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Effect Of Leadership Capability On The Performance Of Level Four Public Hospitals In Kenya

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ABSTRACT

Organizations and more specifically public hospitals are rethinking on strategic management capabilities in order to improve performance. For the government of Kenya to achieve the social pillar of Vision 2030, public health facilities should embrace strategic management capabilities. The study sought to evaluate the effect of leadership capabilities on performance of level four public hospitals in Kenya. The study was anchored on the dynamic capability and transformational leadership theories. The target population was 257 level four public hospitals in Kenya. A sample of 157 level four public hospitals in Kenya was determined using Israel formula. Systematic sampling technique was used to select the respondents. Primary data was collected using questionnaires. Data was analyzed using descriptive and inferential statistics. The coefficient for leadership capability was significant (.185, $p<.05$) an implication that leadership capability significantly affects the performance of level four public hospitals in Kenya. The study concluded that leadership capability significantly affects the performance of level four public hospitals in Kenya. The study recommends hospitals to engage capable leaders who can be able to formulate objectives that reflect vision and mission of the organization. The leaders should also be able to always engage key stakeholders whenever they make strategic decisions.

INTRODUCTION

Leadership capability is an aspect of strategic management adopted by organizations. Leadership capability is undertaken with an aim to improve customer service provision and enhance organizational competitiveness ((Rajasekar, 2014). Strategies adopted by organizations need to be efficient and effective so that they enable a firm achieve her set goals (Hill & Jones, 2010). Leadership capabilities such as abilities to manage change, articulate vision and mission and involve employees in decision making help to enhance organizational productivity. In return leadership capabilities promote organization performance (Wanyoike & Mayande, 2016).

Public healthcare in Kenya has experienced tremendous developments since independence (WHO, 2015). The constitution of Kenya, 2010 devolved the health sector across all 47 counties. The ministry of health provides policy support and technical guidance to priority national programs and stays in charge of the national referral hospitals and remains responsible for human resources for health (university teaching hospitals, public universities and medical schools). The fruits of devolution began to sprout in 2013 where roles were stemmed from national to county level (MoH, 2015). The aim of health sector devolution is to enhance equity in resource allocation, thereby improving service delivery for the majority of Kenyans, especially those residing in rural areas (KPMG, 2013). Despite the fact that the aim of the public health sector in Kenya is to promote quality service delivery to patients, it is noted that majority (87%) of public hospitals in Kenya have a long way to go before realizing Vision 2030 goals of quality health care service to all Kenyans (World Health Organization, 2018).

In Kenya there are several health facilities. Dispensaries and health centers are the first contact facilities for people seeking medical care. Level four public hospitals are facilities that provide clinical care at the district level and act as referrals center of small health care facilities. Level four hospitals are the second in the chain of public health facilities in Kenya which provide healthcare services to the majority of the Kenyans and finally level six public hospitals which also serve as the teaching and referral hospitals in Kenya (Ministry of Health, (MOH), 2015).

Ibahim and Muathe (2017) point out that the state of infrastructural facilities and capacity development in the health sector in Kenya is of great concern. The ratio of doctors, clinical officers, and nurses to that of patients is small as compared to developed countries. With inconsistencies in service delivery in public hospitals in Kenya, it is estimated by the Kenya Medical Association (2018) that 27% of the deaths in level four public hospitals are caused by lack of medical equipment, 21% are caused by frequent strikes by medical staff, 19% are caused by lack of advanced technologies to perform complex medical procedures such as heart and brain surgeries and 33% of the deaths are caused by negligence of patients to adhere to drug prescriptions and incompetence of the medical staff.

Leadership in healthcare is not performing well. There lacks capacity building and skilled management expertise in most public hospitals in Kenya and this has resulted to poor performance (MOH, 2017). Leaders influence their followers in organizations. Leadership has a very strong impact on employees in the sense of offering an environment in the workplace for employees to perform better (Baig, Iqbal, Abrar, Baig, Amjad, Rehman & Awan, 2019). Decisions made in a firm by leaders influence the employees' attitude. When given autonomy by leaders, employees get collaborative knowledge which help firms network and improve their performance. When employees are engaged in firm activities, they can easily communicate and help channel efforts to productive sectors thus netter firm performance (Baig et al.,2019; Rangus & Cerne, 2017).

Leaders values and behaviours affect their choices in strategic decisions, policies and procedures which alternatively affect performance in organizations (Jia, Chen, Mei & Wu, 2017). The

economic shift happening globally is focusing on possessing knowledge as a resource in every organization. Therefore, employees need to have constant upgrading and knowledge enhancement as they accomplish daily tasks. This will ultimately help in job satisfaction-employee satisfaction-better organization performance (Baig et al, 2019). Therefore, the aim of this study was to uncover the effects of leadership capabilities on performance a case of level four hospitals in Kenya. To achieve global health standards there is a need for hospitals to adopt leadership capabilities as a function of strategic management (Ahmed & Muathe, 2017; Ibrahim & Muathe, 2017). Most researchers highlight that performance can be financial or non-financial (Norton & Kaplan, 2006). The current study takes a closer look into service efficiency and effectiveness, customer satisfaction and employee satisfaction as measures of performance. Leadership capability is informed by employee involvement and vision and mission enhancement and change management.

Several works have been done in the area of leadership capability and firm performance (Nzinga, McGivern & English, 2018; Wanyoike & Mayande, 2016)). ((Wanyoike and Mayande (2016) examined factors affecting effective change management in public hospitals in Kenya. The study adopted an exploratory research design and stratified random sampling technique to select a sample size of 64 respondents. Data was analyzed using simple regression method. The findings revealed that there exists a moderate relationship between leadership capabilities and organizational performance. Ability to manage change, articulate the vision, involve employees in the key decision-making process are factors which influence overall organizational productivity. In contrast, this study used a sizeable sample size which was determined using Israel (2009) formula. Using a total population of 257, the calculated sample size was 157 respondents

It is evident that variables of the current study were examined partially and in isolation in past studies thus conceptual gaps to be addressed by this study. Further, the studies were confined to different contexts thus contextual gaps to be addressed and methodological gaps of each study were different thus methodological gaps to be addressed by this study.

LITERATURE REVIEW

The study is anchored on dynamic capability theory and the transformational leader style. The dynamic capabilities theory was developed in 1997 by Teece et al, (1997). It is an expansion of the resource based-view theory of a firm. The theory focuses on the integration and building firm competencies that help a firm survive in the competitive environment. When a firm possess greater dynamic capabilities they perform better. Employees and leadership in a firm are resources that can be utilized to create better performance and increase survival in the environment (Barney, 1991). Rajeskar, (2014) recognizes leadership capability as the ability to influence employees and the workforce to work towards achieving organization goals with minimal resistance. Visionary leaders are able to transform employee thinking resulting to well-equipped employees likely to improve firm performance. These are capabilities that can be used for the gain of a firm (Daft, 2015; Norton & Kaplan, 2013).

The transformational leadership is embedded on the power to influence people and bring about mutual cooperation among people. The theory was developed by Burns (1978) and aims at intrinsic needs of followers. Leaders who establish themselves as role models create trust and confidence in their followers. In this changing environment, transformational leadership is key (Jia et al, 2017). This is because it creates commitment and motivation among employees. Motivation is created through inspirations and expectations that later help employees yield better results (Baig, Iqbal, Abrar, Baig, Amjad, Rehman & Awan, 2019). A leader who adopts the transformational style is aiming at expanding a group autonomy and authority and want the employee to develop. Subordinates feel valued, trusted and they are able to get job satisfaction that improves their productivity. The charisma possessed by transformational leaders help them effectively articulate and the organization mission and vision (Agus, Bernardo, Ashari, Wijatyyanti & Hyun, 2020).

Nzinga, McGivern and English (2018) examined clinical leadership in Kenyan public hospitals through the distributed leadership lens. The study adopted a phenomenological paradigm to analyze data. Data was collected using interview guides and the information was analyzed qualitatively. The results indicated that to a larger extent public hospitals were challenged to implement new changes such as new health systems thus inconsistencies in service delivery. Further, a report by the Ministry of Health (2017) points out that the majority of the public health facilities in Kenya have a minimal expectation about performing leadership. It emerged that, weak leadership and managerial capabilities were factors that contributed to the deteriorating performance of public hospitals in Kenya. Shortage of skilled management expertise and capacity building issues were some of the factors that led to the nonperformance of public hospitals in Kenya.

Baig, Iqbal, Abrar, Baig, Amjad, Rehman & Awan, (2019) studied Impact of leadership styles on employees' performance with moderating role of positive psychological capital. The study aimed at investigating the most effective leadership style that enhances the employees' performance at the workplace and also evaluate the impact of leadership styles (Laissez-faire leadership, Transformational leadership, Transactional leadership,) on employees' performance in the textile sector of Pakistan. The study found out that transformational leadership has a significant impact on employee performance.

Given the positive results yielded by previous studies, the study adopts the following hypothesis.

Ho; There is a relationship between leadership capability and performance of level four public hospitals in Kenya.

METHODOLOGY

The study adopted a positivist philosophy of research as it facilitates new knowledge development (Fisher, 2010). A cross-sectional research design was used to collect data. The target population was 257 level four public hospitals in Kenya. The unit of analysis was employees in Level Four Public hospitals in Kenya while the unit of observation was Level Four Public Hospitals in Kenya. The respondents were doctors, nurses and clinical officers. Stratified random sampling was used

to select the 157 level four public hospitals. Respondents were stratified into groups of doctors clinical officers and nurses. The Israel Formula was used to calculate the ideal sample size. The study used both primary and secondary data. Primary data was collected a 5-point Likert scale questionnaire with both open and close ended questions while secondary data was collected from strategic plans using content analysis. Data collected was cleansed and fed into a computer for coding and analysis. Both descriptive and inferential statistics were used in data analysis. Diagnostic tests of normality, linearity, homogeneity and multicollinearity were done before regression. A multiple regression model was used to show the relationship between the dependent and independent variables.

RESULTS AND DISCUSSSIONS

The target population for this study was 157 respondents who were in charge of health workers in 157 level four public hospitals in Kenya. A total of 138 questionnaires were filled and returned which translates to a response rate of 82%. Babbie (2004) recommended that a 60% return rate is good and a 70% return rate is very good.

Background Information of the Respondents

The study sought to find out the background information of the respondents in terms of gender, age, level of education and profession. This section presents the findings.

Gender Distribution of the Respondents.

The study sought to establish the gender of the respondents. The findings are as presented in Table 1.

Table.1: Gender distribution of Respondents

Gender	Frequency	Percent
Male	56	41
Female	82	59
Total	**138**	**100.0**

The findings in Table 1 indicate that 41% of the respondents were male and 59% were female. This shows that majority of those in charge of health workers in level four hospitals in Kenya are female. The findings also show that the ratio of male and female in the companies is within the third gender rule provided in the Kenyan Constitution.

Distribution of the Respondents by Age

The study sought to find out the age of the respondents by requesting them to indicate their age bracket. The results are as shown in Table 4.2

Table 2: Distribution of the Respondents by Age

Age Bracket	Frequency	Percent
23 years and below	18	13.0
24-29 years	35	25.4

30-35 years	40	29.0
36-41 years	24	17.4
Above 41 years	21	15.2
Total	**138**	**100.0**

The results in Table 2 indicates that 29.0% of the respondents had the age of between 30-35 years, 25.4% were had the age of between 24-29 years, 17.4% had the age of between 36-41 years, 15.2% had the age of above 41 years while 18% had the age of 23 years and below. The study therefore represents the views of health workers with divers age and experience.

Academic Qualification of the Respondents

The study sought to find out the academic qualification of the respondents. The distribution of the level of education of the respondents is as presented in Table 4.3

Table 3: Academic Qualification of the Respondents

Academic Qualification	Frequency	Percent
Certificate	5	3.6
Diploma	77	55.8
Higher National Diploma	26	18.8
Bachelor's Degree	19	13.8
Postgraduate Degree	11	8.0
Total	**138**	**100.0**

The results in Table 3 shows that 55.8% of the respondents had a diploma, 18.8% had a higher national diploma, 13.8% had a bachelor's degree, 8.0% had a postgraduate degree while 3.6% had a Certificate. The findings show that the respondents had attained relevant education and thus they are knowledgeable to provide the information sought by the study.

Distribution of the Respondents by Profession

The respondents were requested to indicate their profession. The findings are as shown in Table 4.

Table 4: Distribution of the Respondents by Profession

Years Worked in the Company	Frequency	Percent
Doctor	27	19.6
Clinical Officer	49	35.5
Nurse	62	44.9
Total	**138**	**100.0**

The results in Table 4 shows that 44.9% of the respondents were nurses, 35.5% were clinical officers while 19.6% were doctors. The study thus represents the response of health workers in the various professions.

Descriptive statistics of Performance of Level Four Hospitals

This section presents the analysis of the dependent variable which is performance of level four hospitals in Kenya. The respondents were requested to respond to eleven statements rated on a five point likert scale ranging from: Strongly Agree; Agree; Not sure; Disagree and Strongly disagree. The findings are presented in Table .6.

Table 4.6: Frequencies, Mean and Standard Deviation for Financial Performance

Statement	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree	Mean	Std. Dev
Patients are attended within the shortest time possible	27.5% (38)	53.6% (74)	5.8% (8)	13.0% (18)	0.0% (0)	3.956	0.927
Doctors, clinical officers and nurses are always ready to attend patients	11.6% (16)	71.0% (98)	12.3% (17)	5.1% (7)	0.0% (0)	3.891	0.658
There are minimal number of strikes in the hospital	2.9% (4)	65.2% (90)	26.1% (36)	5.8% (8)	0.0% (0)	3.652	0.635
There are adequate number of doctors, clinical officers and nurses in the hospital	0% (0)	1.4% (2)	0.7% (1)	50% (69)	47.8% (66)	1.558	0.582
Patients can access consultant doctors at any time	0% (0)	2.2% (3)	2.2% (3)	60.1% (83)	35.5% (49)	1.710	0.618
Patients are served with passion	54.3% (75)	38.4% (53)	0.7% (1)	5.1% (7)	1.4% (2)	4.391	0.858
Instant feedback is provided to patients	0.7% (1)	19.6% (27)	58.0% (80)	21.7% (30)	0% (0)	2.992	0.667
There are minimal patient complaints in the hospital	0% (0)	27.5% (38)	55.1% (76)	16.7% (23)	0.7% (1)	3.094	0.682

Variety of medical services are provided in the hospital	0% (0)	54.3% (75)	35.5% (49)	10.1% (14)	0% (0)	3.442	0.672
The hospital has invested in the state of the art medical equipment	0% (0)	20.3% (28)	55.1% (76)	24.6% (34)	0% (0)	2.956	0.671

The results in Table 4.6 shows that 53.6% of the respondents agreed with the statement that patients are attended within the shortest time possible (mean = 3.956, std = 0.927). The findings also show that 71.0% of the respondents agreed that doctors, clinical officers and nurses are always ready to attend patients (mean = 3.891, std = 0.658) while 65% agreed that there are minimal number of strikes in the hospital (mean = 3.652, std = 0.635).

50% disagreed with the statement that there are adequate number of doctors, clinical officers and nurses in the hospital (mean = 1.558, std = 0.582), 60.1% disagreed with the statement that patients can access consultant doctors at any time (mean = 1.710, std = 0.618), 54.3% strongly agreed that patients are served with passion (mean = 4.391, std = 0.858), 58% were not sure if instant feedback is provided to patients (mean = 2.992, std = 0.667), 55.1% were also not sure if there were minimal patient complaints in the hospital (mean = 3.094, std = 0.682), 54.3% agreed that a variety of medical services are provided in the hospital (mean = 3.442, std = 0.672), while 55.1% were not sure if the hospital has invested in the state of the art medical equipment (mean = 2.956, std = 0.671).

Descriptive Statistics for Leadership capability

The study sought to establish the effect of leadership capability on the performance of level four public hospitals in Kenya. The respondents were thus requested to respond to ten statements rated on a five point Likert scale ranging from: Strongly Agree; Agree; Not sure; Disagree and Strongly disagree. The findings are presented in Table 7

The results in Table 7 show that 84.1% of the respondents agreed that the hospital has visionary leaders who formulate objectives that reflect vision and mission (mean = 3.847, std = 0.496). The results also indicate that 81.9% of the respondents agreed that leaders of the hospital have a long term perspective or vision (mean = 3.818, std = 0.486). Similarly, 81.2% of the respondents agreed that leaders of the hospital always engage key stakeholders whenever they make strategic decisions (mean = 3.797, std = 0.485), 75.4% agreed that the leaders always formulate achievable objectives (mean = 3.797, std = 0.542), 79% agreed that the leaders of the hospital always support the ideas of workers (mean = 3.782, std = 0.523) while 73.2% agreed that the leaders always encourage employees to adapt to new changes (mean = 3.731, std = 0.610).

Table 7: Frequencies, Means and Standard Deviations for Leadership Capability

Statement	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree	Mean	Std. Dev
My hospital has visionary leaders who formulate objectives that reflect vision and mission	2.2% (3)	84.1% (116)	10.1% (14)	3.6% (5)	0% (0)	3.847	0.496
Leaders of my hospital have a long term perspective or vision.	1.4% (2)	81.9% (113)	13.8% (19)	2.9% (4)	0% (0)	3.818	0.486
Leaders of my hospital always engage key stakeholders whenever they make strategic decisions.	0.7% (1)	81.2% (112)	15.2% (21)	2.9% (4)	0% (0)	3.797	0.485
Leaders of my hospital always formulate achievable objectives	3.6% (5)	75.4% (104)	18.1% (25)	2.9% (4)	0% (0)	3.797	0.542
Leaders of my hospital always support the ideas of workers	1.4% (2)	79.0% (109)	15.9% (22)	3.6% (5)	0% (0)	3.782	0.523
Leaders of my hospital always encourage employees to adapt to new changes	2.9% (4)	73.2% (101)	18.1% (25)	5.8% (8)	0% (0)	3.731	0.610
Leaders of my hospital always create awareness of the vision and mission to all workers	1.4% (2)	76.1% (105)	17.4% (24)	5.1% (7)	0% (0)	3.739	0.570
Leaders of my hospital have mechanisms of dealing with industrial disputes such as strikes	0.7% (1)	14.5% (20)	61.6% (85)	21.7% (30)	1.4% (2)	2.913	0.667
Leaders of my hospital are dedicated to improving working conditions of workers	0% (0)	29.0% (40)	60.1% (83)	10.9% (15)	0% (0)	3.181	0.606

Leaders of my hospital are determined to pay workers for extra time worked	0% (0)	8.0% (11)	17.4% (24)	65.2% (90)	9.4% (13)	2.239	0.730

The findings also indicate that 76.1% of the respondents agreed that the leaders of the hospital always create awareness of the vision and mission to all workers (mean = 3.739, std = 0.570), 60.6% were not sure if the leaders have mechanisms of dealing with industrial disputes such as strikes (mean = 2.913, std = 0.667), 60.1% were also not sure if the leaders are dedicated to improving working conditions of workers (mean = 3.181, std = 0.606), while 65.2% of the respondents disagreed that the with the statement that the leaders are determined to pay workers for extra time worked (mean = 2.239, std = 0.730).

Inferential Analysis and Testing of Hypotheses

Inferential analysis was used to test the hypotheses in the study. Diagnostic tests to confirm assumptions of normality, linearity, homoscedasticity and multi-collinearity were carried out before conducting inferential analysis. This section presents the results of the diagnostic and hypotheses tests.

Tests of Assumptions

Linear regression analysis assumes that there is normality, linearity, no multi-collinearity, no autocorrelation and no heteroscedasticity. This section presents the results of diagnostic tests that were carried out to determine linearity multi-collinearity, autocorrelation, normality, homoscedasticity and were carried out before conducting inferential analysis.

Test of Linearity

In regression models, the independent and dependent variables are assumed to be linear. To test this, a normal P-P plot was generated to indicate the relationship between independent and dependent variable. The findings are presented in Figure.1

In regression models, the independent and dependent variables are assumed to be linear. To test this, a normal P-P plot was generated to indicate the relationship between independent and dependent variable. The findings are presented in Figure 1

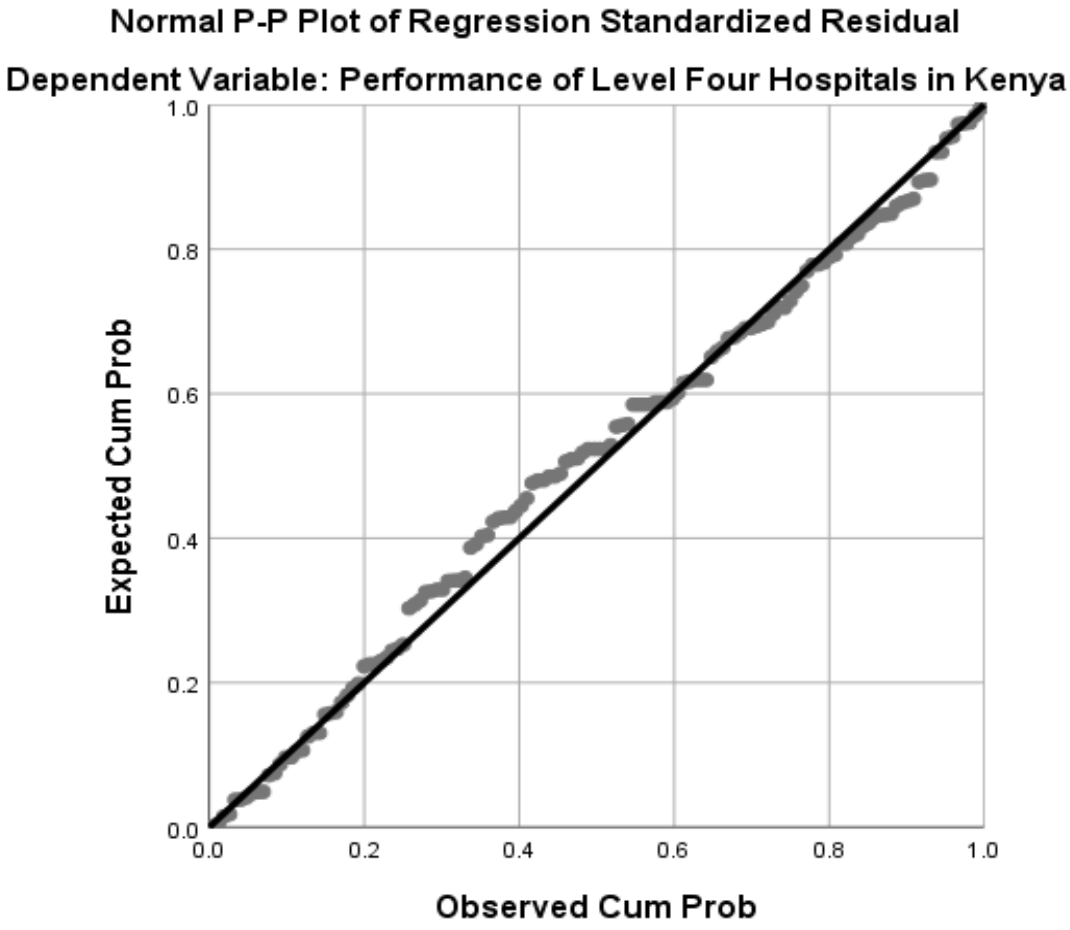

Figure 1: Linearity Test Results

The results in Figure 4.1 shows that the data appear close to the line implying that the independent and dependent variables have a linear relationship.

Test of Multi-collinearity

Regression analysis assumes that the independent variables are not correlated to each other. Pearson correlation analysis was done in order to determine the degree of the correlation between the independent variables. The rule of thumb is that correlation values that are less than 0.8 imply that there is no multi-collinearity problem between the variables (Farndale, Hope, Haily & Killiher, 2010). The results are presented in Table 8. Results of correlation among the independent variables is less than 0.8 for all the variables. The findings imply that there is absence of multi-collinearity as suggested Farndale, Hope, Haily & Killiher, (2010) that correlation values less than 0.8 are sufficiently different measures of separate variables and are not auto-correlated. Variance inflation factor was also used to test multi-collinearity of the variables and the constructs had.863 tolerance indicating absence of multicollinearity.

Test of Autocorrelation

Linear regression requires that there is little or no autocorrelation in the data. Autocorrelation occurs when the error terms or residuals are not independent of each other. Durbin- Watson test was used to test the null hypothesis that the residuals are not linearly autocorrelated. The Durbin-Watson statistic denoted by d ranges in value from 0 to 4 and the acceptable range is between 1.5 and 2.5 (Garson, 2012). The results are presented in Table 9.

Table 9: Autocorrelation Test Results

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson Statistic (d)
1	.656[a]	.430	.413	.28927	2.032

a. Predictors: (Constant), Leadership Capability (Articulate vision and mission, change management and employee involvement).

b. Dependent Variable: Performance of Level Four Hospitals in Kenya

The results in Table 9 shows that the value of Durbin Watson statistic (d =2.032), lies between the two critical values of 1.5<d< 2.5, thus there is no first order linear autocorrelation

Test of Normality

Normality was tested Histrogram. The results are presented in Figure 2

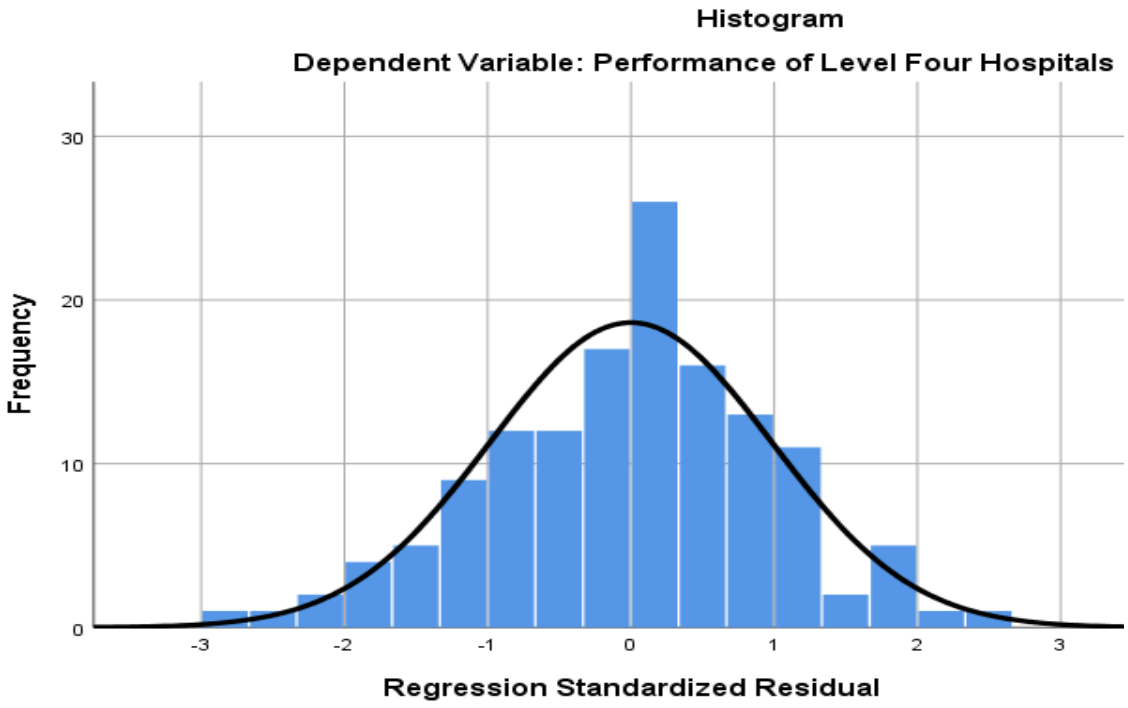

Figure 2: Normality Test Results

The results presented in Figure 2 indicate that the histogram is bell-shaped implying that the data is normally distributed.

Test of Homoscedasticity

Regression models require that there is homoscedasticity which is a situation in which the error term in the relationship between the independent variables and the dependent variable is the same across all values of the independent variables. Homoscedasticity was tested using Scatter plot. The results are presented in Figure 3

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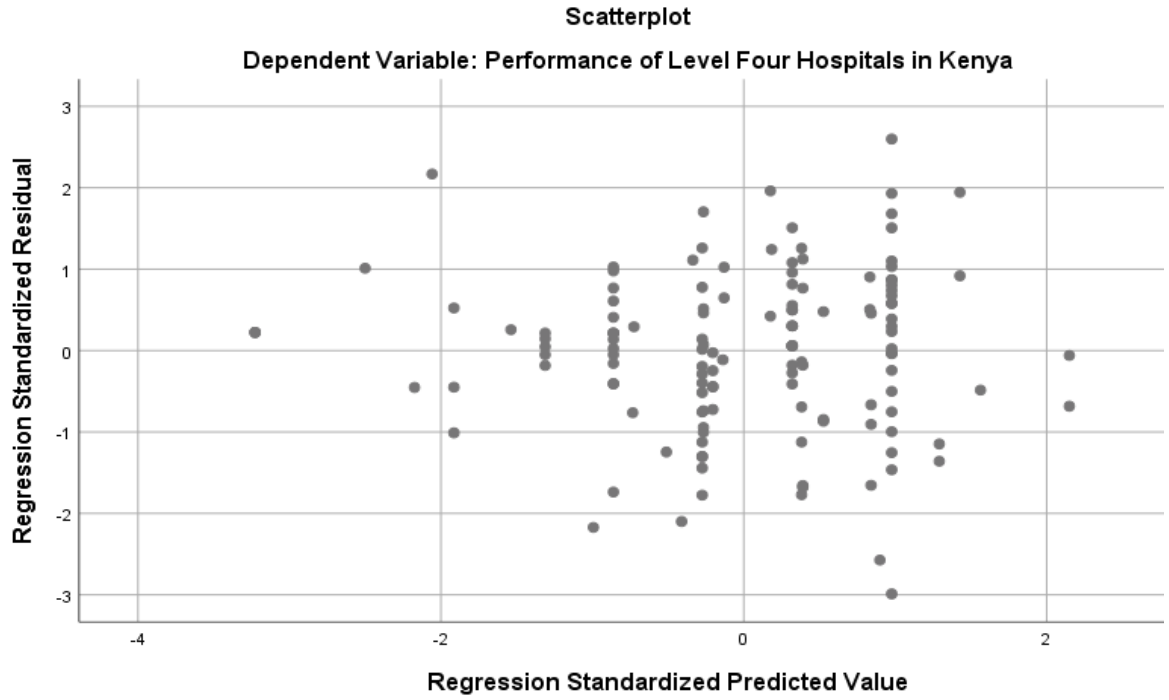

Figure 3: Homoscedasticity Test Results

The findings in Figure 3 show that the data are equally distributed on the X and y axis and there is no obvious pattern and thus there is no presence of heteroscedasticity.

The null hypothesis was tested using the following multiple linear regression model:

$y = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \beta_3 x_3 + \beta_4 x_4 + \varepsilon$ ……. (4.1)

Where: y is the performance of level four public hospitals in Kenya, β_0 is the regression constant, β_1, …., B_4 are coefficients estimated, x_1 is articulation of vision and mission, x_2 is employee involvement, x_3 is change management, ε is the error term.

: **Model Summary**

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.656[a]	.569	.413	.28927

a. Predictors: (Constant), Articulation of vision and mission, employee involvement and change management

The results in Table 10 shows that the coefficient of determination (R^2) is 0.569 meaning that the model estimated explains 57% of the variations in the performance of level four public hospitals in Kenya.

Table: 11 ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	8.407	4	2.102	25.119	.000[b]
	Residual	11.129	133	.084		
	Total	19.536	137			

a. Dependent Variable: Performance of Level Four Public Hospitals in Kenya.

b. Predictors: (Constant), Articulation of vision and mission, employee involvement and change management

The Analysis of Variance (ANOVA) results in Table 11 indicates that the relationship between the independent variables and dependent variable is significant (F = 25.119, sig <.05). This implies that the leadership capabilities variables significantly affect the performance of level four public hospitals in Kenya. Articulation of vision and mission, employee involvement and change management are therefore statistically acceptable as useful in predicting the performance of level four public hospitals in Kenya.

Table 12: Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.020	.202		5.054	.000
	Articulation of vision and mission	.098	.041	.177	2.394	.018
	Employee involvement	.185	.047	.281	3.989	.000
	Change management	.150	.041	.246	3.693	.000

a. Dependent Variable: Performance of Level Four Public Hospitals in Kenya.

The results in table 12 provide the coefficients of the variables used in the study. The regression equation model in this study is as shown in equation 4.1.

$$y = 1.020 + 0.098x_1 + 0.185x_2 + 0.150x_3 + 0.157x_4 \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots (4.2)$$

The results show that the constant term is 1.020, suggesting that holding the variables under consideration to zero, could result to 1.020 units of returns to level four public hospitals in Kenya. This could be due to other factors not considered in this study.

The findings concur with a study by Wanyoike and Mayande (2016). The study also supports the finding of a report by Ministry of Health (2017) which pointed that weak leadership and managerial capabilities contributed to the deteriorating performance of public hospitals in Kenya. The results also concur with the views of the dynamic capability theory which asserts that for organizations to be competitive, unique resources such as technology, assets, processes, and knowledge of employee and information can be utilized to gain sustainable competitiveness (Barney, 1991).

CONCLUSIONS AND RECCOMENDATIONS

The objective of this study was to establish the effect of leadership capability on the performance of level four public hospitals in Kenya. The descriptive results indicated that the respondents agreed that the hospital has visionary leaders who formulate objectives that reflect vision and mission and the leaders of the hospital have a long term perspective or vision. Similarly, the respondents agreed that leaders of the hospital always engage key stakeholders whenever they make strategic decisions, the leaders always formulate achievable objectives, the leaders of the hospital always support the ideas of workers, the leaders always encourage employees to adapt to new changes and the leaders of the hospital always create awareness of the vision and mission to all workers. However, the respondents were not sure if the leaders have mechanisms of dealing with industrial disputes such as strikes. The respondents were also not sure if the leaders are dedicated to improving working conditions of workers and disagreed that the leaders are determined to pay workers for extra time worked.

Inferential statistics was used to test the null hypothesis that there is no relationship between leadership capability and performance of level four public hospitals in Kenya was thus tested using multiple regression analysis. The findings indicated that the coefficient for leadership capability was significant (.185, $p<.05$). The results implied that leadership capability significantly affect the performance of level four public hospitals in Kenya. The null hypothesis that there is a relationship between leadership capability and performance of level four public hospitals in Kenya is thus confirmed and accepted.

The finding indicated that leadership capability significantly affect the performance of level four public hospitals in Kenya. The study thus concludes leadership capability significantly affect the performance of level four public hospitals in Kenya. in particular, visionary leaders who formulate objectives that reflect vision and mission enhance performance. Similarly, leaders with long term perspective or vision and who always engage key stakeholders whenever they make strategic decisions enhance performance. Leaders who always formulate achievable objectives, support the ideas of workers, encourage employees to adapt to new changes and always create awareness of the vision and mission to all workers positively impact on performance. Leaders who have mechanisms of dealing with industrial disputes such as strikes, leaders who are dedicated to improving working conditions of workers and determined to pay workers for extra time worked enhance performance.

The study recommends that hospitals should engage capable leaders who can be able to formulate objectives that reflect vision and mission of the organization. The leaders should also be able to always engage key stakeholders whenever they make strategic decisions, formulate achievable objectives, support the ideas of workers, encourage employees to adapt to new changes and always create awareness of the vision and mission to all workers. The leaders should also have mechanisms of dealing with industrial disputes such as strikes, dedicated to improving working conditions of workers and determined to pay workers for extra time.

The study recommends that other studies be replicated in other levels of hospitals in Kenya or private hospitals to establish whether the findings. Studies can also be replicated in other sectors to establish whether the results will be similar.

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