IMPEDIMENTS TO HEALTHCARE GOVERNANCE IN FRAGILE STATES

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ABSTRACT

Governments, especially in low income countries, are in the most cases grappling with acute challenges associated with the delivery of adequate services to their citizens. In particular, the conceptualization and operationalization of good governance tenets in healthcare systems are an enduring mirage for fragile states. While literature affirms the critical role of effective governance in healthcare delivery systems, the failure of governments in fragile states such as Zimbabwe to provide effective access to equitable and quality healthcare services is symptomatic of weak governance mechanisms. Despite the many studies on health sector governance, there seem to be a persistent lack of clarity on the exact impediments to the effective and efficient governance in healthcare systems in fragile states of the world. This research sought to establish the inherent impediments to effective healthcare governance in fragile states. This was a two-stage multimethod research which started with a directed literature search and focus group discussions to identify the themes that were used to develop the questionnaire for data collection to identify and confirm the inherent impediments to healthcare governance in fragile states. The research showed among others, that healthcare system governance in fragile states is prone to be influenced by the lack of justice-based leadership, leadership legitimacy, clear leadership roles and responsibilities, leadership probity, clear vision and mission, administrative efficiency, performance oriented culture, transparency and predictability, ethical decision-making, rule-bound decision-making and action, delegated authority, leadership accountability, strong regulatory regimes, effective corruption prevention mechanisms and a strong community voice which combined present serious impediments to effective governance of healthcare delivery systems. In practical terms, fragile states healthcare governance may only be improved when the identified impediments are included in the development and implementation of healthcare delivery strategy.

Keywords: Ethics, Governance, Healthcare, Accountability, Transparency, Leadership, Multimethod Research, Fragile States, Impediments.

INTRODUCTION

At all times, society places a major concern on how the authorities respond to the fulfilment and protection of its needs and rights. This seems to have prompted a wide and active interest of several scholars whose goal is to understand the available means by which such societal needs can best be assured. In academic and practitioner discourses, there is a consistent call for authorities to implement stronger governance frameworks in organizations to assure efficient and equitable service delivery to the society. In particular, the significance of an effective governance system is bared in the context of healthcare delivery across the world and it

is easy to see why so much interest is directed on the governance of healthcare delivery. For most of the countries, healthcare delivery depends exclusively on the political, economic and administrative authority's capacity to balance the intertwined issues relating to access, quality, equity and the use of the often scarce resources. This is particularly more important for the fragile states where the limited resources are mostly mismanaged thus undermining operative access to equitable and quality healthcare for the citizens.

While numerous studies (McGorry, 2014; Saini et al., 2017; Singh, 2020; Saini, 2018) clearly indicate the fragile governance in healthcare is consequent of the failure by authorities to balance available resources to healthcare needs, there remains a serious lack of clarity on the exact impediments to the development of solid healthcare governance in highly fragile states such as Zimbabwe. If the outcomes of the country's response to the Covid-19 pandemic are anything to go by, then there is an urgent need to isolate and understand the destructive impediments to healthcare governance in fragile states. In view of that, this study aimed to advance a holistic structure of impediments to effective health governance systems with the overall view to assist the fragile states and possibly the other low-income countries in the development of the basic healthcare governance frameworks to afford equitable and operative healthcare delivery outcomes for their citizens. This paper is structured as follows. The next section reviews the existing literature regarding the general governance frameworks and how they are implemented and based on the discussion, a framework of impediments to effective health governance is shown. This is followed by a brief description of the methodology as applied in this study. Subsequently, the findings of the research and their implications are presented and discussed. Finally, conclusions and implications for further research are outlined.

THEORETICAL FRAMEWORK

As a subject, governance continues to attract the attention of many management scholars with almost all in agreement that governance impacts heavily on the performance of organizations. However, it is difficult to grasp exactly what governance is as the different scholars have different notions of it. It is in order, therefore, to start by clarifying the term as used in this study. In short, governance relates to the use of authority to manage the affairs of any collective society (Rothstein & Varraich, 2017; Bryson, 2018). This becomes so clear when one traces the definition of the word governance. Some scholars broadly associate governance to the way a society formulates and implements its collective decisions (Greer et al., 2016; Poli, 2019; Jagers et al., 2020). For some, governance entails the cooperative actions and practices that any particular society uses to attain or use public goods (Bovaird & Loffler, 2015; Sørensen & Torfing, 2016; Innes & Booher, 2018; Koenig, 2020; McGann & Whelan, 2020). This reflects governance as simply a coordinating mechanism by which the society mobilizes and employs resources, and distributes benefits, obligations and penalties of their collective action (Siregar & Muslihah, 2019). Yet for others, governance relays a notion of both formal and informal rules and procedures that a society uses to manage and resolve the possible conflict among the members of society (Altman, 2015; Skurray, 2015; Poli, 2019). In a similar fashion, some allude that governance is   the exercise of power over the economic, political, and social institutions that control some collective good (Levy, 2015; Rothstein & Varraich, 2017; Jagers et al., 2020). Given the foregoing, for the purpose of this study, healthcare governance thus relates to the exercise of power by society over people and institutions mandated to manage communal

resources for healthcare delivery (Bryson et al., 2014; Martins, 2014; Yimer, 2015; Bryson, 2018)

The aforementioned remind us that healthcare governance is akin to the implementation of community projects which inherently has inevitable snags due to the manifest competing interests (Chang et al., 2013; Martill & Staiger, 2018; Hanrieder, 2019). Not knowing such impediments upfront has the potential to cause inadvertent governance outcomes. The main objective of this study was to close the gaps in existing literature regarding the impediments to effective healthcare governance in order to suggest solutions that will ultimately improve the performance of the healthcare delivery systems in the world's fragile states. Accordingly, the next section now turns to discussing the common impediments confronting the effective implementation of governance systems. This will lead to a directed discussion on the impediments of effective implementation of healthcare governance systems.

Impediments to Effective Governance Systems

For Greer et al. (2016), all well-functioning governance systems are characterised by some distinctive core tenets. Similarly, scholars (Da-Cruz & Marques, 2017; Mollah, 2020) aver that all fragile governance systems mostly lack the basic building blocks of transparency, accountability, participation, integrity, equity and policy capacity, effective implementing structures, and adherence to the rule of law. Further, another stream of thinking is that governance suffers when the authorities make political, social and economic priorities without regard to the general societal consensus and the voices of the underprivileged and the weak in the decision-making processes about resource allocation and distribution (Fung & Wright, 2001; Rodić & Wilson, 2017). Such a practice is claimed to be a recipe for conflictual relations (Greer & da Fonseca, 2015), damaged stakeholder-leadership cooperation (Palumbo & Manna, 2018; Nuhu, 2019), unethical and dishonesty tendencies (Bolman & Deal, 2017), impulsive and self-serving decision-making and implementation (Shen, 2016; Bowman, 2018; Nzo, 2019), short-sighted strategies (Aprile et al., 2019) and deprivation of the majority (Scott, 2013; Yeats & Lennon, 2014; Bolman & Deal, 2017).

In consideration to healthcare systems, literature points out that the associated impediments must be looked at in light of the collective nature of the healthcare systems (Yimer, 2015). In this regard, several scholars (Sørensen & Torfing, 2016; Rodić & Wilson, 2017; Koenig, 2020) argue that healthcare governance depends on the core tenets of legitimacy (democracy), voice, freedom of association, participation, and transparency which if not guaranteed, decision makers can never be held accountable (Arulrajah, 2016). Similarly, scholars (Sørensen & Torfing, 2016; Rodić & Wilson, 2017; Koenig, 2020) maintain that when the authorities exclude the community members from participating in decision-making processes the healthcare governance and delivery system governance will be severely undermined. According to Arulrajah (2016), non-participation of the communities in the governing structures of healthcare systems tends to cloud the important aspect of transparency and by extension good governance. In turn, Cilliers (2016) adds that the non-participation of stakeholders ruins community buy-in to the healthcare policies. Others argue that the high costs associated with participation impede effective healthcare governance (Anderson, 2011; Kohler & Martinez, 2015). In addition, Juiz & Lera (2014) find major snags to healthcare governance outcomes due to incapacities at the community and institutional levels, as well as the weaknesses of the

regulatory frameworks which may allow state actors to play a dominant role in the healthcare governance structures. Kohler and Martinez (2015) maintain a scenario of that nature has the potential to disempower the non-state actor stakeholders with the consequence that synergies for strengthening healthcare governance are lost.

Last but not least, Arulrajah (2016) maintains that weak legal systems coupled with the privation of the incentives for good institutional governance tend to diminish the efficacy of public managers. Hence, Juiz & Lera (2014) stresses the importance of building leadership capacity in order to improve healthcare governance. This suggests an incapacitated leadership cadre and human resources weaken the development and implementation of those policies that enhance the healthcare governance and delivery (Juiz & Lera, 2014). Having studied the major impediments to healthcare governance, the subsequent section discusses the methods that were used to provide the answers to the questions of this study.

RESEARCH METHODOLOGY

This study utilised a two-stage multimethod approach that comprised both the qualitative and quantitative strategies. The implementation of the multimethod allows different methods to be triangulated thus facilitating the discovery and validation of a comprehensive assortment of impediments of effective healthcare governance (Flowerdew, 2014; Howard et al., 2014; Rivkin et al., 2014). The first stage was a desktop research involving secondary literature search on the internet about the possible impediments or snags to effective healthcare system governance. The result of this exercise was then presented to six focus groups drawn from the healthcare ecosystem in Zimbabwe to identify the relevant impediments that mirrored the participants' experiences. This list of themes was then used to develop a questionnaire that was used to tape the performance of the Healthcare governance system from a wider group of stakeholders in the healthcare value chain in Zimbabwe. This second phase of the research was employed to collect the data to ascertain the prevailing impediments to effective healthcare governance in the fragile states. A description of the procedure is presented in the subsequent paragraph.

To complete the second stage of the research, respondents were purposively selected from the different healthcare delivery institutions in Zimbabwe's 10 administrative provinces. All in all, 338 respondents representing all the key constituencies of the national healthcare governance in Zimbabwe took part as indicated in the Table 1.

Table 1
COMPOSITION OF THE STUDY SAMPLE

Constituency	Number
Parliamentary committee on health members	9
Health service board commissioners	4
Ministry of Health principal directors	3
Provincial directors	6
Central hospital CEOs	4

District medical officers	16
District nursing officers	29
Council hospital managers	27
Health service and programme managers	31
Public health workers representatives	63
Private hospital and clinic managers	26
Health allied professions	54
Municipal health oversight councillors	66
Total number of respondents (Sample)	**338**

To identify and confirm the healthcare performance attributes, structured questionnaires were distributed electronically via the Google forms. After a 2 week waiting period, 297 responses were received giving approximately 88 % response rate. After the raw data was inspected for completeness, Statistical Package for Social Sciences (SPSS) software was applied firstly to perform exploratory factor analysis to isolate the latent constructs underlying a set of the measured questionnaire items and secondly to summarise and tabulate the central tendency measures to describe the data, namely, the mean and standard deviations. After this process, Confirmatory factor analysis (CFA) via structural equation modelling (SEM) was applied to evaluate the observed key experiences vis-à-vis the impediments to the effective healthcare governance in fragile states. CFA is a potent multivariate technique for verifying a factor structure of a set of theoretically observed variables (Kline, 2014; Brown, 2015; McNabb, 2015). The model fit was decided by the three widely applied indices, namely, Comparative Fit Index (CFI), Tucker-Lewis Index (TLI) and Root Mean Square Error of Approximation (RMSEA). The CFI, TLI and RMSEA had to be in the recommended ranges, that is, CFI>=0.90, TLI>=0.90 and RMSEA<0.80 (Brown, 2015; McNabb, 2015). In addition, the Cronbach alpha Test was applied to determine the reliability of the observed impediments to effective healthcare governance in fragile states. The next section focuses on the findings that came out of this research.

FINDINGS

The subsequent sections present the research findings from the both the qualitative and quantitative stages of the study. The first qualitative stage was instrumental in generating the reference governance constructs and therefore the governance attributes whose performance was then gauged in the second quantitative stage of the research endeavour. Table 2 shows a summary of the themes that were extracted from the exploratory factor analysis of the collected data in this multimethod research.

Table 2
GOVERNANCE ATTRIBUTES PERFORMANCE

Scale and Subscales	N(Items)	$\bar{\mu}$	$\bar{\sigma}$	$\bar{\alpha}$	CFI	TLI	RAMSEA
Justice-Based Leadership	5	1.434	1.023	0.724	0.921	0.936	0.074
Leadership legitimacy	4	1.317	0.984	0.808	0.901	0.912	0.067
Shared leadership responsibility	9	1.413	0.887	0.886	0.947	0.899	0.070
Leadership probity	6	1.322	1.006	0.713	0.907	0.908	0.054
Vision and mission clarity	5	1.331	1.201	0.779	0.900	0.916	0.067
Administrative efficiency	4	1.478	0.990	0.907	0.961	0.880	0.073
Performance oriented culture	5	1.294	2.013	0.822	0.990	0.896	0.069
Transparency and predictability	6	1.217	1.070	0.793	0.904	0.905	0.029
Ethical decision-making	5	2.608	1.711	0.820	0.900	0.918	0.066
Independent institutions	7	1.602	0.892	0.788	0.896	0.974	0.071
Delegation of decision-making authority	4	2.199	1.222	0.714	0.943	0.937	0.012
Leadership accountability	5	2.376	0.769	0.846	0.911	0.950	0.047
Regulatory quality	7	2.803	1.112	0.792	0.900	0.933	0.068
Systemic rent-seeking and fraudulent behaviour	4	3.573	0.907	0.901	0.894	0.941	0.017
Overall Performance	**81**	**1.466**	**1.040**	**0.815**	**0.920**	**0.920**	**0.058**

Analysis was done on the themes as in Table 1. using the overall mean score of the responses on a five-point score scale, where 1 implied that the attribute was not met at all, 2 implied mediocrities in meeting the attribute, 3 (midpoint) implied the attribute was to a degree met, 4 implied the attribute was satisfactorily met and lastly, 5 meant the attribute was effectively met. The following healthcare governance performance attributes were revealed in the study:

The average mean score for justice-based leadership (1.434) was smaller than the mid-point of the measurement scale thereby indicating that on average the attribute of justice-based leadership experienced in Zimbabwe's healthcare delivery system was unsatisfactory as to support the effective governance of the healthcare system. The comparative fit index (CFI)=0.921, the Tucker-Lewis fit index (TLI)=0.936, and the RMSEA=0.074 indicated a good fit between the model and the survey data. In addition, the Cronbach's alpha, α =0.724 revealed sufficient reliability of measurement scale thus showing that justice-based leadership deficiency in fragile states was responsible for the observed ineffectiveness in their healthcare system governance. This finding is in line with Fischer and Friedman (2014) articulation that leadership in organizations should be trust-based and rule based to be effective.

As well, the overall mean value for leadership legitimacy (1.317) was much lesser than the mid-point of the measurement ranges on the scale thereby indicating that on average the attribute of leadership legitimacy was by no means acceptable. In turn, the comparative fit index (CFI)=0.901, the Tucker-Lewis fit index (TLI)=0.912, and the RMSEA=0.067 pointed toward a good fit concerning the model and the observed data. As well, the Cronbach's alpha, α=0.808 showed acceptable reliability thereby implying that on average, deficit in leadership legitimacy dogged healthcare governance in Zimbabwe and also suggesting that deficiency in leadership legitimacy impeded effective healthcare governance in fragile states and low income countries. This clearly suggests that when there is perceived illegitimacy on the constitution of the system leadership, there is also a high likelihood that the healthcare system governance would be undermined because the involved leaders would not typically be able to marshal the requisite power and authority to run the healthcare institutions. This finding is in conformity with the earlier findings that suggest that leadership legitimacy is the basis upon which good governance can be strengthened and sustained (Levy, 2015; Rothstein & Varraich, 2017; Jagers et al., 2020).

Likewise, the results show that on average the mean score for the element of shared leadership responsibility among the healthcare governance structures (1.413) was well under the mid-point of the measurement scale. This suggested that, on average, there were ambiguities relating to the healthcare system leadership structures in Zimbabwe. Also, the comparative fit index (CFI) =0.947, the Tucker-Lewis fit index (TLI) =0.899, and the RMSEA =0.070 indicated a good fit between the model and the observed data. In addition, the Cronbach's alpha, α =0.887 showed acceptable reliability in so doing indicating average ambiguities regarding the issue of shared leadership responsibility among the diverse healthcare systems governance structures in Zimbabwe. Without doubt, therefore, the absence of shared leadership responsibility undermines the healthcare system governance in fragile states and low income countries (Greer et al., 2016; Poli, 2019; Jagers et al., 2020).

In addition, the average mean value for leadership probity (1.322) was way lower than the mid-point of the range thus demonstrating unsatisfactory levels of leadership probity in the implementation of the healthcare system governance in Zimbabwe. Besides, the comparative fit index (CFI)=0.907, the Tucker-Lewis fit index (TLI)=0.908, and RMSEA=0.067 indicated a good fit relating to the model and the experimental data. Moreover, the Cronbach's alpha, α =0.713 exhibited satisfactory reliability and so indicated that on average there were rampant instances of leadership impropriety within the healthcare system in Zimbabwe to assure effective governance. Therefore, privation of leadership probity in fragile states destabilises the effectiveness of healthcare system governance. Obviously, lack of leadership probity is associated with the erosion of stakeholder trust thereby undercutting the ability of incumbent leaders to effectively govern the healthcare delivery institutions. This finding falls well within the findings of Rodić & Wilson (2017) and also Bolman and Deal (2017) who found that unethical and dishonesty tendencies among leaders are the main sources of poor governance of public goods.

Additionally, the results indicate that the mean value for the vision and mission clarity attribute was lower than the mid-point of the range thereby signifying that the members of the healthcare governance system in Zimbabwe were doubtful about their vision and mission within the health delivery system. Also, the comparative fit index (CFI)=0.900, the Tucker-Lewis fit index (TLI)=0.916, and the RMSEA=0.054 indicated a good fit between the model and the observed data. In addition, the Cronbach's alpha, α=0.779 demonstrated adequate reliability thus

indicating that on average there was widespread ambiguity on the health governance system vision and mission. On this basis, it can be inferred that vision and mission ambiguity is yet another impediment to effective healthcare system governance in fragile states. This finding conforms to the findings of Ebrahim et al. (2014) who earlier established that vision and mission drift indicts the governance in hybrid organizations.

In terms of administrative efficiency, the mean score (1.478) was way lower than mid-point of the range demonstrating on average, a much lower capacity to perform administrative roles in an efficient manner. Besides, the comparative fit index (CFI)=0.961, the Tucker-Lewis fit index (TLI)=0.880, and the RMSEA=0.069 pointed out a good fit between the model and the observed data. In addition, the Cronbach's alpha, α =0.907 confirmed passable reliability consequently indicating that administrative inefficiency is another impediment to effective healthcare system governance in fragile states. Indeed, an inefficient administrative function naturally undercuts the smooth implementation of the healthcare governance system. Scholars (Da-Cruz & Marques, 2017; Mollah, 2020) have similarly found that fragile governance systems are characterised by inefficient administrative structures.

Similarly, the mean value for performance oriented culture (1.294) was lower than the mid-point of the range meaning the healthcare system in Zimbabwe was marked by the absence of a performance oriented culture. The results also indicated a good fit between the model and the observed data as reflected by the comparative fit index (CFI)=0.990, the Tucker-Lewis fit index (TLI)=0.896, and the RMSEA=0.073 that were above the recommended thresholds (Kline, 2014; Dimitrov, 2014; Xia, 2016). This combined with the sufficient Cronbach's alpha, α =0.822 established that effective healthcare governance in fragile sates is likely to be undermined by a deficit of a performance oriented culture in the system. According to Juiz & Lera (2014) the absence of performance-oriented culture among governing structures in healthcare remains one of the major snags to healthcare governance outcomes.

Furthermore, the mean score for transparency and predictability (1.217) was much smaller than mid-point of the range thereby indicating an insignificant amount of transparency and uncertainty in Zimbabwe's healthcare system. Yet another snag to efficient and effective healthcare governance. Also, the comparative fit index (CFI)=0.904, the Tucker-Lewis fit index (TLI)=0.905, and the RMSEA=0.029 indicated a good fit between the model and the observed data. In addition, the Cronbach's alpha, α =0.793 confirmed acceptable reliability therefore indicating that the absence of transparency and predictability is another impediment to effective healthcare system governance in fragile states. This finding corroborates the findings of other studies (Da-Cruz & Marques, 2017; Mollah, 2020) which give prominence to the role of transparency and predictability in strengthening the governance of public goods.

Furthermore, the mean score on ethical decision-making (2.608) was somewhat lesser than the mid-point of the measurement scale thereby showing the existence of unethical decision-making processes in Zimbabwe's healthcare system. With the comparative fit index (CFI)=0.904, the Tucker-Lewis fit index (TLI)=0.905, and the RMSEA=0.029 indicating good fit between the model and the observed data and also the Cronbach's alpha, α =0.793 indicating acceptable reliability of the experimental data, it became clear that unethical decision-making causes the observed ineffective healthcare governance in fragile states. This finding is consistent with the finding in earlier studies (Shen, 2016; Bowman, 2018; Nzo, 2019) which are clear on the negative effects of unethical decision-making processes on the governance of healthcare delivery systems.

Also, the results showed that on average, the mean score for the independent institutions attribute of governance (1.602) was lower than mid-point of the range suggesting that the issue of independent institutions was generally disregarded in Zimbabwe's healthcare system. Besides, the comparative fit index (CFI)=0.896, the Tucker-Lewis fit index (TLI)=0.974, and the RMSEA=0.071 confirmed a good fit between the model and the observed data. In addition, the Cronbach's alpha, α =0.907 confirmed passable reliability. These results in conformity with Arulrajah (2016) were indicative that the absence of independent institutions is one of the impediments confronting effective healthcare governance in fragile states.

Also, it was found that the average mean score describing the delegation of decision-making authority (2.199) was slightly better than pedestrian but all the same below the mid-point of the range. This signalled that on the whole the healthcare governance practice in Zimbabwe was not designed to allow the delegation of decision-making authority. As well, the comparative fit index (CFI)=0.943, the Tucker-Lewis fit index (TLI)=0.937, and the RMSEA=0.012 confirmed a good fit between the model and the observed data. In addition, the Cronbach's alpha, α =0.714 confirmed satisfactory reliability. These results thus indicated the centralization of decision-making authority as an impediment of an operative healthcare governance system in fragile states (Anderson, 2011; Kohler & Martinez, 2015).

The overall mean score for leadership accountability (2.376) was somewhat sounder than mediocre but nonetheless smaller than the mid-point of the measurement ranges. This indicated that the practice of leadership accountability was poor in the healthcare governance system of Zimbabwe. In addition, the comparative fit index (CFI)=0.911, the Tucker-Lewis fit index (TLI)=0.950, and the RMSEA=0.047 proved a good fit between the model and the observed data. Additionally, the Cronbach's alpha, α =0.846 validated satisfactory reliability of the data. The CFA indices as well as the reliability test thus indicate poor leadership accountability as an impotent impediment of healthcare governance in fragile states. This is consistent with the findings of earlier studies (Sørensen & Torfing, 2016; Rodić & Wilson, 2017; Koenig, 2020) which correlate leadership accountability with the level of governance effectiveness.

As well, the average mean score for regulatory quality (2.803) was marginally under the mid-point of the range thereby implying that the attribute of regulatory quality was low to support effective healthcare governance in Zimbabwe's health delivery system. The comparative fit index (CFI)=0.900, the Tucker-Lewis fit index (TLI)=0.933, and the RMSEA=0.068 demonstrated a good fit between the model and the observed data. Furthermore, the Cronbach's alpha, α =0.792 validated satisfactory reliability of the data. This suggested that weak regulatory regimes in fragile states impede effective healthcare governance. This also reflected in the findings of Arulrajah (2016) who also found that lower regulatory quality impedes good institutional governance.

Lastly, the average mean score for systemic rent-seeking and fraudulent behaviour (3.573) was slightly above the mid-point of the range which in turn was revealing that corrupt practices were rampant within the healthcare system in Zimbabwe. As well, the comparative fit index (CFI)=0.896, the Tucker-Lewis fit index (TLI)=0.974, and the RMSEA=0.071 confirmed a good fit between the model and the observed data. In addition, the reliability test, α =0.907 was satisfactory. Combined, these indices confirmed rent-seeking and fraudulent behaviour is a major drawback to effective healthcare governance in fragile states. Scholars (Rodić & Wilson, 2017; Koenig, 2020) also acknowledge the negative impact of systemic rent seeking and fraudulent behaviour on the effectiveness of healthcare governance in developing countries.

CONCLUSION

The findings of the study indicated that there are a significant number of impediments inhibiting effective healthcare governance in fragile states. Most of such impediments have their roots in the ability of the leaders to display the core tenets of performance oriented culture in relation to ethical, transparent and accountable leadership which are essential for promoting predictability and therefore efficient administration and regulation of the healthcare institutions in fragile states. The study has some important practical implications for the fragile states especially regarding the upholding of the tenet of independent institutions to adjudicate the conflict between self-interest and the greater good. Thus, the healthcare leaders in fragile states need to practice the art of open communication, consultation, transparency and accountability as well as subject themselves to rule-bound decision-making processes so as to advance effectiveness in healthcare governance. Only by addressing these impediments to effective healthcare governance can fragile states with limited resources be able to ensure equitable access to healthcare to the majority of their citizens. The study has some limitations. Data was collected from only one fragile state, Zimbabwe, thus limiting the extent to which the findings of this study can be generalizable to the rest of the fragile states in the world. Future researchers can replicate this study by including more fragile states across the world to make comparisons on the impediments of healthcare in fragile states.

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