



East African Journal of Health and Science

eajhs.eanso.org

Volume 9 Issue 2, 2026

Print ISSN: 2707-3912 | Online ISSN: 2707-3920

Title DOI: <https://doi.org/10.37284/2707-3920>



EAST AFRICAN
NATURE &
SCIENCE
ORGANIZATION

Original Article

Strengthening Health Service Quality Through Financial Accountability in Decentralised Health Systems: Evidence from Otuke District - Northern Uganda

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Article DOI: <https://doi.org/10.37284/eajhs.9.2.5234>

Date Published: ABSTRACT

30 June 2026

Keywords:

Financial
Accountability,
Health Service Quality,
Decentralised Health
Systems,
Otuke District.

Purpose: This study examined the influence of financial accountability on health service quality in decentralised health facilities in Otuke district, northern Uganda, focusing on budgeting, financial reporting, and auditing practices. Anchored in public finance management, the agency and stewardship theories, and informed by the SERVQUAL model, it offers empirical evidence to advance theory, guide managerial practice, and inform policy for enhancing healthcare quality outcomes in developing economies. **Methodology:** The study utilised an explanatory sequential research design and a sample size of 268 respondents who were selected using purposive and stratified sampling. Data was gathered using questionnaires and interview guides and analysed using SPSS version 21 data analysis software. Descriptive statistics summarised the demographics, financial accountability, and healthcare quality sub-constructs, while correlation and linear regression procedures examined the relationships between financial accountability and healthcare quality and the predictive effects of financial accountability on healthcare quality. **Findings:** The study registered significant moderate positive associations between budgeting ($r=0.452$, $p<0.000$), financial reporting ($r=0.543$, $p<0.000$), and auditing practices ($r=0.494$, $p<0.000$) and healthcare quality. The linear regression results revealed that budgeting ($R^2=20$, $p<0.001$), financial reporting ($R^2=29.1$, $p<0.001$), and auditing practices ($R^2=24$, $p<0.001$) significantly predicted health service quality in Otuke District health facilities. **Unique contribution to theory, managerial practice, and policy:** The study affirms that financial accountability accelerates healthcare quality in decentralised health governance systems of emerging economies. It advances the public finance management, agency, and stewardship theories by explicating how financial accountability predicts healthcare quality, while incorporating the SERVQUAL model. Practically, it guides healthcare administrators on institutionalising financial accountability mechanisms to boost healthcare quality. Policy-wise, our study recommends stricter financial governance enforcement by the Ugandan government to enhance public healthcare outcomes.

APA CITATION

Meri, J. K., Opio, P. P., Ogo, E. & Aguma, C. (2026). Strengthening Health Service Quality Through Financial Accountability in Decentralised Health Systems: Evidence from Otuke District - Northern Uganda. *East African Journal of Health and Science*, 9(2), 423-438. <https://doi.org/10.37284/eajhs.9.2.5234>

CHICAGO CITATION

Meri, John Kenedy, Peter Paul Opio, Emmanuel Ogo and Ceaser Aguma. 2026. "Strengthening Health Service Quality Through Financial Accountability in Decentralised Health Systems: Evidence from Otuke District - Northern Uganda". *East African Journal of Health and Science* 9 (2), 423-438. <https://doi.org/10.37284/eajhs.9.2.5234>

HARVARD CITATION

Meri, J. K., Opio, P. P., Ogo, E. & Aguma, C. (2026). "Strengthening Health Service Quality Through Financial Accountability in Decentralised Health Systems: Evidence from Otuke District - Northern Uganda", *East African Journal of Health and Science*, 9(2), pp. 423-438. doi: 10.37284/eajhs.9.2.5234

IEEE CITATION

J. K., Meri, P. P., Opio, E., Ogo & C., Aguma "Strengthening Health Service Quality Through Financial Accountability in Decentralised Health Systems: Evidence from Otuke District - Northern Uganda", *EAJHS*, vol. 9, no. 2, pp. 423-438, Jun. 2026.

MLA CITATION

Meri, John Kenedy, Peter Paul Opio, Emmanuel Ogo & Ceaser Aguma, "Strengthening Health Service Quality Through Financial Accountability in Decentralised Health Systems: Evidence from Otuke District - Northern Uganda". *East African Journal of Health and Science*, Vol. 9, no. 2, Jun. 2025, pp. 423-438, doi:10.37284/eajhs.9.2.5234.

INTRODUCTION

Globally, financial accountability is widely recognised as the cornerstone of healthcare governance. It is the mandate of public service delivery actors to effectively manage public funds, ensure robust financial reporting, and guarantee that public funds are utilised for their intended purpose (Gherardi et al., 2021). Empirical studies targeting developed economies like the United States of America and Germany indicate that strong financial accountability frameworks, including financial reporting, budgeting, and financial oversight, improve healthcare quality (Jimenez-Rubio, 2022). On the other hand, healthcare quality indicates the degree to which health services align with patient expectations by enhancing equitable access, timely health service delivery and patient safety (World Health Organization, 2025).

Healthcare systems in Africa consistently face challenges in service delivery despite significant resourcing, a predicament that can be attributed to weak financial governance, stakeholder exclusion, funding delays, etc., which undermine universal health coverage. Even relatively unconventional healthcare systems in countries like Egypt, South Africa, Botswana and Mauritius still experience healthcare quality gaps due to weak financial governance oversight, limited

staffing, and corruption (AlOmari, 2021a). For instance, empirical evidence (Anindya et al., 2021) reported quality coverage gaps of 64%, 48.7% and 43.6% for; postnatal care, family planning and antenatal care respectively implying persistent significant health care quality gaps in Sub-Saharan Africa, while Nesengani et al., (2025) avers that poor financial governance diminished health system efficacy and healthcare quality outcomes, making robust financial accountability practices like financial reporting, allocative efficiency, and auditing a core priority, especially in poverty-stricken health systems like those in Africa.

Regionally, a majority of East African Community member states, like Kenya, Ethiopia, and Tanzania, have decentralised health service delivery to boost equitable access (Yihune Teshale et al., 2025). However, empirical evidence suggests that public health decentralisation reforms have yielded mixed outcomes, especially where ineffective fiscal governance and limited financial autonomy exist. For instance, King et al. (2021) found baseline clinical quality scores in Tanzanian health facilities amounting to 41%, implying that clinical quality gaps were at 59%, demonstrating significant gaps in adherence to clinical quality standards and healthcare delivery. Fortunately, Gadisa (2022) targeted public healthcare facilities

in Ethiopia and reported that financial autonomy accelerated health service quality outcomes.

In Uganda, decentralised efforts emerged in 1993 with the unveiling of the decentralisation policy. It was formally recognised under articles 176-190 of the 1995 constitution and operationalised by the Local Governments Act, which transferred political, administrative, and financial management power, personnel management, and service delivery roles to district local governments (Kyohairwe et al., 2024). These reforms sought to enhance healthcare quality through localised financial governance, and yet no significant healthcare outcomes have been registered (Chen et al., 2021; Turyamureba et al., 2023). National health evaluations indicate persistent gaps in clinical efficacy despite the current decentralised governance regime. For instance, Rokicki et al. (2021) assessed maternal and newborn care quality in Ugandan health centers and revealed that the average healthcare quality score was only 45% while healthcare providers demonstrated significant gaps in infection prevention, vital signs monitoring and prevention of postpartum hemorrhage. These alarming statistics, underscore the vital role of robust financial accountability mechanisms in guaranteeing equitable healthcare access and effective healthcare delivery in Uganda's district local governments.

Discrepancies in healthcare delivery were more pronounced in the Lango sub-region and exclusively in Otuke District, the base of our study, which was attributed to fiscal constraints, governance, capacity, and staffing gaps, which undermined overall public service delivery. Evidence from low-resourced contexts like Otuke district signalled that allocative efficacy, financial oversight, and governance effectiveness significantly advance healthcare quality and patient outcomes (Odhus et al., 2024a). Consequently, reinforcing financial accountability systems from all governance levels is vital in enhancing healthcare quality, which justifies the research inquiry undertaken by our study.

LITERATURE REVIEW

Theoretical Review

Our study was anchored on the public finance management theory (PFM) and the agency and stewardship theories. The PFM theory advanced by Adams (Adams, 1888) and Musgrave (Musgrave & Musgrave, 1959) postulated how governments plan, allocate, control and monitor public funds to enhance the efficacy of public service delivery (Bandyopadhyay & Singh, 2023a). In this study, the PFM theory was majorly applicable in decentralised public service systems where central governments delegate financial governance roles to local governments while retaining oversight authority (Bandyopadhyay & Singh, 2023b). Empirical evidence confirmed that coherent financial accountability enhanced health service delivery and patient satisfaction (Bhati et al., 2023). The PFM theory thus presented a robust framework for examining how strengthened financial accountability systems in Otuke district could improve health service delivery through improved staffing, infrastructure, and scarce resource consumption (World Health Organization, 2023).

The study was also guided by the agency and stewardship theories, which explicated managerial actions and public service delivery outcomes in decentralised governance frameworks. Whereas the agency theory focused on the obligation of local government actors to act in the public interest, it averred that this moral obligation is sometimes compromised, leading to agency conflict (Duff et al., 2024). To overcome this anomaly, the stewardship theory was incorporated, which argues that agents are required to serve the interests of the principals and focuses on ethical management, inclusive oversight responsibility and proactive decision-making as the core pillars of clinical effectiveness and patient satisfaction (Schillemans & Bjørstrøm, 2020).

Finally, the study was hinged on the SERVQUAL model, which presented the service quality dimensions. The core SERVQUAL dimensions targeted by this study were; tangibles, accuracy,

empathy, and timeliness. The SERVQUAL model aided in detecting healthcare quality gaps, the gaps which were more prevalent than others, the factors responsible for these quality gaps, and the measures for mitigating these gaps (AlOmari, 2021b).

Empirical Literature Review

Effects of Budgeting Practices on Health Service Quality

Empirical studies widely reported positive effects of budgeting practices on health service quality in numerous settings, like the United States and China, among others (Jindal et al., 2023; Folland et al., 2024; Guan et al., 2020; De La Perrelle et al., 2020; Li et al., 2020). Notably, accountable resource appropriation, effective financial planning, and tracking mechanisms enhance medical outcomes and general healthcare quality. However, these studies focused on global non-African settings and never comprehensively examined how budgeting influences healthcare quality in decentralised health systems, necessitating further research inquiry by our study.

Effect of Financial Reporting on Health Service Quality

Empirical research indicates that effective financial reporting significantly influences health service quality by reinforcing governance, oversight, and operational performance (Cleverley et al., 2023; Malakoane et al., 2020; Odhus et al., 2024b; Wasti et al., 2023; Abrahams et al., 2022). Research suggests that poor accountability and transparency, weak financial oversight, and ineffective performance monitoring hindered quality improvements in primary healthcare facilities in low- and middle-income economies. Unfortunately, these researches majorly targeted national systems and non-Ugandan settings and overlooked how financial reporting affects service quality in decentralised health centres, signalling the need for research inquiry in Otuke District.

Effect of Auditing Practices on Health Service Quality

Recent studies signal that auditing practices improve healthcare quality by reinforcing financial accountability, monitoring, and financial oversight (Oppong et al., 2023; Hut-Mossel et al., 2021; Foy et al., 2020; Loboda et al., 2023; Arvidsson et al., 2021). Therefore, standardised audits and feedback systems enhance patient outcomes and healthcare efficacy in different contexts. However, empirical results focused on non-African settings, creating contextual gaps in examining how auditing practices influence service quality in decentralised healthcare facilities, a gap that our study addressed in Otuke District in northern Uganda.

RESEARCH METHODOLOGY

Research Design

The study deployed an explanatory sequential research design, implementing quantitative methods first, then qualitative approaches (Creswell & Plano Clark, 2023). The quantitative phase examined the relationship between financial accountability and health service quality, while the qualitative phase captured local government actors' perceptions on accountability mechanisms. Empirical evidence contends that the efficacy of financial accountability is hinged on context, power dynamics and institutional culture, which could be effectively assessed qualitatively (Igbinoba et al., 2023). Therefore, integrating statistical analyses with qualitative insights enhanced construct validity and reinforced the practical relevance of the findings for public sector financial management reforms (Toyon, 2021).

Study Population

The study population comprised 380 participants performing administrative, operational, and front-line clinical roles. The 39 administrative participants comprised district authorities like Chief Administrative Officer, Chief Finance Officer, District Health Officer, Procurement, Human Resource and Audit cadres, Health Unit In-charges and Finance and Health Unit

Management Committee chairpersons, who provided vital information given their vast experience in public financial management. The 105 operational staff consisted of clinical officers of various categories who provided front-line perspectives on healthcare delivery. Finally, 236 patients due for discharge also provided user insights on healthcare quality. In total, 6 Health Centre IIIs in Otuke district, including Olilim, Okwang, Okwongo, Barjobi, Aliwang and Atangwata, were targeted for research inquiry.

Sample Size and Sampling Techniques

For this study, 268 respondents generated from a 380 study population were sampled using purposive, stratified and convenience sampling (Vebrianto et al., 2020). Purposive sampling focused on financial management and oversight staff to guarantee expert insights. Stratified proportionate sampling targeted operational staff so as to guarantee proportionate representation of front-line health service cadres. Convenience sampling targeted patients due for discharge to guarantee user perspectives on healthcare quality. This multilayered approach combined administrative, operational and end-user perspectives, thus producing an information-rich sample which enhanced the validity and reliability of study results (Tin & Bui, 2024).

Data Collection Methods and Instruments

The study deployed surveys and interviews using questionnaires and interview guides for data collection. Interviews targeted key informants from the aforementioned administrative staff category so as to capture in-depth qualitative insights. Questionnaires focused on operational front-line clinical staff categories as well as patients due for discharge from the targeted healthcare centres (Islam & Aldaihani, 2022; Taherdoost, 2021). These approaches were consistent with the explanatory sequential study design by integrating quantitative and qualitative findings, ensuring an inclusive understanding of respondents' experiences and perspectives and contextual realities while guaranteeing the timely collection of large amounts of research data.

Data Collection Procedure

The study observed a systematically planned data collection process to guarantee procedural precision and ethical compliance. A fieldwork plan guided pre-visits to the study sites prior to the commencement of data collection, so as to obtain data collection clearance from Otuke District Local Government Authorities (Abrahams et al., 2022). Questionnaires targeting operational staff and patients due for discharge and interview guides targeting key informants were then administered over a ten-day period under a conducive atmosphere to guarantee unbiased responses. Filled questionnaires were then retrieved on agreed dates, coded, cleaned, and entered into SPSS ahead of data processing and analysis.

Data Processing and Analysis

Quantitative data from coded questionnaires were cleaned so as to detect missing values and outliers before entry into SPSS version 21 data analysis software. Qualitative data underwent thematic content analysis to detect key themes (Braun & Clarke, 2021). Model diagnostic tests like normality, multicollinearity, homoscedasticity, and heteroscedasticity were undertaken. Descriptive statistics, correlation, and regression analyses revealed relationships and predictive effects between financial accountability and healthcare quality outcomes. Interview results were transcribed and reported verbatim to affirm the quantitative results.

Quality Control Procedures

Quality control measures were deployed to guarantee the validity and reliability of data collection instruments. Expert assessment and content validity index procedures reported a content validity index of 0.782, while the pilot study registered a Cronbach alpha value of 0.819. These figures align with established psychometric standards on quality control, implying that the data collection instruments were valid and reliable (Sürücü & Maslakci, 2020).

Ethical Considerations

The study conformed to ethical standards for mixed-methods research targeting human participants (Dubey & Kothari, 2022). Ethical approval was given by the Lira University Research Ethics Committee, and informed consent was secured from respondents. Confidentiality was observed by deploying pseudonyms and secure storage of research data

in password-protected digital files. Interviews were conducted in neutral locations, and research integrity was upheld through accurate and honest reporting. Methodological limitations were then acknowledged (Kolstoe & Pugh, 2024).

RESULTS

Table 1 presents diverse findings relating to the demographic statistics of the study's respondents.

Table 1: Demographic Characteristics of Respondents

Variable	Category	Frequency	Percentage
Q1. Gender	Male	90	47.4
	Female	100	52.6
Q2. Age Bracket	20-25 yrs	26	13.7
	26-31 yrs	62	32.6
	32-37 yrs	56	29.5
	38-43 yrs	20	10.5
	44-49	14	07.4
	Above 49 years	12	06.3
Q3. Qualification	PLE	32	16.8
	O-Level	19	10.0
	A-level	07	03.8
	Certificate	19	10.0
	Ordinary diploma	82	43.1
	Bachelor Degree	21	11.1
	Postgraduate diploma	05	02.6
	Master's Degree	05	02.6
Q4. Marital Status	Single	26	13.7
	Married	149	78.4
	Separated	07	03.7
	Divorced	04	02.1
	Widowed	04	02.1
Q6. Work Experience	1-3 years	24	12.6
	4-7 years	41	21.6
	8-11 years	10	05.3
	12-15 years	07	03.7
	16-21 years	01	0.2
	N/A(Patients)	107	0.5

Source: *Primary Data*

From Table 1, the study sample consisted of 53% females and 47% males, signalling a balanced gender representation which diminished potential respondent bias and enhanced internal validity. However, the slightly superior gender disparity of females could reflect wider demographic inclinations in healthcare delivery in Uganda, where female workers constitute the majority of front-line health workers. Similarly, the majority of respondents (62.1%) were aged 26-37 years,

indicating a younger to middle-aged workforce, which enhanced internal validity. Younger staff may easily get accustomed to digital financial accountability tools, whereas senior staff (6.3%) provided in-depth ancient viewpoints.

Numerous respondents held Ordinary Diplomas (43.1%), with fewer Bachelor's Degrees (11.1%) and postgraduate degrees (5.2%). The limited number of highly qualified staff could be

insightful into the depth of contemporary financial accountability institutions, suggesting that the study results could primarily be reflective of operational-level practices. Relatedly, most participants (78.4%) were married, suggesting a largely stable family and responsibility structure, which potentially enhanced observance of

financial accountability guidelines. Collectively, these findings, comprising a predominantly young, moderately educated and fairly experienced workforce, provided credible and representative insights into how financial accountability mechanisms predicted healthcare quality in the targeted healthcare facilities.

Table 2 presents the descriptive statistics for financial accountability constructs.

Table 2: Descriptive Statistics Summary for Financial Accountability Constructs			
Financial Accountability Construct	N	Mean (M)	Standard Deviation (SD)
Budgeting Practices	190	3.74	1.290
Financial Reporting Practices	190	3.62	1.325
Auditing Practices	190	3.55	1.388

Source: *Primary Data*

From Table 2, the study registered moderate implementation of financial accountability practices in Otuke District health centres. Budgeting was ranked highest (M=3.74; SD=1.290), signalling moderate financial planning and allocative efficacy. Financial reporting followed (M=3.62, SD=1.325), mirroring a moderate observance of financial

reporting practices and variability in its implementation. Auditing practices emerged lowest (M=3.55, SD=1.388), indicating that internal controls were ineffective in Otuke District. Overall, these results suggested that structural vulnerabilities in auditing practices diminish financial oversight.

Table 3 presents the descriptive statistics for health service quality constructs.

Table 3: Descriptive Statistics Summary for Health Service Quality Constructs.			
Health Service Quality Constructs	N	Mean (M)	Standard Deviation (SD)
Accuracy	190	3.36	1.208
Timeliness	190	2.70	1.242
Empathy	190	3.19	1.265
Tangibility	190	2.88	1.201

Source: *Primary Data*

From Table 3, the study revealed that there was a moderate level of health service quality in Otuke District. The service quality determinants begin with accuracy (M=3.36, SD=1.208), indicating moderately reliable diagnosis and patient records, empathy (M=3.19, SD=1.265) inferred moderately perceived patient-centred healthcare, and tangibility (M=2.88, SD=1.201), signalling moderate availability of physical and technological apparatus. Timelines were ranked lowest (M=2.70, SD=1.242), implying delays in

healthcare delivery. In our view, these results signal existing discrepancies in service quality across the six healthcare facilities targeted for research inquiry, underscoring the need to reinforce responsiveness infrastructure and patient-centred services to enhance overall healthcare quality.

Table 4 presents the Pearson correlation results for financial accountability and health service quality.

Table 4: Correlation Coefficients for Financial Accountability and Health Service Quality

Variables		BP	FR	AP	HSD
Budgeting Practices (BP)	Pearson Correlation	1			
	Sig. (2-tailed)				
	N	190			
Financial Reporting (FR)	Pearson Correlation	.689**	1		
	Sig. (2-tailed)	.000			
	N	190	190		
Auditing Practices (AP)	Pearson Correlation	.555**	.763**	1	
	Sig. (2-tailed)	.000	.000		
	N	190	190	190	
Quality of Health Service Delivery (QHSD)	Pearson Correlation	.452**	.543**	.494**	1
	Sig. (2-tailed)	.000	.000	.000	
	N	190	190	190	190

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

Source: Primary Data

Table 4 reported that financial reporting ($r=0.543$, $M=3.62$) and auditing practices ($r=0.494$, $M=3.55$) registered stronger moderate associations with healthcare quality than budgeting practices ($r=0.452$, $M=3.74$), though all these were significant ($p<0.01$), across the six health centre IIIs in Otuke District. The findings

underscored the instrumental role of financial accountability in boosting healthcare quality outcomes in decentralised health systems. The variations in correlation results could reflect uneven budgetary allocations, staffing and funding capacity, compliance with financial reporting standards and workload challenges.

Table 5 presents the linear regression results for budgeting practices and health service quality.

Table 5: Linear Regression for Budgeting Practices and Health Service Quality

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.452	.204	.200	.59556

a. Predictors: (Constant), Budgeting Practices

From Table 5, budgeting practices accounted for a 20% variation in health service quality (Adjusted $R^2=.200$), with the remaining 80% explained by other factors outside the scope of our study. Similarly, the standard error of 0.596 suggested that the regression model significantly predicts healthcare quality, although the model's

explanatory power can be improved by targeting other financial accountability indicators such as regulatory compliance and internal controls.

Table 6 presents the regression coefficients for budgeting practices and health service quality.

Table 6: Coefficients of Regression for Budgeting Practices

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.058	0.179		11.516	.000
	Budgeting Practices	0.313	0.046	0.452	6.755	.000

a. Dependent Variable: Health Service Quality

Table 6 revealed that budgeting practices moderately enhanced healthcare quality in the six Health Centre IIIs in Otuke District ($B=0.313$, $\beta=0.452$). The baseline healthcare quality was

2.058 in the absence of budgeting. The association was substantially significant ($T=6.755$, $p<0.001$). The qualitative insights from KII4 confirmed that “much as comprehensive budgeting was under

implementation, delayed fund releases by the central government interrupted health service delivery". These findings underscore the pivotal role of budgeting in elevating healthcare quality by guiding allocative efficiency.

We aver that, as much as these results inferred that effective financial planning, budget appropriation and monitoring significantly predicted health service quality in Otuke District, the moderate

influence of budgeting practices inferred that other financial accountability apparatus, including auditing and financial reporting and other operational factors like funding, staffing and infrastructural levels, jointly predicted health service quality.

Table 7 presents the linear regression analysis results for financial reporting and health service quality.

Table 7: Linear Regression for Financial Reporting and Health Service Quality

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.543 ^a	.295	.291	.56054

a. Predictors: (Constant), Financial Reporting

From Table 7, financial reporting explained 29.1% of the disparity in health service quality across the six Health Centre IIIs in Otuke District (Adjusted $R^2=29.1$), with the remaining 70.9% attributed to the factors beyond the scope of our study. These results underscore the critical role of financial reporting in enhancing health service

quality by augmenting expenditure tracking, fraud detection and guaranteeing rational resource appropriation.

Table 8 presents the regression coefficients for financial reporting and health service quality.

Table 8: Coefficients of Regression for Financial Reporting

Model	Unstandardized Coefficients		Standardized Coefficients	T	Sig.
	B	Std. Error	Beta		
(Constant)	1.970	.152		13.004	.000
Financial Reporting	.347	.040	.543	8.628	.000

a. Dependent Variable: Health Service Quality

Table 8 reported that financial reporting significantly enhanced healthcare quality at the six-health centre IIIs in Otuke District ($p<0.001$). A one-unit increment in financial reporting heightened healthcare quality by 0.347 units ($B=0.347$). The standardised coefficient ($\beta=0.543$) and the "T" value ($t=8.628$) signalled a modest to strong effect, whereas the constant ($B=1.970$) indicated the baseline healthcare quality level. The qualitative insights highlighted

that "financial reporting fosters transparency and integrity in health service delivery, indicating robust budgetary performance". These results underscore the critical role of financial reporting in advancing clinical quality outcomes in decentralised governance systems.

Table 9 presents the regression summary for auditing practices and health service quality.

Table 9: Model Summary of Regression for Auditing Practices

Model	R	R Square	Adjusted R-Square	Std. Error of the Estimate
1	.494 ^a	.244	.240	.58030

a. Predictors: (Constant), Health Service Quality

From Table 9, auditing practices accounted for 24% of the discrepancy in health service quality

in Otuke District (Adjusted $R^2=0.240$), with 76% of the remaining variation attributed to other

factors beyond the scope of our study. The moderate standard error (0.58030) signalled an accurate prediction of the regression model. These results underscore the pivotal role of auditing in

reinforcing financial accountability by guaranteeing effective expenditure management.

Table 10 presents the regression coefficients for auditing practices and health service quality.

Table 10: Coefficients for Auditing Practices

Model	Unstandardized Coefficients		Standardized Coefficients		T	Sig.
	B	Std. Error	Beta			
1 (Constant)	2.199	0.142			15.471	.000
Auditing Practices	0.289	0.038	0.494		7.585	.000

a. Dependent Variable: Health Service Quality

Table 10 indicates that the intercept (2.199) represents baseline healthcare quality when auditing practices were constant. The regression model was statistically significant (15.471, $p < 0.001$), implying that other factors outside our study's scope affected healthcare quality. A one-unit increment in auditing practices elevated healthcare quality by 0.289 units ($B = 0.289$, $SE = 0.038$). The qualitative insights signalled that *“auditing practices elevated fund utilisation, detected fraud and healthcare quality gaps, and fostered rational resource utilisation, boosting healthcare quality”*. These results underscore the vital role of auditing practices in reinforcing financial accountability and optimising resource allocation in decentralised health governance frameworks like Otuken District.

DISCUSSION

The study examined the correlation between financial accountability and health service quality in Otuken District Health Centre IIIs. In this regard, the study revealed that financial reporting, auditing, and budgeting practices registered moderately significant relationships with health service quality. In our view, these results provide compelling evidence that fortifying financial accountability invaluable improves healthcare quality. The findings align with Oppong et al. (2023b), who reported that strengthened auditing enhanced resource utilisation and consequently healthcare quality in Ghanaian public health facilities. Our study's findings are also in congruence with Finkler et al. (2025), who linked transparent financial reporting to better healthcare quality outcomes in the United States of America

healthcare system. Finally, our results are also concomitant to those of Amedari & Ejidike (2021), who inferred that healthcare quality was linked to reliability in health system governance, including funding adequacy, infrastructure, and availability of sufficient medical supplies.

Our study investigated the influence of financial accountability on health service quality in Health Centre IIIs in Otuken District. In this regard, the study found that financial reporting, auditing practices and budgeting practices were significant predictors of health service quality, with financial reporting and auditing registering stronger predictive power. Our results are concomitant with those of Furqan et al. (2020), who reported that timely audit oversight significantly enhanced public service quality in Indonesia. The study findings are also affiliated with those of Musiega et al. (2024), who revealed that effective public finance management enhanced health system efficiency by aligning healthcare funding with clinical priorities, motivating clinical staff, and hence contributing to improving healthcare quality outcomes in Kenyan hospitals. Finally, our findings were also aligned with those of Kesale et al. (2022), who demonstrated that strong financial accountability mechanisms contribute to enhanced healthcare quality in Tanzania.

Based on the overall results, we therefore contend that the observed ranking for financial accountability constructs could reflect contextual realities in Otuken District, where budgeting practices may primarily target financial planning instead of consistent oversight, diminishing their predictive effects on healthcare quality. In

contrast, the stronger predictive power of financial reporting and auditing practices perhaps arose because they directly govern financial expenditure tracking and verification in real practice. Similarly, the discrepancies in staffing levels, expertise, and institutional norms dictate that financial reporting and auditing could attract superior attention than budget implementation, especially where external oversight by district authorities and development partners is involved. Finally, limited physical and technological infrastructure, funding gaps, and operational challenges could potentially moderate the efficacy of budgeting in translating planned budgetary allocations into significant healthcare quality outcomes.

Overall, our findings align with the theoretical lenses integrated by our study. Therefore, from the public finance management theory (PFM) perspective, the results reinforce the notion that financial reporting and coherent auditing practices are a critical apparatus for guaranteeing efficient utilisation, tracking, and monitoring of public funds. Whereas budgeting plays a vital role in public funds appropriation, the PFM theory guides that effective fund tracking and financial reporting ensure that appropriated funds translate into concrete healthcare quality outcomes.

Our findings also support the agency and stewardship theories in explicating the association between financial accountability and healthcare quality. From the agency theory outlook, the superior predictive effect of financial reporting and auditing practices signals that health care governance actors (agents) must rationally utilise public funds entrusted to them by government and citizens (principals) despite the risks of information asymmetry and agency conflict. Financial reporting and auditing ensure oversight and monitoring, thus enhancing both financial accountability and healthcare quality. From the stewardship theory angle, healthcare actors operating under robust guidelines and financial oversight may likely prioritise patient welfare and governance objectives. Finally, financial accountability frameworks fortify the SERVQUAL model by linking financial

reporting, budgeting, and auditing practices to healthcare quality outcomes like timeliness, tangibles, empathy, and assurance, thereby advancing clinical quality and patient care outcomes.

In the context of Otuke District, the prevalence of auditing and financial reporting perhaps mirrors governance measures that emphasise fiscal discipline and strict ethical governance among healthcare actors. The relatively frail predictive power of budgeting practices could signal the existence of structural limitations, such as staffing and infrastructural gaps and inefficient oversight mechanisms, which explain its incompetence in effectively translating funds appropriation into tangible healthcare quality outcomes.

Strengths

Our study significantly contributes to the linkage between financial accountability mechanisms and health service quality in decentralised health governance frameworks. Drawing from public finance management, agency, and stewardship theories, the study operationalised the SERVQUAL model. The explanatory sequential study design guided the integration of quantitative results and qualitative insights, which enhanced conceptual clarity and methodological precision. Also, the deployment of purposive, stratified proportionate, and convenience sampling guaranteed capturing both managerial, operational, and health service user perspectives. Strict adherence to ethical parameters, including ethical approval and research integrity, reinforced the credibility and trustworthiness of our study's findings.

Limitations

However, the study's confinement to a solitary district constrained the generalisation of findings. Finally, the exclusion of intervening or moderating variables, as well as the cross-sectional nature of quantitative data, restricted in-depth causal examination, necessitating longitudinal research inquiry in order to reinforce our findings.

Recommendations

Based on the study findings, the following policy recommendations are therefore advanced. The Ugandan government should institutionalise more robust financial accountability frameworks in decentralised health governance systems by imposing timely financial reporting, auditing, and exhaustive financial oversight. Policy reforms should also reinforce budget execution and tracking to guarantee that resource appropriation translates into better healthcare service quality outcomes. Finally, local government administrators should enhance the financial management expertise of health centre managers through continuous training and professional development.

CONCLUSION

The study concludes that financial accountability significantly influences healthcare quality in decentralised healthcare facilities in Otuke District. While financial reporting promotes transparency and informed, auditing reinforces regulatory oversight and accountability in resource utilisation, while budgeting ensures effective resource allocation into priority areas. Jointly, these financial accountability apparatuses enhance operational efficiency and service quality outcomes. Healthcare managers and local government actors should therefore fortify financial reporting, auditing and budgeting systems to improve financial accountability, optimise resource allocation and healthcare quality.

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