



Cash Control Practices and Financial Performance of Private Health Centres in Ibanda Municipality, Uganda

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ABSTRACT

Purpose: This study examined the relationship between cash-control practices and financial performance among private health centres in Ibanda Municipality, Uganda.

Methodology: A quantitative, cross-sectional correlational design was adopted. The study targeted 104 financial management personnel from 57 registered private health centres. Data were collected using structured questionnaires, with 89 valid responses obtained (85.6% response rate), and analysed using descriptive statistics, Pearson's correlation, and simple linear regression.

Findings: Cash-control practices were generally implemented, with cash expenditure control most strongly practiced, while cash reconciliation, timely banking of collections, and aspects of cash monitoring were comparatively weaker. Cash-control practices had a strong, positive, and statistically significant relationship with financial performance ($r = .623$, $p < .001$) and explained 38.8% of its variance ($R^2 = .388$).

Conclusion: Stronger cash-control practices are associated with better financial performance among private health centres. Strengthening independent cash reconciliation, timely banking, segregation of duties, staff-advance accountability, and systematic cash monitoring is therefore recommended.

Keywords: Cash-control practices; financial performance; private health centres; Uganda; cash management.

Background to the Study

Financial performance is fundamental to the sustainability of healthcare organisations because it reflects their capacity to generate adequate revenues, maintain liquidity, control expenditures, meet financial obligations, and sustain service delivery (Atrill & McLaney, 2022; World Bank, 2024). Healthcare organisations require continuous financial resources to procure medicines and medical supplies, remunerate employees, maintain infrastructure, meet utility costs and finance other operational activities (World Health Organization [WHO], 2023; WHO, 2024). The ability of a health facility to sustain these activities therefore depends not only on the revenues it generates but also on the effectiveness with which available financial resources are safeguarded, controlled and utilised (World Bank, 2024; WHO, 2024). Consequently, financial performance in healthcare organisations is closely associated with the effective management of financial resources, particularly those that are readily available for meeting routine operational obligations.

Cash is one of the most critical financial resources influencing the day-to-day financial performance of healthcare organisations because it provides the liquidity required to meet immediate operational and financial obligations (Atrill & McLaney, 2022). Healthcare facilities receive and disburse cash through patient payments, pharmacy sales, laboratory services, procurement of medicines and supplies, employee payments, supplier settlements and other operating expenditures (WHO, 2023; WHO, 2024). Effective management of these cash flows enables

health facilities to maintain adequate liquidity, meet obligations when they fall due and sustain uninterrupted service delivery (Atrill & McLaney, 2022). However, the frequent movement and high liquidity of cash also expose healthcare organisations to risks of error, fraud, misappropriation, theft and unauthorised expenditure (Committee of Sponsoring Organizations of the Treadway Commission [COSO], 2013; Association of Certified Fraud Examiners [ACFE], 2024). Such weaknesses can reduce the financial resources available for operations and investment and, consequently, undermine financial performance. Cash-control practices are therefore important mechanisms through which healthcare organisations can safeguard cash, regulate its use and ensure that cash resources are available for legitimate organisational needs (COSO, 2013).

Globally, the importance of cash control in healthcare organisations has increased as facilities face growing operational costs, increasing demand for healthcare services and pressure to use limited financial resources efficiently (WHO, 2023; World Bank, 2024). Effective cash control provides mechanisms for authorising transactions, monitoring collections, ensuring timely banking of receipts, regulating cash disbursements and reconciling cash records with actual cash and bank balances (COSO, 2013; ACCA, 2023). These mechanisms can reduce financial leakages and improve the availability and utilisation of cash for operational requirements. For private healthcare providers in particular, where a substantial proportion of operating resources is generated from internally collected revenues, effective control over cash inflows and outflows is important for maintaining liquidity and supporting sustainable financial performance (World Bank, 2024). Thus, the effectiveness of cash control is relevant not merely to safeguarding cash but also to the capacity of health facilities to meet obligations, sustain operations and finance future growth.

In Africa, the importance of cash control is heightened by resource constraints, increasing healthcare needs and persistent pressure on healthcare organisations to deliver services efficiently with limited financial resources (WHO, 2023; World Bank, 2024). Private health providers depend substantially on revenues generated from patients and other healthcare activities to finance medicines, salaries, utilities, suppliers and other operating costs. The effective collection, safeguarding and utilisation of these revenues is therefore essential to maintaining liquidity and operational continuity (WHO, 2024). Where cash controls are weak, delays in banking, unauthorised payments, inadequate transaction documentation and unreconciled cash balances may increase the risk of financial leakages and reduce the resources available for healthcare operations. Conversely, effective cash controls can strengthen accountability over cash resources, improve expenditure discipline and support the timely settlement of financial obligations (COSO, 2013; ACCA, 2023). Cash control therefore represents an important financial-management mechanism through which private health facilities can translate internally generated revenues into sustainable operational and financial outcomes.

In Uganda, private health facilities play an important role in complementing public healthcare provision and require adequate financial capacity to sustain operations and invest in service delivery. Their financial performance is reflected in their ability to maintain liquidity, generate profits, meet financial obligations and accumulate resources for continued investment in infrastructure, equipment and other productive assets. However, financial-management challenges remain a concern within private health facilities, particularly where limited financial resources must support extensive operational requirements (Nsubuga, 2014). Financial constraints can manifest in slow organisational growth, limited investment, weak profitability and difficulties in meeting obligations as and when they fall due. Such conditions may affect the ability of private health facilities to maintain adequate stocks of medicines and supplies, remunerate employees, maintain equipment and infrastructure and expand their services (Nsubuga, 2014; Ojambo et al., 2026). Since cash represents the immediate financial resource through which these obligations are settled, effective control over cash collections, deposits, disbursements and reconciliations is particularly important for the financial sustainability of private health facilities.

In Ibanda Municipality, private health units provide healthcare services while managing cash inflows from patients and other sources alongside cash outflows for medicines, salaries, utilities, suppliers and other operating requirements. Effective cash-control practices are expected to safeguard cash collections, ensure authorised expenditure, maintain liquidity and enable facilities to meet financial obligations as they fall due (Angom, 2024; Kayesu, 2024). However, the continued experience of slow growth, low profitability, limited asset accumulation and difficulties in settling financial obligations, despite the existence of cash-control procedures, raises concerns

about the effectiveness of these controls in improving financial performance. The concern is therefore not merely whether cash-control mechanisms exist, but whether they are effectively implemented to safeguard and efficiently utilise cash resources. Although previous studies have examined financial management and related practices in healthcare organisations, limited empirical evidence exists on the specific relationship between cash-control practices and financial performance of private health units in Ibanda Municipality. This gap provides a basis for empirically examining whether cash-control practices are associated with financial performance among private health units in Ibanda Municipality, Uganda.

Problem Statement

Cash-control practices are intended to safeguard cash resources, prevent financial leakages, regulate expenditures, maintain liquidity, and ensure that private health units meet their financial obligations as they fall due (COSO, 2013; ACCA, 2023). Private health units in Ibanda Municipality practice various cash-control measures, including cash transaction authorisation, cash collection and recording, timely banking of receipts, controlled cash disbursements and cash reconciliation, which are intended to safeguard cash resources, minimize financial leakages, maintain liquidity and support efficient utilisation of funds (COSO, 2013; ACCA, 2023). Despite the practice of these cash controls, private health units continue to experience poor financial performance characterised by stagnant growth, low profitability, limited asset accumulation and difficulties in meeting financial obligations as and when they fall due. This persistence raises concern about whether existing cash-control practices are being implemented effectively enough to translate cash resources into improved financial performance. Although studies have examined financial management and related practices in healthcare organisations, limited empirical evidence has established the specific relationship between cash-control practices and financial performance among private health units in Ibanda Municipality. The study therefore examines the relationship between cash-control practices and the financial performance of private health units in Ibanda Municipality, Uganda.

Objective of the Study

To determine the relationship between cash-control practices and the financial performance of private health centres in Ibanda Municipality, Uganda.

Research Question

What is the relationship between cash-control practices and the financial performance of private health centres in Ibanda Municipality, Uganda?

Research Hypothesis

H₀: There is no statistically significant relationship between cash-control practices and the financial performance of private health centres in Ibanda Municipality, Uganda.

LITERATURE REVIEW

Definition of Variables

Cash-Control Practices

Cash-control practices refer to the policies, procedures and mechanisms established by an organisation to safeguard cash resources, regulate cash receipts and payments, prevent unauthorised transactions, and ensure the accurate recording, reconciliation and monitoring of cash transactions. The concept is grounded in the broader internal-control framework, which emphasises control activities designed to provide reasonable assurance regarding the achievement of organisational objectives and the safeguarding of resources (COSO, 2013).

In the present study, cash-control practices refer specifically to mechanisms used by private health centres to control cash transactions. These practices comprise cash transaction authorisation, segregation of duties, cash reconciliation, timely banking of cash collections, cash expenditure control and cash monitoring. These dimensions capture both preventive and detective mechanisms intended to reduce errors, unauthorised transactions and cash leakages while strengthening accountability.

Financial Performance

Financial performance refers to the extent to which an organisation achieves favourable financial outcomes through the effective generation and utilisation of its financial resources. Organisational performance is multidimensional and may be assessed using several financial and non-financial indicators depending on the organisational context (Richard et al., 2009).

In this study, financial performance refers to the extent to which private health centres achieve favourable financial outcomes reflected in profitability, revenue growth, liquidity and the ability to meet financial obligations. These indicators were selected because they represent important dimensions of the financial sustainability of private health centres.

Theoretical Underpinning

This study is anchored in Agency Theory, developed by Jensen and Meckling (1976), which explains the challenges that arise when owners or principals delegate responsibility for managing organisational resources to managers and employees acting as agents. The separation of ownership from control creates the potential for goal divergence, information asymmetry and opportunistic behaviour because agents may possess more information about organisational transactions and operations than principals. Consequently, agents may make decisions or undertake transactions that are not fully aligned with the interests of the owners. Agency Theory therefore emphasises the importance of monitoring, accountability and internal control mechanisms in reducing agency conflicts and protecting organisational resources from misuse, waste and unauthorised utilisation.

The theory is particularly relevant to private health centres because owners commonly delegate responsibility for cash collection, recording, banking, custody, expenditure and disbursement to managers, accountants, cashiers and other employees. Such delegation creates an agency relationship in which employees have direct access to financial resources and transaction information, while owners may not be involved in day-to-day cash operations. This information asymmetry can create opportunities for cash leakages, fraud, errors, unauthorised expenditure and misappropriation, particularly where monitoring and accountability mechanisms are weak. Cash-control practices, including cash transaction authorisation, segregation of duties, cash collection and recording, timely banking of receipts, cash reconciliation, expenditure control and regular monitoring, therefore provide mechanisms through which the actions of agents can be constrained, reviewed and held accountable.

From the Agency Theory perspective, effective cash-control practices reduce agency costs by limiting agents' discretion over organisational cash and increasing the transparency and accountability of financial transactions. Authorisation controls ensure that cash transactions are undertaken only by individuals with appropriate authority; segregation of duties reduces the concentration of incompatible responsibilities in one employee; reconciliation facilitates the detection of errors and unexplained differences; timely banking reduces the exposure of collected cash to loss or misuse; while expenditure controls and monitoring help ensure that organisational resources are used for approved and productive purposes. Collectively, these mechanisms reduce opportunities for opportunistic behaviour and improve the reliability of cash records and financial information.

The theory further suggests that stronger cash controls can contribute to improved financial performance by reducing cash leakages and unnecessary expenditures, safeguarding available resources and promoting efficient allocation of cash. When financial resources are protected and appropriately utilised, private health centres are better positioned to maintain liquidity, meet financial obligations, control operating costs, generate and retain income, and invest in productive assets. Thus, Agency Theory provides a theoretical explanation for why weaknesses in cash-control practices may contribute to poor financial outcomes, while effective controls are

expected to enhance profitability, revenue growth, liquidity, asset growth and the ability to meet financial obligations. Accordingly, the theory provides a basis for expecting a positive relationship between cash-control practices and the financial performance of private health centres in Ibanda Municipality.

Empirical Review

Relationship between Cash-Control Practices and Financial Performance

Cash-control practices have received increasing attention in studies examining how organisations safeguard financial resources and improve financial performance. These practices generally include the authorisation of cash transactions, proper recording of cash receipts and payments, timely banking of collections, reconciliation of cash and bank balances, control of cash expenditures, and monitoring of cash movements. Empirical studies generally suggest that effective cash controls enhance accountability over cash resources, reduce financial leakages and strengthen the capacity of organisations to meet their financial obligations. However, the evidence varies across organisational sectors and contexts, particularly regarding the strength and statistical significance of the relationship with financial performance.

Nankya (2024) examined cash management practices and financial performance among agribusiness enterprises in Mbale City and found that cash control significantly predicted financial performance ($\beta = .349$, $p < .001$). The finding suggests that effective control over cash receipts and expenditures is important for strengthening financial outcomes by promoting accountability, limiting cash leakages and ensuring that available resources are used for authorised activities. However, the study was conducted among agribusiness enterprises, whose cash-flow patterns, revenue sources and expenditure requirements differ from those of private health centres. Thus, while the finding supports the importance of cash control in enhancing financial performance, its applicability to private healthcare settings remains uncertain.

Katamba (2024) examined cash management and financial performance among small-scale businesses in Kampala Central Division and found a strong positive relationship between cash management and financial performance ($r = .699$). The finding indicates that effective management and control of cash resources is associated with improved financial outcomes. Since cash control is central to regulating cash receipts, payments and the use of available funds, the finding provides support for the importance of effective cash-control practices in organisational financial performance. However, the study examined cash management as a broader construct, making it difficult to establish the specific contribution of cash-control practices to financial performance. Moreover, its focus on small-scale businesses limits the applicability of the findings to private health centres, which operate under different revenue and expenditure conditions.

Madangu (2022) examined cash management practices and financial performance among SMEs in Pallisa Town Council and reported a positive relationship between the two variables. The finding suggests that effective management and control of cash resources can enhance an organisation's ability to maintain liquidity, meet operating obligations and support favourable financial outcomes. This provides support for the relevance of cash-control practices in financial performance. However, the study focused on SMEs and examined cash management broadly rather than specific cash-control mechanisms such as transaction authorisation, timely banking, reconciliation and expenditure control. Consequently, its findings provide general support for the present study but do not establish how specific cash-control practices relate to financial performance in private health centres.

Evidence from the same geographical context presents a contrasting finding. Masiko (2022) examined cash management practices and financial performance among private secondary schools in Ibanda Municipality and found a weak positive but statistically insignificant relationship between cash-control systems and financial performance ($r = .197$, $p = .149$). This finding suggests that the presence of cash-control mechanisms alone may not be sufficient to produce measurable improvements in financial performance, particularly where their implementation is not sufficiently effective. Although the study is relevant because it was conducted in Ibanda Municipality, its focus on private secondary schools limits the generalisability of the findings to private health centres. Differences in cash collection processes, transaction volumes, expenditure requirements and liquidity

demands between the two sectors may influence how cash-control practices relate to financial performance. The contrasting finding therefore highlights the need for sector-specific evidence on the cash-control–financial performance relationship among private health centres in Ibanda Municipality.

Further evidence from the healthcare sector is provided by Kimathi et al. (2024), who examined the relationship between cash management and financial performance among Level Three and Four public hospitals in Meru County, Kenya. The study found a strong and statistically significant positive relationship between cash management and financial performance ($r = .820$, $p < .05$), indicating that effective control and utilisation of cash resources are associated with stronger financial outcomes in healthcare organisations. The finding is particularly relevant to the present study because health facilities depend on continuous cash flows to meet operational obligations and sustain service delivery. However, the study focused on public hospitals in Kenya, whose financing structures, governance arrangements and revenue sources differ from those of private health centres in Uganda. In addition, its broader focus on cash management does not isolate the contribution of specific cash-control practices. Thus, the finding provides useful healthcare-sector evidence while leaving the relationship between specific cash-control practices and financial performance in private health centres insufficiently established.

Overall, the empirical evidence points to a predominantly positive relationship between cash-control practices and financial performance, although the strength and significance of this relationship vary across contexts. Nankya (2024), Katamba (2024), Madangu (2022) and Kimathi et al. (2024) reported positive relationships, whereas Masiko (2022) found a weak and statistically insignificant relationship. These divergent findings suggest that the contribution of cash controls to financial performance may vary according to the nature of the organisation and the context in which the controls are implemented. A further limitation is that much of the existing literature treats cash management as a broad construct, providing limited evidence on how specific cash-control practices—such as transaction authorisation, segregation of duties, cash reconciliation, timely banking, expenditure control and cash monitoring—collectively relate to financial performance. This limits understanding of which cash-control mechanisms are most relevant to financial performance, particularly within private healthcare settings.

Within Uganda, empirical evidence on the specific relationship between cash-control practices and financial performance among private health centres remains limited. Existing studies have largely examined cash management in SMEs, agribusinesses and private schools, or have focused on public hospitals, providing limited evidence on cash-control practices within privately operated healthcare facilities. Although Masiko (2022) provides evidence from Ibanda Municipality, the study focused on private secondary schools and reported a statistically insignificant relationship between cash-control systems and financial performance. The applicability of these findings to private health centres remains uncertain because healthcare facilities operate with distinct patterns of cash collection, transaction frequency, expenditure commitments and liquidity requirements. Thus, a sectoral and contextual gap remains in understanding whether cash-control practices are significantly related to financial performance in private health centres. The present study addresses this gap by examining the relationship between cash-control practices and financial performance among private health centres in Ibanda Municipality, Uganda.

METHODOLOGY

Research Approach and Design

The study adopted a quantitative research approach using a cross-sectional correlational design. The quantitative approach facilitated the measurement and statistical analysis of cash-control practices and financial performance using numerical data. The cross-sectional design enabled data to be collected from respondents at a single point in time, while the correlational component assessed the direction and strength of the relationship between the study variables. Simple linear regression was further employed to determine the extent to which cash-control practices statistically accounted for variations in financial performance. Given the non-experimental, cross-sectional design, the findings are interpreted as statistical associations and predictive relationships rather than evidence of causality.

Study Area and Population

The study was conducted among private health centres in Ibanda Municipality, Western Uganda. The study population comprised 57 registered private health centres, which constituted the sampling frame. The target respondents were managers, accountants, finance officers, cashiers, administrators and proprietors who were directly involved in, or knowledgeable about, the financial operations of their respective health centres.

Sample Size and Sampling Strategy

A census approach was adopted at the health-centre level because the population of 57 private health centres was relatively small and manageable. The study targeted 104 financial-management personnel across the 57 health centres. Purposive sampling was used to select respondents with relevant knowledge of cash-control practices and financial operations. Of the 104 targeted respondents, 89 returned valid questionnaires, representing an 85.6% response rate. The analysis was therefore based on 89 respondent-level observations. Where multiple respondents were drawn from the same health centre, the potential for correlated responses was recognised as a methodological limitation.

Measurement of Variables

Cash-control practices constituted the independent variable and were measured using six dimensions: cash transaction authorisation, segregation of duties, cash reconciliation, timely banking of cash collections, cash expenditure control, and cash monitoring. Financial performance was the dependent variable, measured in terms of profitability, revenue growth, liquidity, and the ability to meet financial obligations.

The constructs were measured using structured questionnaire items rated on a five-point Likert scale ranging from 1 = strongly disagree to 5 = strongly agree. The questionnaire items were developed from relevant literature and adapted to the operational context of private health centres.

Data Collection Instrument and Procedure

Primary data were collected using a structured questionnaire comprising sections on respondent characteristics, cash-control practices and financial performance. Prior to data collection, the necessary institutional and administrative approvals were obtained. Respondents were informed about the study purpose, voluntary participation and confidentiality of the information provided. Completed questionnaires were checked for completeness, coded and prepared for analysis. Where access was granted, relevant financial records were reviewed as supplementary evidence; however, the statistical analysis reported in this study was based on questionnaire data.

Validity and Reliability

Content validity was established through expert review by specialists in accounting, finance and research methodology. The experts assessed the relevance, clarity and adequacy of the questionnaire items, and a Content Validity Index (CVI) was computed to determine the extent to which the items adequately represented the study constructs.

Reliability was assessed through a pilot study involving respondents from private health facilities outside the study area. Internal consistency of the measurement scales was evaluated using Cronbach's alpha, with a coefficient of 0.70 or higher considered acceptable.

Data Analysis

Data were coded and analysed using the Statistical Package for the Social Sciences (SPSS). Descriptive statistics, including frequencies, percentages, means and standard deviations, were used to summarise respondent characteristics and the distribution of responses. Pearson's product-moment correlation coefficient was used to

assess the direction and strength of the relationship between cash-control practices and financial performance. Simple linear regression was employed to determine the proportion of variance in financial performance statistically accounted for by cash-control practices. Statistical significance was assessed at the 5% level, with $p < .05$ considered statistically significant. In interpreting the findings, the cross-sectional and non-experimental nature of the study was considered; therefore, observed relationships were treated as associations rather than definitive causal effects.

RESULTS AND DISCUSSION

Respondent Characteristics

The study targeted 104 financial-management personnel from private health centres in Ibanda Municipality. Of these, 89 completed and returned usable questionnaires, representing a response rate of 85.6%. The response rate was considered adequate for the analysis and provided sufficient observations for assessing the relationship between cash-control practices and financial performance.

Table 1: Questionnaire Response Rate

Response status	Frequency	Percentage (%)
Questionnaires distributed	104	100.0
Usable questionnaires returned	89	85.6
Unreturned/non-usable questionnaires	15	14.4
Total	104	100.0

Source: Primary data, 2026.

The demographic characteristics of the 89 respondents are presented in Table 2.

Table 2: Respondent Characteristics

Characteristic	Category	Frequency	Percentage (%)
Gender	Male	47	52.8
	Female	42	47.2
Age	20–29 years	8	9.0
	30–39 years	38	42.7
	40–49 years	31	34.8



	50–59 years	12	13.5
Length of service	Less than 1 year	8	9.0
	1–5 years	18	20.2
	More than 5 years	63	70.8
Marital status	Single	16	18.0
	Married	71	79.8
	Widowed	2	2.2
Education level	Tertiary	52	58.4
	University	37	41.6

Source: Primary data, 2026.

Gender

The findings indicate that 47 respondents (52.8%) were male and 42 (47.2%) were female. The relatively balanced distribution suggests that the study incorporated perspectives from both male and female personnel involved in the financial operations of private health centres.

Age

The majority of respondents were aged 30–39 years (42.7%), followed by those aged 40–49 years (34.8%). Respondents aged 50–59 years constituted 13.5%, while those aged 20–29 years accounted for 9.0%. Thus, most respondents were aged between 30 and 49 years. This indicates that the respondents were predominantly drawn from an age group likely to have accumulated meaningful professional and organisational experience.

Duration of Service

The majority of respondents, 63 (70.8%), had worked in their respective health centres for five years or more. Eighteen respondents (20.2%) had worked for between one and five years, while 8 (9.0%) had served for less than one year. The high proportion of respondents with five or more years of service suggests that most respondents had substantial familiarity with the financial procedures and operational practices of their respective health centres.

Marital Status

The findings show that 71 respondents (79.8%) were married, 16 (18.0%) were single and 2 (2.2%) were widowed. Marital status is presented as part of the respondent profile but does not form part of the substantive analysis of the relationship between cash-control practices and financial performance.



Education Level

The findings indicate that 52 respondents (58.4%) had attained tertiary education, while 37 (41.6%) had attained university education. Thus, all respondents possessed post-secondary educational qualifications. This profile suggests that respondents generally had an educational background that enabled them to understand questionnaire items concerning financial-management practices and organisational financial performance.

Cash-Control Practices among Private Health Centres

Cash-control practices were assessed across six dimensions: cash transaction authorisation, segregation of duties, cash reconciliation, timely banking of cash collections, cash expenditure control, and cash monitoring. Respondents rated each indicator on a five-point Likert scale, with higher mean scores indicating stronger reported implementation.

Table 3: Cash-Control Practices among Private Health Centres

Cash-control dimension and indicator	N	Mean	SD
Cash Transaction Authorisation			
Payments authorised by designated personnel before payment	89	3.83	.888
Bank withdrawals require prior approval	89	3.58	.614
Cash expenditure supported by approved documentation	89	3.29	.763
Clearly defined approval levels	89	3.61	.618
Unauthorised transactions identified and investigated promptly	89	3.18	.666
Segregation of Duties			
Cash receiving separated from cash recording	89	3.27	.829
Authoriser different from person making payment	89	3.43	.736
Cash-handling responsibilities clearly assigned	89	3.56	.599
Cashiers do not approve their own transactions	89	3.25	.585
Cash records reviewed by another person	89	3.81	.653
Cash Reconciliation			
Cash balances regularly reconciled with accounting records	89	3.42	.818



Bank reconciliations prepared regularly	89	3.18	.722
Reconciliation differences investigated promptly	89	3.06	.688
Cash records reconciled with receipts and vouchers	89	3.28	.811
Reconciliations independently reviewed and approved	89	3.01	.846
Timely Banking of Cash Collections			
Cash collections deposited promptly	89	3.09	.837
Cash not unnecessarily retained at the health centre	89	3.28	.694
Daily collections compared with patient receipts	89	3.67	.866
Deposit slips maintained and reconciled	89	3.73	.816
Banking delays reported to management	89	3.37	.654
Cash Expenditure Control			
Expenditures made only for approved activities	89	3.89	.766
Payments supported by valid documents	89	3.66	.886
Petty-cash expenditures subject to established limits	89	3.94	.698
Cash advances properly authorised and accounted for	89	3.18	.584
Unretired advances followed up by management	89	3.61	.652
Cash Monitoring			
Management regularly reviews cash balances and movements	89	3.41	.726
Cash transactions reviewed for errors and irregularities	89	3.11	.701
Management receives regular cash reports	89	3.16	.699
Identified cash-control weaknesses promptly addressed	89	3.79	.862

Source: Primary Data, 2026.

The findings indicate that cash-control practices were generally implemented across the sampled health centres, although their strength varied considerably by dimension. Cash expenditure control was the strongest area, particularly the application of petty-cash limits ($M = 3.94$, $SD = 0.698$) and restriction of expenditures to approved activities ($M = 3.89$, $SD = 0.766$). Payment authorisation ($M = 3.83$, $SD = 0.888$) and independent review of cash records ($M = 3.81$, $SD = 0.653$) were also relatively strong.

In contrast, cash reconciliation and timely banking showed comparatively weaker implementation. Independent review and approval of reconciliations recorded the lowest mean ($M = 3.01$, $SD = 0.846$), followed by prompt investigation of reconciliation differences ($M = 3.06$, $SD = 0.688$) and prompt banking of cash collections ($M = 3.09$, $SD = 0.837$).

Similarly, routine review of cash transactions for errors and irregularities recorded a mean of 3.11 ($SD = 0.701$). These findings suggest that preventive controls, particularly expenditure approval and petty-cash restrictions, were more established than detective controls involving reconciliation, investigation of discrepancies and systematic monitoring.

Cash transaction authorisation was generally established. Payments authorised by designated personnel recorded a mean of 3.83 ($SD = 0.888$), while clearly defined approval levels and prior approval of bank withdrawals recorded means of 3.61 ($SD = 0.618$) and 3.58 ($SD = 0.614$), respectively. However, prompt identification and investigation of unauthorised transactions was comparatively weaker ($M = 3.18$, $SD = 0.666$), indicating a potential gap between preventing unauthorised transactions and detecting them when they occur.

Segregation of duties was also generally practised, but complete separation of incompatible functions was less consistent. Review of cash records by another person recorded a relatively high mean ($M = 3.81$, $SD = 0.653$), whereas separation of cash receiving from recording ($M = 3.27$, $SD = 0.829$) and prevention of cashiers from approving their own transactions ($M = 3.25$, $SD = 0.585$) recorded lower scores. This indicates that responsibilities were assigned within the health centres, but some incompatible cash-handling functions may still be combined.

Cash reconciliation represented another area requiring strengthening. Although cash balances were regularly reconciled with accounting records ($M = 3.42$, $SD = 0.818$), independent review and approval of reconciliations was weak ($M = 3.01$, $SD = 0.846$). The relatively low score for prompt investigation of reconciliation differences ($M = 3.06$, $SD = 0.688$) further suggests that discrepancies may not always be investigated and resolved promptly.

Timely banking controls produced mixed results. Daily collections were compared with patient receipts ($M = 3.67$, $SD = 0.866$), and deposit slips were maintained and reconciled ($M = 3.73$, $SD = 0.816$). However, prompt banking of collections recorded a lower mean of 3.09 ($SD = 0.837$). Thus, documentation and verification of collections appeared stronger than the timely transfer of physical cash to the bank, creating potential exposure to cash loss or misuse while funds remain on the premises.

Overall, the results indicate that private health centres had established basic cash-control systems, but weaknesses remained particularly in reconciliation, timely banking, independent review, staff-advance accountability and detective monitoring. These weaknesses are important because effective cash control requires not only authorisation of transactions but also timely verification, reconciliation and corrective action.

Financial Performance of Private Health Centres

Financial performance was assessed in terms of profitability, revenue growth, and liquidity and ability to meet financial obligations. Higher mean scores indicate more favourable reported financial performance.

Table 4: Financial Performance of Private Health Centres

Financial-performance dimension and indicator	N	Mean	SD
Profitability			
Sufficient income to cover operating costs	89	3.83	.944
Positive financial results in recent years	89	3.71	.568
Sufficient surplus/profit from operations	89	4.04	.947
Profitability has improved over time	89	3.92	.828
Revenue Growth			
Revenue has increased over recent years	89	3.86	.853
Healthcare-service revenue is sufficient to support operations	89	3.14	.858
Patient-related revenues have grown	89	4.20	.797
Stable flow of operating revenue	89	3.96	.366
Liquidity and Ability to Meet Financial Obligations			
Sufficient cash to meet short-term obligations	89	3.83	.856
Ability to pay suppliers on time	89	3.12	.853
Routine operating expenses can be met when due	89	4.21	.798
Adequate cash reserves for unexpected expenses	89	3.86	.671

Source: Primary Data, 2026.

The results indicate generally favourable reported financial performance, although important areas of financial pressure were evident. Profitability received relatively high ratings, with sufficient surplus or profit from operations recording the highest profitability mean ($M = 4.04$, $SD = 0.947$), followed by improvement in profitability over time ($M = 3.92$, $SD = 0.828$). Sufficient income to cover operating costs recorded a mean of 3.83 ($SD = 0.944$), while positive financial results in recent years recorded 3.71 ($SD = 0.568$).

Revenue growth was also positively rated. Growth in patient-related revenue recorded the highest mean across the financial-performance indicators ($M = 4.20$, $SD = 0.797$), followed by a stable flow of operating revenue ($M = 3.96$, $SD = 0.366$) and increased revenue over recent years ($M = 3.86$, $SD = 0.853$). However, the sufficiency of healthcare-service revenue to support operations recorded a considerably lower mean of 3.14 ($SD = 0.858$). This suggests that revenue may be growing without necessarily providing sufficient financial capacity to support all operational requirements.

Liquidity was generally favourably rated, with the ability to meet routine operating expenses recording a mean of 4.21 ($SD = 0.798$). Adequate cash reserves for unexpected expenses recorded 3.86 ($SD = 0.671$), while sufficient cash to meet short-term obligations recorded 3.83 ($SD = 0.856$). However, the ability to pay suppliers on time recorded the lowest mean within this dimension ($M = 3.12$, $SD = 0.853$). This indicates that supplier obligations may constitute a greater liquidity constraint than routine operating expenses.

Because financial performance was measured using respondents' assessments rather than exclusively audited financial statements, these findings represent **reported financial performance** and should not be interpreted as independently verified accounting ratios.

Relationship between Cash-Control Practices and Financial Performance

Pearson's product-moment correlation analysis was conducted to determine the direction and strength of the relationship between cash-control practices and financial performance.

Table 5: Correlation between Cash-Control Practices and Financial Performance

Variables	Financial Performance
Cash-control practices	$r = .623$
Significance (2-tailed)	$p < .001$
N	89

Source: Primary Data, 2026.

The results show a **strong, positive and statistically significant relationship** between cash-control practices and financial performance ($r = .623$, $p < .001$). This indicates that private health centres reporting stronger cash-control practices also tended to report better financial performance. The finding provides empirical support for the proposition that effective control over cash transactions is associated with improved financial outcomes.

From an Agency Theory perspective, effective cash controls can reduce opportunities for misuse of organisational resources by strengthening authorisation, accountability, monitoring and independent verification. The positive association observed in this study is therefore consistent with the theoretical expectation that stronger monitoring and control mechanisms can contribute to more efficient utilisation of organisational resources.

However, the cross-sectional and non-experimental nature of the study means that the finding should be interpreted as an association rather than evidence of a causal effect. Other organisational and environmental factors may also influence financial performance.

Regression Analysis

Simple linear regression was conducted to determine the extent to which cash-control practices statistically accounted for variation in financial performance.

Table 6: Regression Model Summary

R	R Square	Adjusted R Square	Std. Error of the Estimate
.623	.388	.381	—

Source: Primary Data, 2026.

The regression results indicate an R^2 of .388, meaning that cash-control practices statistically accounted for 38.8% of the variance in reported financial performance among the sampled private health centres. The remaining 61.2% was attributable to other factors not included in the model.

The explanatory power of 38.8% indicates that cash control represents a substantial component of financial performance within the study context. The result reinforces the correlation finding that stronger cash-control practices are associated with better financial performance. Nevertheless, the unexplained proportion indicates that financial performance is multidimensional and may also depend on factors such as revenue management, cost control, patient volumes, pricing, debt management, inventory management, access to finance and broader market conditions.

Taken together, the correlation and regression results provide evidence of a meaningful statistical relationship between cash-control practices and financial performance among private health centres in Ibanda Municipality. The findings particularly highlight the importance of strengthening reconciliation, timely banking, segregation of incompatible duties, accountability for staff advances and systematic monitoring alongside existing expenditure controls.

DISCUSSION OF FINDINGS

Cash transaction authorisation was generally practiced among private health centres, particularly through approval of cash payments by designated personnel, defined authority levels and prior approval of bank withdrawals. However, the comparatively lower rating for identifying and investigating unauthorised transactions suggests that preventive controls were stronger than detective controls. This finding is consistent with Asiimwe et al. (2025) and Tenywa (2024), who reported that clearly defined authorisation responsibilities and authority limits strengthen accountability and reduce financial irregularities. The findings therefore suggest that health centres have established mechanisms for preventing unauthorised cash disbursements but require stronger post-transaction scrutiny. Regular review and prompt investigation of unusual or unauthorised transactions could strengthen cash accountability and support financial performance.

Segregation of duties was generally practiced, particularly through the assignment of cash-handling responsibilities and independent review of cash records. However, the comparatively weaker separation of cash receiving from recording and the prevention of cashiers from approving their own transactions indicate that some incompatible duties may still be combined. This finding agrees with Turyomurugyendo et al. (2026) and Kiconco et al. (2022), who found that segregation of financial responsibilities strengthens accountability and reduces opportunities for errors and irregularities. The findings suggest that while basic segregation mechanisms exist, staffing constraints may limit their full implementation in some facilities. Health centres should therefore

strengthen the separation of cash custody, recording, authorisation and review functions, with independent supervisory checks serving as compensating controls where complete segregation is impractical.

Cash reconciliation emerged as a comparatively weaker area of cash control, particularly regarding the prompt investigation of reconciliation differences and independent review of reconciliations. Although health centres generally reconciled cash balances with accounting records, weaknesses in follow-up and independent verification may reduce the effectiveness of the reconciliation process as a detective control. This finding is consistent with Odoch (2022), who emphasised the importance of independent checking of financial records in identifying and correcting errors and irregularities. The findings therefore highlight the need to move beyond the preparation of reconciliations towards systematic review and resolution of identified differences. Regular reconciliation, independent review and timely investigation of discrepancies should consequently be strengthened.

Cash deposit verification and documentation were relatively well practiced, particularly through the maintenance of bank deposit slips and comparison of daily collections with patient receipts. These procedures enhance accountability by linking amounts collected to amounts deposited and facilitating the identification of discrepancies. However, the comparatively lower rating for prompt banking of collections indicates that cash may remain in facilities longer than necessary, increasing its exposure to loss, misuse or unauthorised access. The finding is consistent with Nsubuga (2014), who emphasised the importance of financial controls in private health institutions. The findings suggest that effective documentation should be complemented by strict banking timelines, with responsibility for deposits clearly assigned and unexplained delays promptly reported and investigated.

Cash expenditure control emerged as the strongest cash-control practice, particularly through expenditure limits, approval of payments and supporting documentation. This suggests that private health centres have relatively strong preventive controls over the authorisation, documentation and use of cash for operational expenditures. The finding is consistent with Turyahebwa et al. (2022) and Kiconco et al. (2022), who associated effective cash controls with stronger accountability and financial performance. Nevertheless, the comparatively weaker control over cash advances indicates a potential gap in ensuring that funds issued for operational purposes are properly authorised, accounted for and retired. Health centres should therefore strengthen advance controls through prior approval, adequate supporting documentation, defined retirement deadlines and systematic follow-up of outstanding advances.

Cash monitoring was generally practiced, particularly through management's response to identified weaknesses in cash-control procedures. However, regular review of cash transactions and reporting of cash collections and expenditures to management were comparatively weaker. This pattern suggests that monitoring was more reactive than systematic, with greater emphasis on responding to identified weaknesses than on routinely reviewing cash activities. The finding is consistent with Okello (2022), who emphasised regular monitoring of cash transactions as important for detecting irregularities and control weaknesses. Private health centres should therefore institutionalise routine review of cash collections, deposits, payments and expenditures through regular cash reports, transaction reviews and documented management follow-up.

Overall Relationship between Cash-Control Practices and Financial Performance

The study established a strong positive and statistically significant relationship between cash-control practices and financial performance among private health centres in Ibanda Municipality ($r = .623$, $p < .001$). The regression model further indicated that cash-control practices statistically accounted for 38.8% of the variation in reported financial performance. This suggests that effective control over cash collections, deposits, expenditures and related transactions is an important factor associated with financial performance, although it does not fully explain differences in performance across health centres. The finding is consistent with Madangu (2022) and Katamba (2024), who reported positive relationships between cash management and financial performance, and with Turyahebwa et al. (2022), who associated effective cash controls with improved organisational performance. However, the finding contrasts with Masiko (2022), who reported a weak and statistically insignificant relationship between cash-control systems and financial performance among private

secondary schools in the same municipality ($r = .197$, $p = .149$). The difference may partly reflect sector-specific operating environments, as private health centres handle frequent patient-related collections, supplier payments, payroll obligations and other operational cash transactions.

Overall, the results provide empirical support for the relevance of cash-control practices to financial performance in private health centres. However, the R^2 of .388 also indicates that 61.2% of the variation in reported financial performance remains associated with other factors not captured in the model. These may include revenue management, cost control, debt management, patient volumes, competition, access to financing and broader operational conditions. Given the cross-sectional and non-experimental design, the results should be interpreted as evidence of association rather than causation.

CONCLUSION

The study concludes that cash-control practices are significantly and positively associated with financial performance among private health centres in Ibanda Municipality, Uganda. The six examined dimensions—cash transaction authorisation, segregation of duties, cash reconciliation, timely banking of cash collections, cash expenditure control and cash monitoring—were generally practiced, although the strength of implementation varied across individual control activities.

Cash expenditure control emerged as the strongest area, particularly in relation to expenditure approval, expenditure limits and supporting documentation. In contrast, comparatively weaker practices were observed in prompt banking of cash collections, independent review and follow-up of reconciliations, segregation of some incompatible duties, accountability for cash advances, and systematic monitoring and reporting.

The study further concludes that cash-control practices had a strong positive and statistically significant association with financial performance ($r = .623$, $p < .001$). The regression model indicated that cash-control practices statistically accounted for 38.8% of the variance in reported financial performance. This finding demonstrates the importance of effective cash-control systems in the financial management of private health centres.

However, the study does not establish a causal relationship between cash-control practices and financial performance because of its cross-sectional and non-experimental design. The findings therefore indicate that stronger cash-control practices are associated with better reported financial performance, rather than demonstrating that improvements in cash control directly cause improvements in financial performance.

RECOMMENDATIONS

Based on the findings, the study recommends the following:

Strengthen transaction review and investigation. Private health-centre management should maintain existing pre-payment authorisation procedures while strengthening post-transaction review. Cash and bank transactions should be periodically reviewed to identify unusual or unauthorised transactions, with identified irregularities investigated, documented and resolved promptly.

Strengthen segregation of duties. Management should separate cash receiving, recording, authorisation, payment and reconciliation responsibilities wherever staffing permits. Where complete segregation is impractical, independent supervisory review, periodic surprise cash counts and independent review of reconciliations should be used as compensating controls.

Improve cash reconciliation. Health centres should establish formal schedules for cash and bank reconciliations. Reconciliation differences should be investigated and resolved within defined timelines, while reconciliations should be independently reviewed and approved by personnel who did not prepare them.

Ensure prompt banking of collections. Private health centres should establish clear procedures requiring timely banking of daily cash collections. Responsibility for deposits should be assigned to specific personnel, deposit slips independently verified, and unexplained banking delays reported to management and documented.

Strengthen cash-advance accountability. Although expenditure control was the strongest dimension, cash advances represented a comparatively weaker area. Management should strengthen procedures for advance approval, documentation, retirement and follow-up. Outstanding advances should be reviewed regularly and escalated where retirement deadlines are not met.

Institutionalise systematic cash monitoring. Management should move from predominantly reactive monitoring towards continuous and structured oversight of cash activities. Regular cash reports, transaction reviews, cash counts, bank reconciliations and documented follow-up of control weaknesses should form part of routine management practice.

Areas For Further Research

Future research should employ longitudinal designs to examine whether changes in cash-control practices are associated with changes in financial performance over time. Such designs would provide stronger evidence regarding the temporal relationship between the two variables.

Further studies should examine the individual dimensions of cash control, particularly cash reconciliation, timely banking, segregation of duties, cash-advance accountability and cash monitoring, to determine their respective contributions to financial performance.

Since cash-control practices statistically accounted for 38.8% of the variation in reported financial performance, future research should investigate additional organisational and environmental factors that may explain the remaining variation. Potential factors include cost management, revenue diversification, patient volumes, access to financing, debt management and competitive conditions.

Finally, similar studies should be conducted among private health centres in other districts and municipalities in Uganda and across different categories of health facilities. Comparative and multi-site studies would help establish whether the relationship observed in Ibanda Municipality is generalisable across different geographical and organisational contexts.

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