled by this current study after testing the hypothesis that there is no significant effect of out-of-pocket financing on health service delivery in Lyantonde hospital.

3.0 Methodology

3.1 Research Design

The study employed a correlation design to establish the underlying effect/relationship among study variables and a case study design to obtain information, and opinions from a large group of people in order to describe some characteristics of a phenomenon (Saunders, Lewis, &Thornhill, 2012). This design was also earlier supported by Litze (2007) who asserted that mixed designs utilise different groups of people who differ in interest, but share other characteristics such as socioeconomic status, educational background and ethnicity. Also, since Zikmund , Babin, Carr, and Griffin (2013) explained that a research design provides a blueprint or action plan for an entire research study, a correlation survey design will be adequate for the study. Both qualitative and quantitative methods will be used in order to reduce bias. Quantitative designs are plans for carrying out research oriented towards quantification and are applied in order to describe current conditions or to investigate relationships, including cause and effect relationships (Amin, 2005). Quantitative approaches were adopted when sampling, collecting data, Controlling data quality and in analyzing data. Qualitative approach will be helpful in interpreting people's thoughts, opinions and perceptions about Health sector financing and health service delivery. The qualitative data will give a narrative and descriptive information that will explain and give deeper understanding and insight into a problem as suggested by Amin, (2005).

3.2 Area of Study

The study was conducted in Lyantonde hospital located in Lyantonde district on Masaka – Mbarara road, 185 kms from Kampala the capital city of Uganda.

3.3Study Population

On the proposition of Cohen, Manion, and Marrison (2011) that a study population as applied in social sciences ought to refer to the total number of individuals who are assumed to be affected by a given research problem from which a study sample can be obtained. On that basis, the study was conducted in Lyantonde hospital. The current study consciously considered only the special clinics patients to include, the diabetic, HIV/AIDS and maternity patients as these are regular. This study however considered the

staff numbers to be 355 and 62,000 inpatients and 104,000 outpatients as anticipated by Ministry of Health (2016).Therefore, the study comprised of 166,355 individuals as its population of study.

3.4Sampling procedures

3.4.1 Sample Size Selection

Though the study reached out to all concerned individuals, Daniel (2012) raises the importance and need of comprehensive and objective sampling that saves time, effort, and money while providing useful, reliable and valid results that can be generalized on all study population. Therefore, the study used Krejcie and Morgan (1970) as indicated in table 3.1 below to select respondents from their respective categories to increase the probability of every category being represented;

Table 3.1: Shows Sample Size Selection from Different Categories of the Study Population.

Department of Respondent	Population	Sample	Sampling Technique
Top Hospital Management	10	10	Census Inquiry
Other Administrative Staff	22	17	Purposive Sampling
Other Technical Staff	97	59	Simple Random Sampling
Special Clinic Patients	39	28	Purposive Sampling
Total Population	**168**	**114**	

Source: Lyantonde Hospital Staff List (2020), &Patients Register (2020).

Members of top management comprised of Hospital administrator, Human resource, Finance and procurement, Obstetrics/gynaecology, Paediatrics, Laboratory services, Surgery, Radiology, Nursing, technical staff and administrative staff.

3.4.2 Sampling Techniques

The following techniques were used in the study;

Stratified random sampling; Stratified random sampling was employed because of its highly cost-effective and increases the chances many strata being represented in the study (Lynn, 2016). Some respondents will be selected this method.

Simple random sampling; technique was also used to select 382 respondents from among inpatients and outpatients. This is because this category has very many elements from which to select and they almost share similar characteristics. This sampling technique was applied to increase the probability of representation since there are many members in such categories.

Census Inquiry; The study also selected respondents because of their small numbers in their respective categories as advised by Kothari (2011).

3.5 Sources of Data

The study used both primary data sources and secondary data sources to enable the researcher meet the study objectives. The researcher made use of the secondary sources of information. This is because Wild and Diggines (2013) asserted that information obtained from various secondary sources ought to be assessed for content, quality, usability, cost and presentation to make important interpretations that relate to the study.

3.6 Data Collection Sources & Instruments

Structured Questionnaire;

The study used a 4-point Likert Scaled questionnaire with alternatives such as Never, Rarely, Sometimes, and Always.

Except for the 4 hospital top administrators, 712 respondents from the different classifications of health practitioners, inpatients, and outpatients filled the questionnaires that comprised of part A about the health service delivery, and Part B about public financing strategies;6items collected data on government financing strategies, 6 on donor financing, 6on out-of-pocket financing strategies, and 3 on the moderating variables.

For objectivity reservations, only inpatients and outpatients would rate the hospital on parameters of service delivery while health practitioners rated public financing variable.

The researcher, assisted by others delivered the questionnaires to offices of sampled respondents and were retrieved later in the above categories. This tool was helpful in collecting the needed data in a short time and results were easily quantifiable for a statistical analysis of the study variables.

Interview Guide;

This study also needed a qualitative approach, interviews were used and these consisted of open-ended questions that provided qualitative data (Johnson & Christensen, 2014) and was thus useful in this research as one of the leading instruments of collecting data (De Vos,Strydom, Fouché, & Delport,2014).

The study also interviewed 4top hospital administrators by use of an interview guide that possessed pre-determined questions that were open-ended. These officers were interviewed to generate in-depth qualitative responses since they might possess a deeper understanding of study topic given their experience, qualification, and positions. This tool was used as advised by Kothari (2011) that an interview guide explores all relevant issues covered in the study and bridges the gap that a questionnaire might have left.

Document Analysis

On the basis that researchers can get sensitive information that otherwise may be difficult to attain (Curtis, Murphy,& Shields, 2014) and the cost-effectiveness (Denscombe, 2014) of documentary analysis made this tool also viable for this current study.

The study therefore collected information from relevant documents to the study like minutes from management meetings held over the years.

3.7 Data Quality Control

3.7.1 Instruments' Validity

Amin (2005) guided that research tools/instruments are deemed valid when they possess questions that are in line with the intended objectives of study. To ensure instruments' validity, the researcher sought rating from experts in the field of study research and finance management to ascertain whether items of the research instruments are indeed representative of the research problem being studied by rating each item as relevant (R) or irrelevant (IR). From such rating, content validity indices (CVI) will be computed using the following formula:

$$CVI = \frac{\text{Number of questions rated as relevant (R)}}{\text{Total Number of questions in the instrument (R + IR)}}$$

If CVI is more than 0.7, then the instrument will be considered valid as recommended by Amin (2005).

3.5.2 Data Reliability

The researcher intends to test the internal consistency of data from the questionnaire to ascertain its reliability and hence establish its ability to yield consistent results. Reliability refers to how consistent a research instrument or procedure is. The researcher carried out statistical tests to ensure that the key research instruments used were reliable. A pilot study of randomly selected respondents from Masaka Regional Referral Hospital helped to participate in pre-testing the questionnaires for Cronbach's Alpha Coefficient.

As Amin(2005) points out that the closer the Cronbach's Alpha to 1, the higher the internal reliability but not less than 0.7.

3.8 Data management

3.8.1 Measurement of variables

The dependent variable of the study; health sector service delivery will be measured by quality of health care services offered, sustainability, timeliness, and accessibility to health services.The independent variable of the study; health financing will be measured by government funding, donor funding and out of pocket financing. A questionnaire with 5 point rating scale as per Likert scale ranging from strongly disagree (1) to strongly agree (5) will be used to obtain the extent to respondents agree or disagree with the measurement parameter of the variable. The measurement scale of 1 up to five on every statement simply measures the strength of the respondents' opinion on the particular statement. If the respondent ticks 1 it implies that one strongly disagrees with the

statement, 2 = disagrees, 3 = neutral in other words one does not take any side on the statement, 4 = agrees and 5 = strongly agrees with the statement under discussion.

3.8.2 Data Management and Processing

In management of data, the researcher made sure that the collected data was stored in a secure and safe place and is treated as confidential. Soft and hard copies of the document were restricted from access by unauthorized persons by password and locks.
The analyzed data was be used for the study only and for academic purposes specifically.

3.8.3 Data Processing

Data editing, sorting, coding, entering and cleaning will be done by the researcher and some research assistants before analysis to cater for any errors and omissions. Presentation, analysis and discussions was done to achieve the study objectives.

3.9 Data Analysis

According to Sekaran (2003), data analysis is the evaluation of data. It is the process of systematically applying statistical and logical techniques to describe, summarize and compare data.

3.9.1 Qualitative data analysis

Leedy and Ormrod 2010:135)further state that qualitative researchers construct interpretive narrative from their data and try to capture the complexity of the phenomenon under study. Qualitative data is the process by which data is not described through numerical values, but rather by some sort of descriptive context and such a text is analyzed. Qualitative researchers aim to gather an in-depth understanding of human behavior and the reasons that govern such behavior. Qualitative data will be obtained from open ended questionnaires and by conducting interviews with other respondents to provide additional information to study problem. Qualitative analysis will involve categorizing data and then attaching it to the appropriate categories. Interview responses will be critically analysed and added in the discussions to back up the findings on the various objectives. Data from questionnaires where necessary, will be quoted as stated by respondents to strengthen the interpretation.Qualitative data analysis techniques will include, thematic Analysis, and narrative analysis

3.9.2 Quantitative data analysis

Quantitative research methods are research methods dealing with numbers and anything that is measurable in a systematic way of investigation of phenomena and their relationships. It is used to answer questions on relationships within measurable variables with an intention to explain, predict and control phenomena (Leedy 1993). Quantitative methods examine cause and effect relationships Muijs (2011:9). The data collected through close ended questionnaires will be edited; coded and analyzed using Statistical Package for Social Sciences (SPSS) version 20 because this is one of the best and most recommendable packages for analyzing social sciences research data. The statistics majorly to be used will include; percentages, frequencies, mean and standard deviation to measure the central tendencies between the study variables. To determine the effect of health financing on health sector service delivery, regression analysis will carried out. Also, inferential statistics will be used to indicate the degree and direction of the study variables.

3.10 Ethical Considerations

Private (2014) defined that research ethics as a term is used to identify and describe actions that researchers have to take in order to conduct moral and responsible research by anticipating how their research affected others be it in a positive or negative way. The study upheld among others the following ethical principles of social science research;

Informed consent

Kumar (2011) states that collecting information from an organization or people without seeking consent was considered unethical, hence the researcher took note to seek informed consent from the people who participated in the study. An introductory section was at the beginning of each research tool explaining the purpose of the study and seeking respondents' informed participation.

Confidentiality

Further, Kumar (2011) opined that it is unethical to share information about respondents for purposes other than those for research and it is unethical to identify them and their information they provided. Therefore, the researcher did not disclose the identities of respondents and did not supply feedback for purposes other than for this study. Also, all reviewed were returned safely to their archives as originally obtained.

Reporting

The researcher endeavoured to report the research outcomes objectively in a manner that did not slant or change them to serve personal interests since this would be very unethical. The researcher thus reported the findings in a clear, unbiased, accurate, and objective ways possible.

4.0 Results of the Study

4.1 Response rate

The study presented the response rate to indicate whether the returned questionnaires was sufficient enough for analysis

Table 4.1: Response rate

No	Category	Population	Sample size	Return rate	% of return
1		1	1	-	-
2					100%
3					75%
4					93%
5					865
	Total	**96**	**114**	**94**	**82.5%**

Source: Field Data (2021)

From table 4.1 above, it indicated that out of 114 questionnaires issued to the respondents only 94 were returned fully filled forming a response rate of 82.5%. On the other hand out of 11 intended interviews, only 8 were realized, forming a response rate of 72%. This exceeds the requirement indicated by Holbrook, Jon, and Alison (2007), that emphatically stated that response rate lower than 54% is minimally less accurate.

4.2.1: Gender of the respondents

This subsection presents findings of the gender of respondents in terms of male and female. Data on this variable was collected, analysed and is presented in table 4.2 below;

Table 4.2 Showing Gender of the respondents

		Frequency	Percent
Valid	male	53	56.4
	female	41	43.6
	Total	94	100.0

Source: Field Data (2021)

Findings from the table above reveal that 53(56.2%) of the respondents were male and 41(43.6%) were female. Findings from the table above reveal that 53(56.2%) of the respondents were male and 41(43.6%) were female. This means that male respondents participated more in this study. This implies that since there are more men, there are more responsive and readily available for work as they may not be affected by long maternity leaves and their nature is that they can work all the time day or night leading to improved health service delivery.

4.2.2: Age of the respondents

This subsection considered the age of the respondents in terms of age brackets. Data on this variable was collected, analyzed and is presented in table 4.3 below;

Table 4.3: Age bracket of the respondents

		Frequency	Percent
Valid	26 – 35	39	41.5
	36 – 45	16	17.0
	46 years and above	39	41.5
	Total	94	100.0

Source: Field data (2021)

Findings from table 4.3 show that majority of the respondents 39(41.5%) were aged 46 years and above, 39(41.5%) of the respondents were also aged between 26-35 years while 16(17.0%) of the respondents were aged between 36-45 years. This implies that 41.5 percent of employees have adequate experience and have stability to work and thus a positive impact to service delivery. It is also true that the other 41.5 percent is of young energetic and enthusiastic category and this leads to better health service delivery.

4.2.3: Level of education

This subsection considered level of education of the respondents in terms of certificate, Diploma, Bachelor's Degree, and Master's Degree. Data on this variable was collected, analysed and is presented in table 4.4 below;

Table 4.4: Showing Level of Education

		Frequency	Percent
Valid	certificate level	22	23.4
	diploma level	35	37.2
	Bachelor's Degree	27	28.7
	Master's Degree	10	10.6
	Total	94	100.0

Source: Field Data (2021)

Findings in the table above reveal that majority of the respondents 35(37.2%) were diploma holders, 27(28.7%) of the respondents were bachelor's degree holders, 22(23.4%) were certificate holders and 10(10.6%) of the respondents were master's degree holders. The findings show that majority of the respondents were diploma holders and this implies that they have acquired enough skill during their training and therefore capable of providing better services to the hospital.

4.2.4: Working period with the hospital

This subsection considered working period of the respondents with Lyantonde Hospital. Data on this variable was collected, analyzed and is presented in table 4.5 below;

Table 4.5 showing working period with Lyantonde Hospital

		Frequency	Percent
Valid	less than one year	9	9.6
	2 - 5 years	32	34.0
	6 - 9 years	13	13.8
	10 years and above	40	42.6
	Total	94	100.0

Source: Field Data (2021)

According to table 4.5 above, 42.6% of the respondents had worked with Lyantonde Hospital for 10 years and above, 34.0% had worked for 1-5 years, 13.8% had worked for 6-9 years at the Hospital and 9.6% of the respondents had worked for less than one year. This means that most of the respondents had worked with Lyantonde Hospital for a period of 10 years and above. This implies that most of the staff at the hospital had acquired enough experience that to clearly understand how the different sources of finance have affected the level of service delivery in the hospital.

4.3 Health Financing and Health Service Delivery

The study used frequencies, percentages, mean and standard deviation to determine the perceptions of respondent's on health financing and health Service Delivery in Lyantonde Hospital.

4.3.1 Government Financing and Health Sector Service Delivery

The first objective of this study was to determine the effect of government financing on health sector service delivery in public sector. The data on this objective was collected, analyzed and is presented below;

Table 4.5: Descriptive statistics on Government Financing

		1 f(%)	2 f(%)	3 f(%)	4 f(%)	M	std
1	Government fully provides funds for the hospital budget	11(11.7%)	10(10.6%)	46(48.9%)	27(28.7%)	2.95	.932
2	Government quarterly funds/releases come on time	5(5.3%)	18(19.1%)	53(56.4%)	18(19.1%)	2.89	0.769

3	Government financing strategies are flexible to address any unbudgeted for outbreaks	38(40.4%)	32(34.0%)	15(16.0%)	9(9.6%)	1.95	0.977
4	There is value for money expenditure of government funds	14(14.9%)	10(10.6%)	33(35.1%)	37(39.4%)	2.99	1.052
5	Government funds are aligned with expected health service delivery objectives	14(14.9)	11(11.7%)	36(38.3%)	33(35.1%)	2.94	1.035
6	Government funding are sufficient to cover essential health inputs in the Hospital	51(54.3%)	23(24.5%)	12(12.8%)	8(8.5%)	1.76	.980

Source: *Field Data (2021)*

1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Always, m = mean, std = standard deviation

Findings in table 4.5 above on whether 'Government fully provides funds for the hospital budget,' reveal that majority of the respondents 46(48.9%) said it sometimes, 27(28.7%) of the respondents said it always, 11(11.7%) of the respondents said it always and 10(10.6%) of the respondents said it rarely. The mean is 2.95 meaning that to some extent the government sometimes fully provides funds for the hospital budget and the standard deviation is 0.932. This implies that service delivery is boosted since there is full funding of the budget by the government thereby facilitating hospital activities to run smoothly. This is not in line with Dulal, Magar, Dulal, Khatiwada, and Hamal (2014) who in their study examined the effect of health sector budget allocation (financing) and outcome and established that budget requirements to meet the population's needs were still limited in Nepal because the health sector budget (financing) could not achieve even gainful results due to mismatch in policy and policy implementation despite of political commitment.

On finding out whether Government quarterly funds/releases come on time, 53(56.4%) majority of the respondents said they are sometimes, 18(19.1%) of the respondents said they are always, 18(19.1%) of the respondents said they are rarely and 5(5.3%) of the respondents said they are never. The mean is 2.89 indicating that that government quarterly funds come on time and the standard deviation is 0.769 indicating a variance in responses. The findings imply that Government quarterly funds the hospital is in a better position to plan and implement

In accordance with the statement on whether 'Government financing strategies are flexible to address any unbudgeted for outbreaks,' results from the table above reveal that 38(40.4%) majority of the respondents said they are never, 32(34.0%) of the respondents said they are rarely, 15(16.0%) said they are sometimes and 9(9.6%) of the respondents said they are always. The mean is 1.95 and the standard deviation is 0.977. The findings mean that Government financing strategies are never flexible to address any unbudgeted for outbreaks. This implies that service delivery is impeded and the hospital does not do enough to extent better services to the general public since there is inflexibility in financing.

On the basis of the findings in the table above about whether there is value for money expenditure of government funds, majority of the respondents 37(39.4%) said there is always, 33(35.1%) of the respondents said sometimes, 14(14.9%) of the respondents said never, and 10(10.6%) of the respondents said rarely. The mean is 2.99 implying that to some extent there is value for money expenditure of government funds and the standard deviation is 1.052 showing a variance in responses. The findings imply that funds are properly allocated for the right activities they are meant to do and this ensures that service delivery is not affected in any way or the other.

On finding out whether 'Government funds are aligned with expected health service delivery objectives,' results from table 4.5 show that majority of the respondents 36(38.3%) said they are sometimes, 33(35.1%) said they are always, 14(14.9) of the respondents said they are never and 11(11.7%) of the respondents said they are rarely. The mean is 2.94 and the standard deviation is 1.035 indicating a variance in responses. The findings mean that to government funds are to a great extent aligned with expected health service delivery objectives and this implies that the set objectives are easily achieved since there is financing and it this makes it easy for the hospital to attain a high level of service delivery to its clients.

On the basis of the statement that 'Government funding are sufficient to cover essential health inputs in the Hospital,' majority of the respondents 51(54.3%) said never, 23(24.5%) of the respondents said rarely, 12(12.8%) of the respondents said sometimes and

8(8.5%) of the respondents said always. The mean is 1.76 and the standard deviation is 0.980. The findings implies mean that government funding are never sufficient to cover essential health inputs in the Hospital and this implies that the health workers at the hospital will not be in position to deliver effectively since the funds are not sufficient to cover essential inputs and hence the level of service delivery is affected negatively.

Table 4.6: Descriptive statistics on Donor Financing in Lyantonde Hospital

		1	2	3	4	M	Std
1	There are several donor funding partners for the hospital	8(8.5%)	26(27.7%)	33(35.1%)	27(28.7%)	2.84	0.942
2	Donor funding partners meet their pledged financial support	2(2.1%)	24(25.5%)	39(41.5%)	29(30.9%)	3.01	0.810
3	Conditional funds from donor partners are realistic	15(16.0%)	8(8.5%)	52(55.3%)	19(20.2%)	2.80	0.946
4	There is value for money expenditure of donor funds	4(4.3%)	27(28.7%)	21(22.3%)	42(44.7%)	3.07	0.953
5	Donor funds are released on time as budgeted	12(12.8%)	17(18.1%)	48(51.1%)	17(18.1%)	2.74	0.903
6	There is proper monitoring of donor funds	11(11.7%)	10(10.6%)	30(31.9%)	43(45.7%)	3.12	1.014

Source: *Field Data (2021)*

1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Always, m = mean, std = standard deviation

With reference to the findings on whether 'there are several donor funding partners for the hospital,' results from the table above reveal that majority of the respondents 33(35.1%) said sometimes, 27(28.7%) of the respondents said always, 26(27.7%) of the respondents said rarely and 8(8.5%) of the respondents said never. The mean is 2.84 and the standard deviation is 0.942 indicating a variance in responses. This means that there are sometimes several donor funding partners for the hospital and this implies additional funds coming to the hospital which boosts its activities thereby increasing the level of service delivery in the hospital.

On finding out whether 'Donor funding partners meet their pledged financial support,' 39(41.5%) of the respondents said sometimes, 29(30.9%) of the respondents said always, 24(25.5%) of the respondents said rarely and 2(2.1%) of the respondents said never. The mean is 3.01 and the standard deviation is 0.810 indicating a variance in responses. The findings mean that donor funding partners sometimes meet their pledged financial support and this implies additional funds are availed to the hospital to carry out its activities and therefore this boosts service delivery. The findings are opposed by Shaw, Wang, Kress, and Hovig (2015) who evaluated resource commitments to primary health care (PHC) by donors and established that though donor funding for health among Low in Countries had mushroomed over the last decade, it had remained a minimal failing to fulfil their spending targets prescribed by international forums to attain universal access to basic/essential PHC services.

Findings from table 4.6 above reveal that 52(55.3%) majority of the respondents say 'Conditional funds from donor partners are sometimes realistic,' 19(20.2%) of the respondents said they are always, 15(16.0%) of the respondents said they are never,' and 8(8.5%) of the respondents said they are rarely. The mean is 2.80. This indicates that conditional funds from donor partners are sometimes realistic and the standard deviation is 0.946. The findings imply that the hospital gets these funds which are used to add on what they have and therefore, the hospital easy does its work smoothly without any interruptions.

On finding out whether there is value for money expenditure of donor funds, results from table 4.6 show that 42(44.7%) majority of the respondents said there is always, 27(28.7%) of the respondents said rarely, 21(22.3%) of the respondents said sometimes and 4(4.3%) of the respondents said never. The mean is 3.07 indicating that there is always value for money expenditure of donor funds and the standard deviation is 0.953. The findings imply that the hospital proper utilizes donor funds to do what they are meant to and this ensures routine support from the donors to the hospital which in turn ensures that there is effective service delivery given to the public by the hospital.

On finding out whether 'Donor funds are released on time as budgeted,' results from table 4.6 reveal that majority of the respondents 48(51.1%) said they are sometimes, 17(18.1%) said they are rarely, 17(18.1%) of the responds said they are always, and 12(12.8%) of the respondents said they are never. The mean is 2.74 and the standard deviation is 0.903 indicating a variance in responses. The findings mean that donor funds are sometimes released on time as budgeted and this implies that when the funds are released at the time they are needed as budgeted, service delivery in the hospital is boosted.

On finding out whether there is proper monitoring of donor funds, majority of the respondents 43(45.7%) said always, 30(31.9%) of the respondents said sometimes, 11(11.7%) of the respondents said never and 10(10.6%) of the respondents said rarely. The mean

is 3.12 indicating that there is always proper monitoring of donor funds to a great extent and the standard deviation is 1.014. This implies that proper monitoring brings about proper accountability of the use of these funds and therefore, the funds are used for the right activities intended towards enhancing service delivery in the hospital. However, the findings are not in line with Ejughemre (2013) who noted that there were reports besides where donor funds were allocated but the problem of corruption and mismanagement of these funds in many countries were bothering issues warranting urgent solutions.

Table 4.7: Descriptive statistics on Out-Of-Pocket Financing in Lyantonde Hospital

		1	2	3	4	M	Std
1	There are well-known out-of-pocket fees for different services	21(22.3%)	17(18.1%)	30(31.9%)	26(27.7%)	2.65	1.114
2	The available out-of-pocket fees are sufficient to fund services	34(36.2%)	37(39.4%)	17(18.1%)	6(6.4%)	1.95	.896
3	Out-of-pocket fees do not scare away community members to receive desired services	31(33.0%)	18(19.1%)	33(35.1%)	12(12.8%)	2.28	1.062
4	Out-of-pocket fees are lawfully charged while receiving services	23(24.5%)	8(8.5%)	47(50.0%)	16(17.0%)	2.60	1.040
5	Out-of-pocket fees are applied fairly to all patients	26(27.7%)	18(19.1%)	16(17.0%)	34(36.2%)	2.62	1.237
6	Out-of-pocket fees are affordable to patients to receive health services	41(43.6%)	16(17.0%)	17(18.1%)	20(21.3%)	2.17	1.206

Source: *Field Data (2021)*

1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Always, m = mean, std = standard deviation

Findings from table 4.7 reveals that majority of the respondents 30(31.9%) said that there are sometimes well-known out-of-pocket fees for different services, 26(27.7%) of the respondents said always, 21(22.3%) of the respondents said never and 17(18.1%) of the respondents said they are rare. The mean is 2.65 and the standard deviation is 1.114 indicating a variance in responses. The findings mean that majority of the respondents said there are sometimes well-known out-of-pocket fees for different services and this implies that these funds are important on supplementing on government funds and hence provide additional facilitation to the service providers in the hospital and this enhances the quality of services provided by the hospital.

On finding out whether the available out-of-pocket fees are sufficient to fund services, 37(39.4%) majority of the respondents said rarely, 34(36.2%) of the respondents said they are never, 17(18.1%) of the respondents said sometimes and 6(6.4%) of the respondents said they are always. The mean is 1.95 and the standard deviation is 0.896. The findings mean that available out-of-pocket fees are rarely sufficient to fund services and this implies that the hospital service delivery does not match the expected level since these funds are meant to boost the available funds.

On the basis of the statement that 'Out-of-pocket fees do not scare away community members to receive desired services,' results from table 4.7 above reveal that 33(35.1%) majority of the respondents said they sometimes, 31(33.0%) of the respondents said they never, 18(19.1%) of the respondents said they rarely and 12(12.8%) of the respondents said they always. The mean is 2.28 and standard deviation is 1.062. The findings show that most of the respondents said sometimes out-of-pocket fees do not scare away community members to receive desired services and this implies that the fee that the hospital charges is affordable to the members of the community and therefore this encourages health service providers to continuously provide better services to the community. However, Palasca and Jaba (2015) found that there was a consistent tendency of European governments to diminish spending on healthcare during crisis which led to increase in out of pocket payments in most countries which do not have robust health insurance policies and a decrease in the number of people accessing healthcare services.

With reference to the statement 'Out-of-pocket fees are lawfully charged while receiving services,' findings in the table above reveal that majority of the respondents 47(50.0%) said they are sometimes, 23(24.5%) of the respondents said they are never, 16(17.0%) of the respondents said they are always, 8(8.5%) of the respondents said they are rarely. The mean is 2.60 indicating that that to some extent out-of-pocket fees are sometimes lawfully charged while receiving services and the standard deviation is 1.040 indicating a variance in responses.

On finding out whether 'Out-of-pocket fees are applied fairly to all patients,' results from the table show that 34(36.2%) majority of the respondents said they are always, 26(27.7%) of the respondents said they are never, 18(19.1%) of the respondents said they are rarely and 16(17.0%) of the respondents said they are sometimes. The mean is 2.62 indicating that the fees are always fairly applied

to all patients and the standard deviation is 1.237. This implies that there is no segregation and the same service is extended to all patients and this creates contentment among the patients about the services that they get from the hospital.

Findings on whether 'Out-of-pocket fees are affordable to patients to receive health services,' from the table reveal that 41(43.6%) of the respondents said they are never, 20(21.3%) of the respondents said they are always, 17(18.1%) of the respondents said they are sometimes and 16(17.0%) of the respondents said they are rarely. The mean is 2.17 and the standard deviation is 1.206 indicating there were variances in responses. The findings show that majority of the respondents said that Out-of-pocket fees are never affordable to patients to receive health services. This implies that some patients are hindered from getting health services due to their non-affordability of the fees that the hospital charges.

Table 4.8: Descriptive statistics on Health Service Delivery in Lyantonde Hospital

		1	2	3	4	M	Std
1	The Health Sector infrastructure is of good quality	12(12.8%)	25(26.6%)	40(42.6%)	17(18.1%)	2.66	.922
2	The Hospital has competent staff to deliver better health services	2(2.1%)	17(18.1%)	32(34.0%)	43(45.7%)	3.23	.822
3	The quality of health services provided has helped to improve service delivery in the hospital	2(2.1%)	10(10.6%)	29(30.9%)	53(56.4%)	3.41	.768
4	Stakeholders have commended the health services provided by the Hospital	7(7.4%)	6(6.4%)	37(39.4%)	44(46.8%)	3.26	.879
5	There is accessibility of health services in the Hospital	0(0.0%)	6(6.4%)	29(30.9%)	59(62.8%)	3.56	.614
6	Customers have been referring others to use the services provided by the sector	0(0.0%)	10(10.6%)	36(38.3%)	48(51.1%)	3.40	.677
7	Most of the Hospital health sector projects are completed in time	13(13.8%)	13(13.8%)	45(47.9%)	23(24.5%)	2.83	.958
8	There is always required staff to provide health services to all beneficiaries	0(0.0%)	16(17.0%)	49(52.1%)	29(30.9%)	3.14	.682
9	The necessary facilities are available to provide health services in the Hospital	10(10.6%)	12(12.8%)	31(33.0%)	41(43.6%)	3.10	.995
10	There has been effective control of costs in the Hospital	21(22.3%)	17(18.1%)	37(39.4%)	19(20.2%)	2.57	1.052

Source: *Field Data (2021)*

1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Always, m = mean, std = standard deviation

On finding out whether 'the health sector infrastructure is of good quality,' results from the table reveal that 40(42.6%) majority of the respondents said sometimes, 25(26.6%) of the respondents said rarely, 17(18.1%) of the respondents said always and 12(12.8%) of the respondents said never. The mean is 2.66 and the standard deviation is 0.922 indicating a variance in responses. The findings mean the Health Sector infrastructure is sometimes of good quality and this implies that good health infrastructure makes it easy for the health service providers to extend better services to the clients. This is not in line with Korir (2010) who in his study using an exploratory approach in Kenya observed that though after independence in 1963, the government pledged to fight diseases, ignorance and poverty but later experienced lapses in the health status trend evident in the souring child mortality rates despite the massive expansion of health infrastructure after independence, the inability of the government to effectively provide health services leading to a sharp increase in demand for health services.

In accordance with the statement on whether 'the hospital has competent staff to deliver better health services,' findings from table 4.8 reveal that 43(45.7%) of the respondents said always, 32(34.0%) of the respondents said sometimes, 17(18.1%) of the respondents said rarely and 2(2.1%) said never. The mean is 3.23 indicating that to a great extent the hospital has competent staff to deliver better health services and the standard deviation is 0.822. This implies that with the competent staff being present, they do understand and have experience to deliver better services.

On finding out whether the quality of health services provided has helped to improve service delivery in the hospital, majority of the respondents 53(56.4%) said always, 29(30.9%) of the respondents said sometimes, 10(10.6%) of the respondents said rarely and 2(2.1%) of the respondents said never. The mean was 3.41 indicating that to a great extent the quality of health services provided

has always helped to improve service delivery and the standard deviation is 0.768. This is in line with Nyongesa, Onyango, and Kakai (2014) sought to identify factors which determined patients' satisfaction with health care services at Pumwani Maternity Hospital in Nairobi Kenya who found that despite the high cost services, inadequate staffing and poor sanitation, the hospital managed to offer quality services that satisfied the majority of clients.

Findings on whether 'Stakeholders have commended the health services provided by the Hospital,' reveal that 44(46.8%) majority of the respondents said they have always, 37(39.4%) of the respondents said they have sometimes, 7(7.4%) of the respondents said they have neverand 6(6.4%) said have rarely. The mean is 3.26 indicating that stakeholders have always commended the health services provided by the Hospital and the standard deviation is 0.879 showing a variance in responses. The findings imply that the hospital is doing commendable work and this boosts the morale of health workers to continuously deliver better services to the patients.

With reference to the table above, findings on whether 'there is accessibility of health services in the Hospital' reveal that majority of the respondents 59(62.8%) said there is always,29(30.9%) said sometimes,6(6.4%) of the respondents say rarely and 0(0.0%) said never.The mean is 3.56 and the standard deviation is 0.614. The findings mean that there is always accessibility of health services in the hospital.

On finding out whether Customers have been referring others to use the services provided by the sector, results from table 4.8 above show that 48(51.1%) majority of the respondents said they have always, 36(38.3%) of the respondents said they have sometimes , and 10(10.6%) of the respondents said they rarely. The mean is 3.40 indicating that patients refer others to use the services provided by the sector and the standard deviation is 0.677. The findings imply that the hospital is doing its best to extend better services to the patients in the hospital.

On finding out whether 'Most of the Hospital health sector projects are completed in time,' majority of the respondents 45(47.9%) said they are sometimes, 23(24.5%) of the respondents said they are always, 13(13.8%) of the respondents said they are rarely and 13(13.8%) of the respondents said they are never. The mean was 2.83 and the standard deviation is 0.958. The findings show that majority of the respondents said sometimes most of the hospital projects are completed in time and this implies that with timely completion of these projects, they make work easy for the health service providers to give better services to the patients.

Results on whether 'there is always required staff to provide health services to all beneficiaries,' show that majority of the respondents 49(52.1%) said there is sometimes, 29(30.9%) of the respondents said there is always, 16(17.0%) of the respondents said there is rarely. The mean is 3.14 and the standard deviation is 0.682. The findings mean that the hospital sometimes has the required staff to provide health services to all beneficiaries and this implies that the service provider to patient ratio is reduced and hence patients are given more attention and well attended to.

Findings on whether 'the necessary facilities are available to provide health services in the Hospital,' reveal that 41(43.6%) majority of the respondents said they are always, 31(33.0%) of the respondents said they are sometimes, 12(12.8%) of the respondents said they are rarely and 10(10.6%) of the respondents said they are never. The mean is 3.10 and the standard deviation is 0.995. The findings mean that the necessary facilities are always available to provide health services in the Hospital and this implies that service providers find it easy to do their work since the needed equipment is readily available and hence better services are received by the patients.
This is in disagreement with Ondoa, Basheka, and Basaasa (2013) who examined the institutional dynamics affecting health service delivery at Jinja Regional Referral Hospital in Eastern Uganda and found out that medical supplies (equipment) were not a significant predictor of government health facilities' service delivery but were seriously affected by inadequate facilities.

On finding out whether there has been effective control of costs in the Hospital, results from table 4.8 above reveal that 37(39.4%) of the respondents said there has sometimes been, 21(22.3%) of the respondents said there has never been,19(20.2%) of the respondents said there has always been, and 17(18.1%) of the respondents said there has rarely been. The mean is 2.57 and the standard deviation is 1.052. This implies that majority of the respondents say 'there has sometimes been effective control of costs in the Hospital.'

Table 4.9: Descriptive statistics on Moderating Variables

		1	2	3	4	M	Std
1	The Number of patients affects health service delivery	8(8.5%)	4(4.3%)	40(42.6%)	42(44.7%)	3.23	.885

2	Staff Qualification levels affect health service delivery	9(9.6%)	10(10.6%)	26(27.7%)	49(52.1%)	3.22	.985
3	Staff Experience levels affect health service delivery	12(12.8%)	5(5.3%)	20(21.3%)	57(60.6%)	3.30	1.046

Source: *Field Data (2021)*

1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Always, m = mean, std = standard deviation

Findings on whether the number of patients affects health service delivery reveal that 42(44.7%) majority of the respondents said it always, 40(42.6%) said it sometimes, 8(8.5%) of the respondents said it never and 4(4.3%) of the respondents said it rarely. The mean is 3.23 indicating that to some extent the number of patients always affects health service delivery as in the table and the standard deviation is 0.885. This implies that when the health facility is not overcrowded, health service providers are most likely to deliver better service as this eases pressure on them.

On finding out whether 'staff qualification levels affect health service delivery,' results from the table show that 49(52.1%) of the respondents said it always, 26(27.7%) of the respondents said it sometimes, 10(10.6%) of the respondents said it rarely and 9(9.6%) of the respondents said it never. The mean is 3.22 and the standard deviation is 0.985. This shows that staff qualification levels always affects health service delivery in the hospital and this implies better services are provided to the patients since all the staff are professionals.

In accordance with the statement on whether 'staff experience levels affect health service delivery,' findings in the table above indicate that 57(60.6%) of the respondents said it always, 20(21.3%) of the respondents said it sometimes, 12(12.8%) of the respondents said it never and 5(5.3%) of the respondents said it rarely. The mean is 3.30 and the standard deviation is 1.046. The findings mean that staff experience levels always affect health service delivery

4.4: Relationship between health financing and health sector service delivery

4.4.1. Government financing and health sector service delivery

The study aimed at examining the relationship between government financing and health sector service delivery. Table 4.10 represents the respondent's opinion.

Table 4.10: Relationship between government financing and health sector service delivery.

Correlations

		Service delivery	Government financing
Service delivery	Pearson Correlation	1	.220*
	Sig. (2-tailed)		.033
	N	94	94
Government financing	Pearson Correlation	.220*	1
	Sig. (2-tailed)	.033	
	N	94	94

*. Correlation is significant at the 0.05 level (2-tailed).

Field Data (2021)

Results from the table above reveal that there is a moderate positive correlation between government financing and health sector service delivery at (r) = 0.220*, p= 0.33 at the level of significance 0.05(2-tailed). This indicates that government financing when timed well, has a small effect on service delivery in the hospital. Wanjau, Muiruri, and Ayodo (2012) contends that minimal government financing leads to a decrease in provision of service quality coupled by the ineffective communication channels, low employees' capacity, low technology adoption affects delivery of service quality to patients in public health sector affecting health service quality perceptions, patient satisfaction and loyalty.

4.4.2. Donor financing and health sector service delivery

The study aimed at examining the relationship between donor financing and health sector service delivery. Table 4.11 represents the respondent's opinion.

Table 4.11: Relationship between Donor financing and health sector service delivery.

Correlations

		Service delivery	Donor financing
Service delivery	Pearson Correlation	1	.388**
	Sig. (2-tailed)		.000
	N	94	94
Donor financing	Pearson Correlation	.388**	1
	Sig. (2-tailed)	.000	
	N	94	94

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

Field Data (2021)

Findings from the table reveal that there is a moderate positive correlation between donor financing and health sector service delivery at (r) = 0.388**, p= 0.00 at the level of significance 0.01(2-tailed). This means that donor financing is timely received, service delivery in the hospital improves.

4.4.3. Out-of-pocket financing and health sector service delivery

The study aimed at establishing the relationship between out-of-pocket financing and health sector service delivery. Table 4.12 represents the respondent's opinion.

Table 4.12: Relationship between Out-of-pocket financing and health sector service delivery.

Correlations

		Service delivery	Out-of-pocket financing
Service delivery	Pearson Correlation	1	.241*
	Sig. (2-tailed)		.019
	N	94	94
Out-of-pocket financing	Pearson Correlation	.241*	1
	Sig. (2-tailed)	.019	
	N	94	94

*. Correlation is significant at the 0.05 level (2-tailed).

Field Data (2021)

Results from table 4.12 above reveal that there is a moderate positive correlation between out-of-pocket financing and health sector service delivery at (r) = 0.241*, p= 0.019 at the level of significance 0.05(2-tailed). This means that when out-of-pocket financing is more emphasized, service delivery in the hospital is slightly improved.

4.5. Effect of health financing on health sector service delivery.

4.5.1. Effect of government financing on health sector service delivery

The study examined the effect of government financing on health sector service delivery. Findings on this objective and how it affects service delivery are presented in table 4.13 below;

Table 4.13. Effect of government financing on service delivery

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.220[a]	.048	.038	.48362

a. Predictors: (Constant), Government financing

Source: Field Data (2021)

The model summary in the table above using predictor variable government financing reveals that adjusted R Square value is 0.38. This implies that 38% (0.38*100) variations in the level of service delivery is explained by government financing while the remaining 62% is explained by other factors which were not covered by the study.

Table 4.14. Variation in government financing and service delivery

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	1.095	1	1.095	4.683	.033[b]
	Residual	21.517	92	.234		
	Total	22.613	93			

a. Dependent Variable: service delivery
b. Predictors: (Constant), Government financing
Field Data (2021)

The study used ANOVA statistical technique to analyse data. The study had the level of significance at α=0.033. It can be deduced from the regression that government financing is significant to health service delivery at F= 4.683(0.033[b]). Since the calculated level of significance 0.033[b] is less than 0.05, then the study accepted the first hypothesis that stated "there is a statistically positive and significant effect of government financing on health service delivery in public hospitals."

4.5.2. Effect of Donor financing on health sector service delivery

The study examined the effect of donor financing on health sector service delivery. Findings on this objective and how it affects service delivery are presented in table 4.15 below;

Table 4.15. Effect of Donor financing on service delivery

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.388[a]	.151	.141	.45690

a. Predictors: (Constant), Donor financing

Source: Field Data (2021)

The model summary in the table 4.15 using predictor variable donor financing reveals that adjusted R Square value is 0.141. This implied that 14.1% (0.141*100) variations in the level of health service delivery is due to donor financing while the remaining 85.9% is explained by other factors.

Table 4.16. Variation in donor financing and service delivery

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	3.407	1	3.407	16.320	.000[b]
	Residual	19.206	92	.209		
	Total	22.613	93			

a. Dependent Variable: service delivery
b. Predictors: (Constant), Donor financing
Source: Field Data (2021)

The study used ANOVA statistical technique to analyse data. The study had the level of significance at α=0.000. It can be deduced from the regression that donor financing is significant to health service delivery at F= 16.320(0.000[b]). Since the calculated level of significance 0.000[b] is less than 0.05, then the study accept the second hypothesis that stated "there is a statistically positive and significant effect of donor financing on health sector service delivery in public hospitals."

4.5.3. Effect of Out-of-pocket financing on health sector service delivery

The study examined the effect of out-of-pocket financing on health sector service delivery. Findings on this objective and how it affects service delivery are presented in table 4.17 below;

Table 4.17. Effect of Out-of-pocket financing on service delivery

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.241[a]	.058	.048	.48111

a. Predictors: (Constant), out-of-pocket financing
Source: Field Data (2021)

The model summary in the table 4.17 using predictor variable out-of-pocket financing reveals that adjusted R Square value is 0.48. This implies that 48.0% (0.48*100) variations in the level of health service delivery is explained by out-of-pocket financing while the remaining 52.0% is explained by other factors. According to (Okech, 2014), increase of out-of-pocket payments and decrease of government spending in Ugandan hospitals has continued to contribute towards high incidences of health expenditures. This has been because of mainly relying on private sources of finance (out-of-pocket) that has reduced employee morale, drug stock outs, and worsened the state of medical facilities, and increased costs of services breeding corruption-related tendencies in government hospitals (Nabukeera, 2016).

Table 4.18. Variation in out-of-pocket financing and health service delivery

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1.318	1	1.318	5.693	.019[b]
	Residual	21.295	92	.231		
	Total	22.613	93			

a. Dependent Variable: service delivery

b. Predictors: (Constant), out-of-pocket financing

Source: Field Data (2021)

The study used ANOVA statistical technique to analyse data. The study had the level of significance at α=0.019. It can be deduced from the regression that out-of-pocket financing is significant to health service delivery at F= 5.693(0.019[b]). Since the calculated level of significance 0.019[b] is less than 0.05, then the study therefore accepts the third hypothesis that stated "there is a statistically positive and significant effect of out-of-pocket financing on health sector service delivery in public hospitals.

4.5.4. Effect of government financing, Donor financing and Out-of-pocket financing on health sector service delivery.

The study examined the effect of government financing, donor financing and out-of-pocket financing health sector service delivery. The findings on these objectives and how they affect service delivery are presented in table 4.19 below;

Table 4.19. Effect of health care financing on health service delivery

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.400[a]	.160	.132	.45940

a. Predictors: (Constant), Government financing, out-of-pocket financing, Donor financing

Source: Field Data (2021)

The model summary in table 4.19 above using predictor variables government financing, donor financing and out-of-pocket financing reveals that adjusted R Square value is 0.132. This implies that 13.2% (0.132*100) variations in the level of health service delivery is explained by government financing, donor financing and out-of-pocket financing while the remaining 86.8% is explained by other factors.

Table 4.20: Regression of Coefficients of health financing and health sector service delivery

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.121	.274		7.749	.000
	Out-of-pocket financing	.070	.088	.086	.798	.427
	Donor financing	.244	.084	.331	2.917	.004
	Government financing	.044	.098	.049	.451	.653

a. Dependent Variable: service delivery

Source: Field Data (2021)

The study used coefficients (beta values) and statistical technique to analyse data. This helped to determine the extent and direction of the effect of government financing, donor financing and on health sector service delivery and how they impact on it. The study revealed that government financing, donor financing and out-of-pocket financing have beta values of 0.49, 0.331 and 0.86. It can be deduced from the regression that 1% increase in in government financing, donor financing and out-of-pocket financing, health sector service delivery will be increased by 0.49, 0.331 and 0.86 respectively. At 100% increase in government financing, donor financing

and out-of-pocket financing; health sector service delivery is likely to increase by 49.0%, 33.1% and 86.0%. Therefore, more emphasis should be put in to increase government financing, donor financing and out-of-pocket financing to improve on health service delivery in the hospital.

5.0. Conclusions

Basing on the findings, the researcher concluded that;

5.1. Effect of government financing oh health service delivery

The findings showed that there is a moderate positive correlation between government financing and health sector service delivery at (r) = 0.220*, p= 0.33 at the level of significance 0.05(2-tailed). This indicates that government financing when timely, has a small effect on service delivery in the hospital. The study showed that government financing has a beta value of 0.49. It can be deduced from the regression that at 1% increase in government financing, health service delivery is increased by 0.49% and at 100% increase in government financing, health service delivery is likely to increase by 49%. Therefore, government financing should be increased and be made timely so as to enable the hospital improve on service delivery.

5.2. Effect of Donor financing on health service delivery

Results showed that there is a moderate positive correlation between donor financing and health sector service delivery at (r) = 0.388**, p= 0.00 at the level of significance 0.01(2-tailed). This means that donor financing is timely received, service delivery in the hospital improves. The study revealed that donor financing has a beta value of 0.331. It can be deduced from the regression that at 1% increase in donor financing, health sector service delivery is increased by 0.331% and at 100% increase in donor financing, health sector service delivery is likely to increase by 33.1%. Therefore, donor financing should be increased so as to enable the hospital improve on service delivery.

5.3. Effect of out-of-pocket financing on health service delivery

Findings revealed a moderate positive correlation between out-of-pocket financing and health sector service delivery at (r) = 0.241*, p= 0.019 at the level of significance 0.05(2-tailed). This means that when out-of-pocket financing is more emphasized, service delivery in the hospital is slightly improved. The study also revealed that out-of-pocket financing has a beta value of 0.86. It can be deduced from the regression that at 1% increase in out-of-pocket financing, health sector service delivery is increased by 0.86% and at 100% increase in out-of-pocket financing, health sector service delivery is likely to increase by 86.0%. Therefore, out-of-pocket financing should be more emphasized so as to enable the hospital improve on service delivery.

References

Addae-Korankye, A. (2013). Challenges of Financing Health Care in Ghana: The Case of National Health Insurance Scheme. *International Journal of Asian Social Science*, Vol. 3(2): 511-522.

Adisah-Atta, I. (2017). Financing Health Care in Ghana: Are Ghanaians Willing to Pay Higher Taxes for Better Health Care? Findings from Afrobarometer, *Social Science Journal*, Vol. 6(90), Pages: 2-19.

Akortsu, M. A. (2013) 'Financing public healthcare institutions in Ghana'.doi: 10.1108/14777261111134383.

Amin, M. (2005).*Social Science Research: Conception, Methodology and Analysis*, Kampala; Makerere University Printery.

Anton, S.G. &Onofrei, M. (2013).Health Care Performance and Health Financing Systems in Countries from Central and Eastern Europe, *Transylvanian Review of Administrative Sciences*, Vol. No. 35 E/2012, pp. 22-32

Aregbeshola, B.S. & Khan, S.M. (2018).Out-of-pocket payments, catastrophic health expenditure and poverty among households in Nigeria 2010.*International Journal of Health Policy Management*, Vol. 7(9), Pages: 798–806.

Australian Aid (2016).*The Impact of Out-of-Pocket Expenditures on Families and Barriers to Use of Maternal and Child Health Services in Papua New Guinea: Evidence from the Papua New Guinea Household Survey 1996 and Household Income and Expenditure Survey 2009–2010*. https://www.adb.org/sites/default/files/publication/30344/impact-oop-expenditures-mnch-services-png.pdf

Bonfrer, I. (2015) 'Evaluating Health Care Financing Reforms in Africa', *Journal of Economics and Business*, Vol. 4(2), Pages: 2–3.

Borghi, J., Munthali, S., Million, L. B., & Martinez-Alvarez, M. (2018). Health financing at district level in Malawi: an analysis of the distribution of funds at two points in time. *Health policy and planning*, Vol. 33(1), 59-69.

Burgoine, K., Ikiror, J., Akol, S., Kakai, M., Talyewoya, S., Sande, A., Otim, T., Okello, F., Hewitt-Smith, A., &Olupot-Olupot, P. (2018). Staged implementation of a two-tiered hospital-based neonatal care package in a resource-limited setting in Eastern Uganda.*BMJ Global Health*, Vol. 3: e000586.doi:10.1136/bmjgh-2017-000586.

Che-Chi, P. &Urdal, H. (2018). The evolving role of traditional birth attendants in maternal health in post-conflict Africa: A qualitative study of Burundi and northern Uganda. *SAGE Open Medicine*, Vol. 6, Pages: 1–9.

Civil Society Budget Advocacy Group (2017). *CSO Sector Position Paper on the Health Ministerial Policy Statement FY 2017/18*. Pages: 1-8. Accessed December 2018 onhttp://csbag.org/wp-content/uploads/2017/08/CSO-SECTOR-POSITION-PAPER-ON-THE-HEALTH-MINISTERIAL-POLICY-STATEMENT-FY-2017-18-.pdf

Cohen, L., Manion, L., &Marrison, K. (2011).*Research Methods in Education* (7th ed). London: Routledge Taylor & Francis Group.

Curtis, W., Murphy, M & Shields, S. (2014). *Research and Education*. New York: Routledge.

Daniel, J. (2012). *Sampling Essentials: Practical Guidelines for Making Sampling Choices.*California: Sage Publications.

De Vos, A.S., Strydom, H., Fouché, C.B. &Delport, C. S. L. (2014).*Research at grassroots: for the social sciences and human service professions.* Pretoria. Van Schaik.

Denscombe, M. 2014. *The Good Research Guide for Small Scale Social Research Projects. 3rd Ed*. USA: McGraw-Hill Companies.

Dulal, R.K., Magar, A., Dulal, K.S., Khatiwada, D., &Hamal, P.K. (2014).Analysis of Health Sector Budget of Nepal.*Journal of Nepal Medical Association*. Vol. 52(1), Pages: 811-821.

Ejughemre, U. (2013). Donor Support and the Impacts on Health System Strengthening in Sub-Saharan Africa: Assessing the Evidence through a Review of the Literature, *American Journal of Public Health Research,* Vol. 1(7), Pages: 146-151.

Fox, W. &Bayat, M.S. (2013).*A guide to managing research*. Cape Town: Juta.

Govinda, R. &Mita, C. (2012). Health Care Financing Reforms in India.*National Institute of Public Finance and Policy Working Paper No: 2012-100.* Pages: 1-35. Accessed December 2018 on https://www.researchgate.net/profile/Govinda_Rao/publication/241763971_Health_Care_Financing_Reforms_in_India/links/004635289e5ad1df3c000000/Health-Care-Financing-Reforms-in-India.pdf

Johnson, B. & Christensen, L. (2012).*Educational Research: Quantitative, Qualitative, and Mixed Approaches.* USA: Sage Publications.

Korir, J.K. (2010).*The Data Envelopment Analysis and Stochastic Frontier Approaches to the Measurement of Hospital Efficiency in Kenya*. Unpublished PhD Thesis, Kenyatta University.https://ir-library.ku.ac.ke/bitstream/handle/123456789/6894/Julius%20K.%20Korir.pdf;sequence=1

Kothari, C.R (2011). *Research Methodology: Methods and Techniques.* New Delhi: New Age International Publishers.

Krejcie, R.V., & Morgan, D.W. (1970).Determining Sample Size for Research Activities. *Educational and Psychological Measurement,* Vol. 30, Pages: 607-610.

Kumar, R. 2011. *Research methodology*. New Delhi: Sage Publications.

Lee, W. Y., & Shaw, I. (2014). The impact of out-of-pocket payments on health care inequity: the case of national health insurance in South Korea. *International journal of environmental research and public health*, Vol. 11(7), Pages: 7304-7318.

Leedy, P.D. & Ormond, J.E. (2014).*Practical research: Planning and design 10th Edition.* Essex: Pearson.

Lynn, P. (2016).The advantage and disadvantage of implicitly stratified sampling, *Understanding Society Working Paper Series*, No. 2016 – 05. Accessed January 2019 on https://www.understandingsociety.ac.uk/sites/default/files/downloads/working-papers/2016-05.pdf

Magaka, R. &Swere, K. (2016). Challenges Hindering the Accessibility of Tanzania's Health Service: A Literature Review. *International Journal of Economics and Finance*.Vol. 8.242. 10.5539/ijef.v8n8p242.

Massuda A, Hone T, Leles F.A.G., de Castro, M.C., &Atun, R. (2018). The Brazilian health system at crossroads: progress, crisis and resilience. *Bio Medical Journal of Global Health*; Vol. 3(1), Pages: 1-8

Mbabazi, T. (2008): *Guide to Research and Research Methodology*, Jotain Company Ltd, Kampala, Uganda

Ministry of Health (2016).*Ministerial Policy Statement: Vote 170 Mbale Regional Referral Hospital.* Accessed December, 2018 on http://parliamentwatch.ug/wp-content/uploads/2015/04/Ministerial-policy-Statement-for-Ministry-of-Health-FY-2015-16.pdf

Mukasa, N. (2012). Uganda Healthcare system profile: Background, Organization, Polices and Challenges. *Journal of Sustainable Regional Health Systems*. Issue 1, Vol. 1(1): 2-10.

Munge, K. & Briggs, A.H. (2014); The progressivity of health-care financing in Kenya, *Health Policy and Planning*, Vol. 29, Issue 7, 1 October 2014, Pages 912–920

Mutopo, Y. (2017). *Rethinking Health Care Financing Models. The Case of Zimbabwe's Health Sector*, Unpublished Masters' Thesis, University of Cape Town, South-Africa. Accessed January 2019 on https://open.uct.ac.za/bitstream/handle/11427/27236/thesis_com_2017_mutopo_yvonne.pdf?sequence=1

Nabukeera, M. (2016). Challenges and Barriers to the Health Service Delivery System in Uganda, *Journal of Nursing and Health Science*, Vol. 5(Issue 2, Ver. V), Pages: 30-38.

Nyongesa, W.M., Onyango, R., &Kakai, R. (2014).Determinants of clients' satisfaction with healthcare services at Pumwani Maternity Hospital in Nairobi - Kenya.*International Journal of Social and Behavioural Sciences*. Vol. 2(1): 11 - 17.

Ojakaa, D., Olango, S., & Jarvis, J. (2014). Factors affecting motivation and retention of primary health care workers in three disparate regions in Kenya. *Human resources for health*, Vol. 12(33), Pages: 1-13.

Okech, T.C. (2014). Analytical review of health care reforms in Uganda and its implication on health equity, *World Journal of Medicine and Medical Science Research*, Vol. 2(4), Pages: 55-62.

Ondoa, C.J., Basheka, B.C., &Basaasa, M.M. (2013).institutional dynamics and health service delivery in regional referral hospitals in Uganda: What lessons from a case of Jinja Regional Hospital? *African Journal of Governance and Development*, Vol. 2(1): 40-56.

Palasca, S. &Jaba, E. (2015). Economic Crisis' Repercussions on European Healthcare Systems, *Procedia Economics and Finance*, Vol. 23(1), Pages: 525–533.

Paul, E., Albert, L., &Bisala, B.N. (2018). Performance-based financing in low-income and middle-income countries: isn't it time for a rethink? *BMJ Global Health*, Vol. 3(1), Pages: 20-29.

Rudasingwa, M., &Uwizeye, M. R. (2017). Physicians' and nurses' attitudes towards performance-based financial incentives in Burundi: a qualitative study in the province of Gitega. *Global Health Action*, *10*(1), Pages: 1-14.

Saunders, M., Lewis, M. &Thornhill, A. (2012).*Research Methods for Business Students, 6th Edition.* Pearson Education: London.

Schieber, G., Cashin, C., Saleh, K., &Lavado, R. (2012).*Health Financing in Ghana*. Washington, DC: World Bank. doi:10.1596/978-0-8213-9566-0

Seitio-Kgokgwe, O., Gauld, R., Hill, C.P., & Barnett, P. (2014).Assessing Performance of Botswana's Public Hospital System: The Use of the World Health Organization Health System Performance Assessment Framework.*International journal of health policy and management*.Vol, 3(4), Pages: 179-189

Shaw, R.P., Wang, H., Kress, D., &Hovig, D. (2015). Donor and Domestic Financing of Primary Health Care in Low Income Countries, *Health Systems & Reform*, Vol. 1(1), Pages: 72-88, DOI: 10.1080/23288604.2014.996413

Simon, M.K. & Goes, J. (2013), *Dissertation and Scholarly Research: Recipes for Success*. Seattle, WA: Dissertation Success LLC.

Van-Wyk, M. &Taole, M. (2015).*Educational Research: An African perspective.* Cape Town: Oxford University Press Southern Africa.

Verbeke, F., Kaze, S., Ajeneza, L., Nkurunziza, L., Sindatuma, G., Asmini, H., Bastelaere, S., &Mugisho, E. (2017).Implementing Burundi's national e-health enterprise architecture: past, present and future.*Journal of Health Informatics in Africa*.Vol. 44. 90-9790. 10.12856/JHIA-2017-v4-i1-178

Verguet, S., Olson, Z.D., Babigumira, J.B., Desalegn, D., Johansson, K.A., Kruk, M.E., Levin, C.E., Nugent, R.A., Pecenka, C., Shrime, M.G., Memirie, S.T., Watkins, D.A., & Jamison, D.T. (2015).Health gains and financial risk protection afforded by public financing of selected interventions in Ethiopia: an extended cost-effectiveness analysis. *Lancet Global Health*, Vol.3: e288–e296.

Wanjau, K.N., Muiruri, B.W., &Ayodo, E. (2012). Factors Affecting Provision of Service Quality in the Public Health Sector: A Case of Kenyatta National Hospital, *International Journal of Humanities and Social Science*, Vol. 2(13), Pages: 114-125.

Wild, J. &Diggines, C. 2013.*Marketing Research 2nd Edition*. Cape Town: Juta.

World Health Organization (2013), *Planning and budgeting to deliver services for mental health.* Geneva, (Mental Health Policy and Service Guidance Package).

Yunusa, U., Irinoye, O., Suberu, A., Garba, A., M., Timothy, G., Dalhatu, A. & Ahmed, S. (2014). Trends and Challenges of Public Health Care Financing System in Nigeria: The Way Forward. *IOSR Journal of Economics and Finance*, Vol. 4(Issue 3), Pages: 28-34.

Zikmund, B.J., Carr, J.C., & Griffin, M. (2013).*Business Research Methods.9th Edition.*South Western: Cengage Learning