THE INTERNATIONAL JOURNAL OF BUSINESS & MANAGEMENT

Clinical Governance and Organizational Effectiveness: A Comparative Study of Public and Private Hospitals in Ghana

Bernard Nmashie Nmai
Lecturer, Department of Business Administration, University of Professional Studies, Accra, Ghana
Marco Elikem Mensah
Assistant Lecturer, Department of Business Administration, University of Professional Studies, Accra, Ghana
Eric Delle
Lecturer, Department of Business Administration, University of Professional Studies, Accra, Ghana

Abstract:
Clinical governance is required to ensure the effectiveness of healthcare institutions in every economy. We sought to examine empirically the extent to which clinical governance relate to organizational effectiveness in healthcare institutions in Ghana as well as investigate difference in clinical governance and organizational effectiveness between public and private sector hospitals. Cross-sectional survey design was utilized in which data were collected from 143 respondents from public and private hospitals within the Greater Accra Metropolis of Ghana via reliable questionnaire. The hypotheses were tested using inferential statistical tests such as Pearson Product-Moment correlation and Independent t-test. It was revealed that clinical governance related significantly and positively to organizational effectiveness. It was also found that private hospitals were more effective than public hospitals. However, there was no significant difference in clinical governance between public and private hospitals in Ghana. The findings were consistent with clinical governance theories. The implications for the development of an effective clinical governance structure in healthcare institutions have been discussed.

Keywords: *Clinical governance, organizational effectiveness, public, private, hospital, Ghana*

1. Introduction

1.1. Background of the Study

Healthcare institutions are important settings for the provision of quality health care services for patients and a country. The changing nature of the healthcare environment requires that healthcare institutions either public or private lead within organizational systems to fulfil regulatory, health consumer (patient), family, physician and staff expectations, and provide excellence services across care environments (Parsons & Cornett, 2011; The Kings Fund, 2011; Patton & Pawar, 2012). Corporate governance has been conceptualized as clinical governance in the healthcare environment with clinical governance reported to be associated with organizational effectiveness or performance (Love, 2011).

According to Parker (2006) the premise of clinical governance is that, healthcare institutions should not just be well-managed but run effectively and internally regulated, both formally and informally. Within the care environment, clinical governance ensures that there is information sharing, idea generation for improving health consumer care, consensus building between health team members, fostering individual accountability and increasing team responsibility (Chiarella, 2008; Beglinger, Hauge, Krause & Ziebarth, 2011; Newman, 2011; Swanson & Tidwell, 2011). When implemented well, clinical governance will ensure that health care institutions whether public or private provide health services that are both safe and of a high quality.

The manner in which health care services are provided by Ghanaian health institutions has become a major source of worry with many questioning the relevance of such institutions. Previously viewed as life-saving institutions, now most Ghanaians see these institutions are death grounds. However, given that clinical governance has been found to guarantee effectiveness of healthcare institutions, the present study seeks to investigate in the context of Ghanaian health sector the relationship between clinical governance and organizational effectiveness, and also ascertain difference in clinical governance and organizational effectiveness between public and private hospitals in Ghana.

1.2. Problem Statement

Research shows that interest in healthcare organization-based studies has dropped significantly in the past few years (Davies, 2003). Specifically, researches on hospital as a social organization which is a central focus of medical sociology has experienced low interest in the last thirty years (Freidson, 1970). Interest in healthcare environment-based research with focus on clinical governance has increased among scholars outside the realms of sociology (Davies, 2003). Literature shows that of all hospitals in the United States the top one hundred performers in year 2000 had consistently better clinical outcomes- that is, fewer complications and mortalities (Bolman, 1991). In addition, these hospitals were found to perform better financially with lower expenses and higher profit margins, they treated more patients and sicker patients. These findings, which arose from unwavering commitment to improving safety and quality were associated with clinical governance (Bolman, 1991).

High commitment to clinical governance would reduce cost and bring positive financial benefits to hospitals. Researchers in the US reported that if all hospitals will adhered to clinical governance principles, they would perform at the same standard as the top one hundred health care institutions and hence reduce adverse events and achieve annual cost savings of 12 billion US dollars. Similarly, the National Health Service (NHS) in the United Kingdom has reported that improvements in the health system were associated with commitment to clinical governance (Leatherman & Sutherland,). At the moment, there is no evidence of empirical research report of the link between clinical governance and organizational effectiveness in the Ghanaian healthcare environment as well as a comparative study of clinical governance and organizational effectiveness in this context. Thus, the present study seeks to fill this gap.

1.3. Objectives of the Study

The study specifically seeks to;

1. Investigate the relationship between clinical governance and organizational effectiveness
2. Examine difference in clinical governance between public and private hospitals
3. Ascertain whether a difference in organizational effectiveness exist between public and private hospitals

2. Literature Review

2.1. Theoretical Framework

Theories such as agency, stewardship and stakeholder would be used to discuss the theoretical relationship between clinical governance and organizational effectiveness.

2.2. Agency Theory

Agency is a contract under which one or more persons (principals) engage other persons (agents) to perform some services on their behalf that involves delegating some decision-making authority to the agents (Jensen & Meckling, 1976). It is an accepted fact that the principal-agent theory is generally considered the starting point for any debate on the issue of corporate governance emanating from the classical thesis on The Modern Corporation and Private Property by Berle and Means (2002). According to classical thesis, the fundamental agency problem in modern firms is primarily due to the separation between finance and management. Modern firms are seen to suffer from separation of ownership and control and therefore are run by professional managers (agents) who cannot be held accountable by dispersed shareholders.

2.3. Stakeholder Theory

Healthcare institutions have numerous stakeholders such as patients, governments, creditors, bankers, etc. Thus, the effectiveness of healthcare institutions would largely be measured by how well they provide quality and safe services to their stakeholders and in particular patients whose satisfaction is usually used as a measure of the effectiveness or performance of these institutions. Accordingly, stakeholder theory of clinical governance highlights the various constituents of an institution whether formal or informal. John and Senbet (2004) advanced that there are many parties with competing interests in the operations of healthcare institutions who naturally would want their needs met by such institutions. They also stressed the role of non-market mechanisms such as the size of the board, committee structure as importance to firm performance or effectiveness. Against this backdrop, the incorporation of clinical governance with its aim to ensure the delivery of safe and quality healthcare services would ensure that hospitals are effective.

2.4. Stewardship Theory

According to the stewardship theory, a manager's objective is primarily to maximize the firm's performance because a manager's need of achievement and success are satisfied when the firm is performing well (Donaldson & Davis, 1991; Davis, Schoorman & Donaldson, 1997; Muth & Donaldson, 1998). In inference to this theory, clinical governance would provide the right framework for the effective discharge of healthcare services so that the key objectives and aspirations of healthcare institutions would be met.

2.4.1. Origin of the Concept of Clinical Governance

The term 'clinical governance' evolved out of the term 'corporate governance', a popular term in the world of business with its purpose to ensure corporate legal protection (McSherry & Pearce, 2002). Within the context of healthcare institutions it was observed that corporate governance only addressed the 'non-clinical' aspects of healthcare provision and that to gain total corporate 'management,' 'clinical' governance instead of corporate governance was required (McSherry & Pearce, 2002). Reports suggested

that the call for clinical governance was premise on the assumption that "the professional competence of the medical profession was the best guarantee of an acceptable level of medical care" had been increasingly questioned (Malin, Wilmott & Manthorpe, 2002: 127). For example, complaints such as decline in clinical standards, service provision and delivery, reinforced by the media coverage at the time of clinical failures (Harvey, 1998; Scally & Donaldson, 1998; Swage, 2000) necessitated the incorporation of clinical governance in healthcare institutions.

2.5. The Concept of Clinical Governance

Several definitions of clinical governance have been proposed in literature. For example, the Department of Health (1998b:33) defined clinical governance as 'A framework through which national health service organizations are accountable for continuously improving the quality of their services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish.' This definition was criticised for likening clinical governance terms such as supremacy, domination, power or authority and the fact that it was not clear in the definition who was doing the governing and who is to be governed. Further, the description of clinical governance as a process was another contentious issue (Department of Health, 1998: 1:1.2). However, the concept can be viewed as part of a new approach to quality (Department of Health, 1998b; Kings Fund, 1999), an organizational innovation (Walshe et al., 2000), an integrated approach with organization-wide implications (Som, 2004), a framework (Halligan & Donaldson, 2001), and a system to improve quality care that will facilitate excellence (Campbell et al., 2002).

The central premise of clinical governance is safe and quality health care. Within this mindset, clinical governance has given all health organizations a statutory duty to seek quality improvements in health care within their own organizations. Precisely, Scally (1999; 2000) expressed that clinical governance reporting should include some research on the effectiveness of clinical governance and its impact on the culture and creation of best practice. Studies to support the impact of clinical governance on quality improvement had been carried out. Thomas (2003) examined published literature and reported that there was little published works showing evidence of how clinical governance has made measurable difference in quality improvement. He reviewed 335 papers and found 114 potentially relevant with 10 attributing changes in quality to clinical governance directly. Of these, only three attempted to provide data to support the assertion (Thomas, 2003:251).

2.5.1. The Concept of Organizational Effectiveness

Organizational effectiveness is one construct that has attracted research attention in organizational behaviour and management literature. An organization is effective to the extent that it has achieved its objectives or goals at the organizational level (Cameron & Whetton, 1983; Quinn & Rohrbaugh, 1983).

Organizational effectiveness has been defined as the extent to which an organization fulfils its objectives (Thibodeaus & Favilla, 1995). The term effectiveness refers to the achievement of the formal objectives of services of the organization (Boyne, 2003). We refer to *perceived effectiveness* as the extent to which citizens perceive an organization to be capable and effective accomplishing its core mission. The concept of organizational effectiveness emphasizes process control, information management and goal setting (Quinn, 1998; Denison, Haaland & Goelzer, 2004). Thus, in the healthcare setting, effectiveness is attained when safe and quality health service is delivered, equipment and materials to provide better healthcare is available and the general healthcare environment is right for the provision of continuous improved health service. Since organizations and their mission vary, the measure of organizational effectiveness takes into account the organization and what they are into to determine indicators or what constitutes effectiveness. Thus, researchers have indicated that measurement of organizational effectiveness is an important step in the development of an organization (Handa & Adas, 1996). Its importance in designing and establishing an effective organization has been discussed by scholars.

Difference in organizational effectiveness between public and private sector organizations has been explained in literature. According to the property right theory, the main reason why private organizations (as opposed to public organizations) have an inherent incentive to improve the quality and productivity of services (Alchian & Demsetz, 1972; Clarkson, 1972). Further, funding of public organizations' depends on political decisions, whereas private organizations funding depends on how the organization is performing in the market. The effectiveness of public and private sector organizations is explained by public choice theory. This theory states that as opposed to public organizations, private sector organizations have an incentive to accommodate the interests of consumers and the quality of service (Boyne, 1998; Chubb & Moe, 1988). In addition, public sector organizations have been reported as characterized by high level of burdensome administrative rules and procedures that has a negative effect on performance (Bozeman, 1993). Similarly, public sector organizations are associated with high levels of red tapeism (Rainey & Bozeman, 2000).

2.5.2. Empirical Literature

A review on literature on clinical governance shows that there is no available Ghanaian empirical study neither is there African-based empirical evidence reported on clinical governance. For example, Walshe (2000) reported that although there is support for the concept of clinical governance in literature, the implication of it was found to be hindered by available resources, time and skills. Thus, the problem appeared to by lack of structures and strategies than leadership, information systems and analysis of practice.

Wallace et al (2001a; 2001b) carried out a study involving senior managers in Trusts. In their study, they used postal survey and interviews to investigate attitude towards clinical governance. They found that attitude towards clinical governance was undecided and that many Trust leaders utilized clinical governance as a new label for staff development activities. Another study was conducted in England specifically from the Centre of Healthcare Management, University of Manchester to examine progress of implementing

clinical governance and the impact of clinical governance initiative (Walshe et al., 2003). The study involved a survey of 270 Trusts who were given questionnaire to complete. The questionnaire which was completed by individuals at varying levels within the organizational hierarchy in National Health Service Trusts yielded 100% response rate (Walshe et al., 2003:11). The result which involved both qualitative and quantitative data showed that clinical governance was well established and embedded at the corporate level of hospital Trusts, with many regarding having systems and structures in place as being sufficient. Despite this, evidence suggests that "existing systems are fragmented, far from comprehensive in their coverage and of very mixed effectiveness" (Walshe et al. 2003:39). In addition, it was observed that the costs of the implementation of clinical governance were not generally known, as there was a considerable variation in the figures given and in what had or had not been included.

In an earlier study, Walshe et al (2001) purely qualitative in nature in which they explored the use of external approaches to quality improvement in health care organizations in one region, reported that preparing for reviews was a substantial and time-consuming task, but overall did not generate wholly new knowledge and did not lead to major new policy change. They also found that there was little research on the effectiveness of external quality reviews, and that more attention to the design and impact of external review would help maximize its benefits and minimise costs and adverse effects. The study involved personal and telephone interviews with senior managers and clinicians of 47 National Health Service Trusts in the West Midlands in which the impact of external reviews of clinical governance was investigated.

Grainger *et al.* (2002) carried out a cross-sectional qualitative study based on in-depth interviews and observation of 43 acute and non-acute Trusts in the West Midlands region in order to determine the rating of the Trusts' competencies across five areas of clinical governance. 'Turbulent' environments were found in three-quarters of the Trusts in the study, but it was stated that the 'top team' Trusts exhibited characteristics of clear leadership, a recognition of both clinical and managerial components in clinical governance, senior team vision and a facilitative approach. It was found that there was a focus on the patient, an open culture, minimal blame and collaborative working with the Health Authority and access to resources present in the 'top team' Trusts. The study concluded that there must be attention paid to resources and to the organizational and cultural environment within Trusts if high quality clinical governance was to become the norm. Nevertheless, one might wonder whether these Trusts would still do well with these components anyway, if good leadership were apparent. Peak *et al.* (2005) utilized a case study methodology to investigate one hospital Trust on the core functions of clinical governance. They reported that a description of the implementation of clinical governance using a self-developed theoretical model was an example of a robust system for clinical governance implementation. However, their study did not show evidence of the link between clinical governance and improve patient care.

Other researchers also focused on attitude towards clinical governance. Murray et al. (2004) investigated knowledge and attitudes towards clinical governance among 539 staff in the South of England using questionnaire survey. The questionnaire focused on audited clinical governance implementation and identified the training needs of staff and managers. The result showed that there were varying knowledge about clinical governance, but attitude towards clinical governance was generally positive. In a quantitative research, Freeman's *et al.* (1999) utilized self-completed postal questionnaire to provide a baseline assessment of the early progress and development of clinical governance across thirty-nine Trusts in the South West region. It was found that despite some early progress made in establishing structures, there was a considerable way to go below board and sub-board level in linking clinical governance to existing systems. The main barriers to implementation were seen as resource issues and the need for a change in culture, and a view that this organizational culture cannot be changed to 'order.' Issues around organizational hierarchies, clinician-manager relationships, difficulties in changing clinical practice and the need for interventions at all levels to facilitate the necessary changes were apparent.

2.5.3. Research Hypotheses

Based on the above specific objectives, the following hypotheses have been developed:

1. Clinical governance will relate significantly and positively to organizational effectiveness
2. Private hospitals will have a significantly better clinical governance compared to public hospitals
3. Private hospitals will be significantly effective than public hospitals

3. Methodology

3.1. Research Design

Cross-sectional survey design was used investigate difference in clinical governance and organizational effectiveness between public and private hospitals and also to ascertain the relationship between clinical governance and organizational effectiveness with data collected at a single point in time via questionnaire. The study followed the quantitative research approach because numeric data were collected via reliable questionnaire. In addition, hypotheses were tested using inferential statistical test such as Pearson Product-Moment correlation.

3.2. Sample Size and Sampling Procedure

The study comprised 143 respondents drawn from two hospitals (1 public and 1 private hospital) within the Greater Accra Metropolis. We utilized non-probability sampling methods to select the hospitals and respondents. Specifically, convenience sampling method was used to select the hospitals and respondents. Thus, hospitals that were close and were interested in the study were selected. In addition, respondents who were around at the time of data collection, and had time to complete the research instrument were selected. The

sample was heterogeneous in nature comprising respondents of different demographic composition. The distribution of the sample along demographic factors is presented in Table 1.

Variables		Frequency	Percent (%)
Sex:	Male	67	46.9
	Female	76	53.1
Tenure:	5years and below	81	56.6
	6 to 10years	35	24.5
	11years and above	27	18.9
Education:	DBS	3	2.1
	HND	24	16.8
	First degree	42	29.4
	Master's degree	9	6.3
	PhD	1	0.7
	Medical Doctor	14	9.8
	Diploma in Nursing	33	23.1
	Degree Nursing	17	11.9
Job position:	Managerial	41	28.7
	Non-managerial	102	71.3
Hospital type:	Public	95	66.4
	Private	48	33.6
Total Number of Respondents (N=143)			

Table 1: Sample Characteristics of Respondents

Analysis of demographic information showed that the sample was made up of 53.1 percent females and 46.7 percent males. In terms of tenure, it was observed that the study was dominated by respondents who had worked for 5years and below (56.6%). In addition, the majority of respondents had First degree qualification (29.4%). Further, the study was dominated by non-managers (71.3%) and respondents from public hospital (66.4%).

3.2.1. Instrumentation

Questionnaire was developed and used measure clinical governance. The design of the questionnaire was done following extensive review of corporate governance literature. Clinical governance was measured with 27-items. The scale measures five dimensions of clinical governance: hospital board functions (6-items); internal audit (4-items); hospital compliance (5-items); code of clinical governance (6-items); and hospital structure (6-items). All the items were anchored on a 5-point Likert scale ranging from strongly agree (5) to strongly disagree (1). Reliability analysis was performed for this scale and all the dimensions were found to have reliability coefficients exceeding the acceptable threshold of 0.70 (Nunnally, 1978). The following Cronbach alpha values were obtained for the dimensions of clinical governance in this study: corporate governance hospital board function (α=.808), corporate governance internal audit (α=.752), corporate governance hospital compliance (α=.851), code of corporate governance (α=.835), and corporate governance hospital structure (α=.867). Sample items on the scale included: "the board regulates hospital procedures, processes and systems of monitoring", "In this hospital, internal audit is independent in its responsibilities and functions across departments" etc.

Organizational effectiveness was also measured using a developed scale. The scale contains 10-items anchored on a 7-point Likert scale ranging from strongly agree (7) to strongly disagree (1). Test of reliability showed that this scale has an acceptable coefficient of .903. Sample items on the scale included: "provision of quality healthcare to patients is vital in this organization", "In this hospital, human resource development is important" etc.

3.2.2. Data Collection Procedure

We obtained permission from the two hospitals through the Human Resource Units. Officially, we send a letter introducing the purpose of the study and the use the data would be put to. After permission was granted, we proceeded to administer questionnaire to respondents who willingly consented to complete the survey instrument. The questionnaire contains specific instructions regarding how each respondent was to complete it. Instructions such as confidentiality, anonymity, voluntary participation and informed consent were all provided on the face of the questionnaire. Each respondent was entitled to complete one survey packet. Out of the 200 questionnaires administered, 143 were retrieved and used for the analysis producing a response rate of 71.5 percent. Data collection was done within one month.

4. Results

This study investigated the relationship between clinical governance and organizational effectiveness using public and private hospitals in the Greater Accra metropolis. Specifically, the study examined the relationship between dimensions of clinical governance and organizational effectiveness and also to ascertain difference in clinical governance between public and private hospitals.

4.1. Hypotheses

1. Clinical governance will relate significantly and positively to organizational effectiveness
2. Private hospitals will have significantly better clinical governance compared to public hospitals
3. Private hospitals will demonstrate significantly high level of organizational effectiveness than their public counterparts

Results of the first hypothesis which stated that "clinical governance will relate significantly and positively to organizational effectiveness" is presented in Table 4.1.

1	2
Clinical governance	-
Organizational effectiveness	.649**

Table 2: Bivariate Correlation between Clinical Governance and Organizational Effectiveness

As shown in Table 2, a statistically significant positive relationship was found between clinical governance and organizational effectiveness (r=.649, p=.000). This implies that the presence of clinical governance was significantly associated with increased organizational effectiveness.

Result for hypothesis 2 which stated that "Private hospitals will have significantly better clinical governance compared to public hospitals" is presented in Table 3.

Variables	**N**	**Mean**	**SD**	**df**	**t**	**Sig.**	**Eta Sq**
Public	95	99.435	14.361	141	-.474	.637	.002
Private	48	100.875	18.096				
Total	143						

Table 3: Summary of Mean, Standard deviation score and Independent t-test Results of Difference in Clinical Governance between Public and Private Hospitals

The result in Table 3 indicates that no statistically significant difference in clinical governance exist between public and private hospitals [$t_{(141)}$ =-.474, p=.637]. Thus, the hypothesis that private hospitals will have significantly better clinical governance (M=100.875, SD=18.096) compared to public hospitals (M=99.435, SD=14.361) was not supported. In terms of effect size, sector of organization accounted for a very small effect size on clinical governance (Cohen, 1988).

Result of the final hypothesis which stated that "Private hospitals will demonstrate significantly high level of organizational effectiveness than their public counterparts" is presented in Table 5.

Variables	**N**	**Mean**	**SD**	**df**	**t**	**Sig.**	**Eta Sq**
Public	95	51.821	10.531	141	-2.361	.020	.038
Private	48	56.250	10.712				
Total	143	108.071	21.243				

Table 5: Summary of Mean, Standard deviation score and Independent t-test Results of Difference in Organizational Effectiveness between Public and Private Hospitals

The result in Table 5 suggests that a statistically significant difference in organizational effectiveness exist between public and private hospitals [$t_{(141)}$ = -2.361, p=.020]. Thus, hypothesis 3 is supported. This implies that private hospitals are more effective (M=56.250, SD=10.712) than public hospitals (M=51.821, SD=10.531). The eta squared value showed that, sector of organization contributed 3.8 percent of the variance in organizational effectiveness. Following Cohen's (1988) prescription, it is clear that the effect size was small.

4.2. Discussion of Findings

An effective healthcare institution is a desirable one because it satisfies the health needs of society. The present study sought to examine the relationship between clinical governance and effectiveness of health care institutions and also determine difference in clinical governance and effectiveness between public and private hospitals within the Greater Accra Metropolis. As expected, the first hypothesis which stated that clinical governance will relate significantly and positively to organizational effectiveness was supported. This finding corroborated existing literature (Campbell et al., 2002; Harvey, 1998; Scally & Donaldson, 1998; Swage, 2000; Thomas, 2003). Making clinical governance an integral part of healthcare institutions was relevant in ensuring the provision of safe and quality healthcare services (Campbell et al., 2002). In addition, clinical governance in healthcare environment facilitated improved quality healthcare service (Thomas, 2003) while other researchers reported that the design and implementation of clinical governance resulted in improvement in clinical standards, service provision and delivery (Harvey, 1998; Scally & Donaldson, 1998; Swage, 2000).

Contrary to the expectation of the study, the hypothesis that private hospitals will have significantly better clinical governance compared to public hospitals was not supported. This finding is consistent with previous research outcomes (Harvey, 1998; Scally &

Donaldson, 1998; Swage, 2000). Healthcare institutions, public or private have some form of governance structure which directs the flow of activities. Since the design and implementation of clinical governance into healthcare institutions was occasioned by decline in clinical standards and service provision, it is not surprising that no significant difference in clinical governance was found between public and private hospitals in this study (Harvey, 1998; Scally & Donaldson, 1998; Swage, 2000).

In addition, the study confirmed the hypothesis that private hospitals will demonstrate significantly high level of organizational effectiveness than their public counterparts. This finding is consistent with previous literature (Alchian & Demsetz, 1972; Boyne, 1998; Clarskon, 1972; Chubb & Moe, 1988).

Literature reports that in terms of effectiveness, private sector organizations are better than public organizations because public sector organizations are characterized by burdensome administrative rules and procedures that has negative effect on performance (Bozeman, 1993) as well as high levels of red tapeism (Rainey & Bozeman, 2000) while private sector organizations have less stressful administrative procedures and rules. Similarly, private sector organizations accommodate the interest of consumers and focus on quality service compared to public sector organizations (Boyne, 1998; Chubb & Moe, 1988).

In addition, public sector organizations have been reported as characterized by high level of burdensome administrative rules and procedures that has a negative effect on performance (Bozeman, 1993). Similarly, public sector organizations

4.3. Limitations of the Study

This study is not without limitations. For example, the significant relationship revealed in this study does not suggest cause-effect relationship because the cross-sectional design used prevents us from drawing cause-effect relationship. In addition, only two hospitals were involved, one public and one private. This makes it difficult to generalize the findings given that the sample in terms of hospitals was small.

4.4. Recommendation for Practice

The empirical evidence posted in this study has significant implication for practice in both public and private healthcare institutions. First, there is the urgent need for the design of an effective clinical governance framework to provide a clear direction for the design of clinical and administrative functions of health facilities. Second, it was important that clinical governance framework was implemented so that the intended objective of improved and continuous quality health care would continue to be provided. Also, to realize the benefits of a clinical governance system, there was the need to have competent clinical and administrative staff to manage the various sectors of the healthcare institution.

Finally, there is the need to have a supportive culture because clinical governance framework can only strive when the prevailing culture is supportive of such a system.

4.5. Conclusion

Healthcare institutions are life-saving centres where patients from time to time go to receive safe and quality healthcare. The discharge of efficient and effective health service is influenced by structures and designs of the institution. This study found clinical governance to be associated significantly to hospital effectiveness. This manifests that the presence of clinical governance ensures the discharge of quality health care, standard clinical practice and improved performance of the healthcare institution. Finally, the study is consistent with the property right and public choice theory of organizations (Alchian & Demsetz, 1972; Clarkson, 1972; Rainey & Bozeman, 2000).

5. References

i. Alchian, A.A. & H. Demsetz (1972): "Production, Information Costs, and Economic Organization". The American Economic Review, 62(5), 777-795.
ii. Beglinger, J., Hauge, B., Krause, S., & Ziebarth, L. (2011). Shaping future nurse leaders through shared governance. Nursing Clinicians of Northern America, 46, 129–135.
iii. Bolman, D. (1991). Reframing Organisations, Jossey-Bass Inc., Publishers.
iv. Boyne, G. A. (1998). Bureaucratic theory meets reality? Public choice and service contracting in US local government. Public Administration Review 58, 474–84.
v. Bozeman, B. A. (1993). Theory of Government “Red Tape”. Journal of Public Administration Research and Theory, 273-303.
vi. Campbell, S.M., Sheaff, R., Sibbald, B., Marshall, M.N., Pickard, S., Gask, L., Halliwell, S., Rogers, A., & Roland, M.O. (2002). Implementing Clinical Governance in English primary care groups/Trusts: reconciling quality improvement and quality assurance. Quality and Safety in Health Care, 11**,** 9-14.
vii. Chiarella, M. (2008). New and Emerging nurse led models of primary healthcare [Discussion Paper]. Canberra, Australian Capital Territory: Australian Government National Health and Hospitals Reform Commission. Retrievedfromhttp://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E/$File/New%20and%20emerging%20nurseled%20models%20of%20primary%20health%20care%20(M%20 chiarella).pdf.
viii. Chubb, J.E. & T.M. Moe (1988): "Politics, Markets, and the Organization of Schools". The American Political Science Review, 82(4), 1065-1087.

ix. Clarkson, K.W. (1972): "Some Implications of Property Rights in Hospital Management". Journal of Law and Economics, 15(2), 363-384.
x. Davies, C. (2003) Some of our concepts are missing: reflections on the absence of a sociology of organizations in Sociology of Health and Illness, Sociology of Health & Illness 25: (Silver Anniversary Issue) 172-190.
xi. Department of Health (1998b) A First Class Service: Quality in the New NHS, Leeds: Department of Health.
xii. Freidson, E. (1970). Profession of Medicine, a Study of the Sociology of Applied Knowledge, Chicago: The University of Chicago Press.
xiii. Halligan A, and Donaldson L.J. (2001) Implementing Clinical Governance: turning vision into reality, British Medical Journal, 322: 1413-1417.
xiv. Harvey, G. (1998) Improving patient care: Getting to grips with Clinical Governance, RCN Magazine Autumn 8-9.
xv. Jensen, M. & Meckling, W. (1976).Theory of the Firm: Managerial Behaviour, Agency Costs and Ownership Structure, Journal of Financial Economics, pp 305 - 360.
xvi. John, K., & Senbet, L. (2004). Corporate Governance and Board Effectiveness. Journal of Banking and Finance, 22, 371 - 403.
xvii. Leatherman, S. and Sutherland, K. (2003) The Quest for Quality in the NHS: A mid-term evaluation of the ten-year quality agenda, London: The Nuffield Trust.
xviii. Love, I. (2011). Corporate governance and performance around the world: What we know and what we don't know. The World Bank Research Observer, 26(1), 42-70.
xix. Kings Fund (1999) 'What is Clinical Governance?' Briefing February London: Kings Fund.
xx. Malin, N. Wilmot, S., & Manthorpe, J. (2002) Key Concepts and Debates in Health and Social Policy, Buckingham: Open University Press.
xxi. McSherry, R., & Pearce, P. (2002) Clinical Governance, A Guide to Implementation for Healthcare Professionals, Oxford: Blackwell Science Ltd.
xxii. Murray, J. Fell-Rayner, H. Fine, H. Karia, N., & Sweetingham, R. (2004) What do NHS staff think and know about Clinical Governance? Clinical Governance: An International Journal, 3**,** 172-180.
xxiii. Muth, M.M., & Donaldson, L. (1998). Stewardship Theory and Board Structure: a Contingency Approach. Corporate Governance: An International Review, 6(1), 5-28.
xxiv. Newman, K. (2011). Transforming organizational culture through nursing shared governance. Nursing Clinicians of Northern America, 46, 45– 58.
xxv. Parker, H. (2006). Governing the corporation. In Business: The ultimate resource (Eds), (294-295). Cambridge, MA: Basic Books.
xxvi. Parsons, M. & Cornett, P. (2011). Sustaining the pivotal organizational outcome: magnet recognition. Journal of Nursing Management, 36, 277-289.
xxvii. Patton, P., & Pawar, M. (2012). New clinical executive models: One system's approach to chief nursing officer – chief medical officer co-leadership. Nursing Administration Quarterly, 36(4), 320–324.
xxviii. Peak, M. Burke, R. Ryan, S. Wratten, K. Turnock, R. & Vellenoweth, C. (2005) Clinical Governance – the turn of continuous improvement? Clinical Governance: An International Journal, 10(2): 98-105.
xxix. Rainey, H. G., & Bozeman, B. (2000). Comparing Public and Private Organizations: Empirical Research and the Power of the A Priori. Journal of Public Administration Research & Theory, 10:447.
xxx. Scally, G. Clinical Governance Annual Report 1999/2000, NHS Executive Bristol, June 2000.
xxxi. Scally, G. and Donaldson, L. (1998) Clinical Governance and the Drive for Quality improvement in the New NHS in England, British Medical Journal, 317: 61-65.
xxxii. Som, C.V. (2004), Clinical governance: a fresh look at its definition, Clinical Governance: an International Journal, 9**(**2): 87-90.
xxxiii. Swage, T. (2000) Clinical Governance in Health Care Practice, London: Butterworth Heinemann.
xxxiv. Swanson, J. & Tidwell, C. (2011). Improving the culture of patient safety through the Magnet(R) Journey. The Online Journal of Issues in Nursing, 16(3).
xxxv. The Kings Fund (2011). The Future of Leadership and Management in the NHS: No more Heroes, London.
xxxvi. Thomas, M. (2003). The evidence-base for Clinical Governance, Journal of Evaluation in Clinical Practice, 8(2), 251-254.
xxxvii. Wallace, L.M. Freeman, T. Latham, L. Walshe, K. and Spurgeon, P. (2001a) Organizational strategies for changing clinical practice: how Trusts are meeting the challenges of Clinical Governance, Quality in Health Care, 10: 76-82.
xxxviii. Wallace, L.M. Spurgeon, P. Latham, L. Freeman, T. and Walshe, K. (2001b) Clinical Governance, organizational culture and change management in the new NHS, Clinician in Management, 10: 23-31.
xxxix. Walsh, M. (2000) Nursing Frontiers Accountability and the Boundaries of Care, Oxford: Butterworth-Heinemann.
xl. Walsh, M. and Small, N. (2001) Clinical Governance in primary care: early impressions based on Bradford South and West Primary Care Group's experience, British Journal of Clinical Governance **6**(2): 109-118.
xli. Walshe, K. (2000) Clinical Governance: a call for real change, Change Performance and Quality Health Care, 8**(**4): 192-194.
xlii. Walshe, K. (2001) Clinical Governance: scope to improve, Health Service Journal, 110(5728): 30-32.
xliii. Walshe, K. (2003) Regulating Healthcare, A Prescription for Improvement? Buckingham: Open University Press.