

Healthcare Financing, Working Capital and Financial Performance: Evidence from Private Hospitals in Kenya

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Abstract

This study examines the intervening effect of working capital on the relationship between healthcare financing and the financial performance of private hospitals in Kenya. Anchored on the Keynesian liquidity preference theory and supported by the resource-based view, the pecking order and trade-off theories, the research investigates whether the liquidity that hospitals maintain constitutes the channel through which loan facilities, out-of-pocket payments and insurance receipts are converted into profitability. Adopting a positivist philosophy and a longitudinal panel design, the study conducted a census of all 153 level 4B and above private hospitals in Kenya over the period 2019 to 2023, yielding 765 hospital-year observations drawn from audited annual reports. Working capital was measured by the current ratio, the financing variables as natural logarithms of their total annual values and financial performance as the return on assets. The intervening effect was tested using the Baron and Kenny four-step mediation procedure estimated within a fixed-effects framework selected on the basis of the Hausman specification test. All four mediation conditions were satisfied: healthcare financing significantly affected financial performance and working capital, working capital strongly and significantly affected financial performance ($\beta = 4.743$, $p < 0.001$), and, when working capital was introduced alongside the financing components, it remained dominant ($\beta = 0.901$, $p < 0.001$) while the direct effects of out-of-pocket payments and insurance receipts became insignificant and that of loan facilities was greatly reduced. The null hypothesis of no significant intervening effect was therefore rejected, with mediation full in respect of out-of-pocket payments and insurance receipts and partial in respect of loan facilities. The study concludes that working capital is the central mechanism through which healthcare financing shapes hospital profitability and recommends disciplined liquidity management, efficient conversion of patient and insurance revenue into working capital, and financing strategies that safeguard short-term solvency.

Keywords: Working capital, healthcare financing, mediation, current ratio, financial performance, private hospitals, Kenya

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I. INTRODUCTION

A. Background

Working capital, the surplus of current assets over current liabilities, is the pool of resources that a firm deploys in its daily operations, and its efficient management is widely regarded as a precondition for business success (Wasiuzzaman, 2015; Altaf & Ahmad, 2019). In healthcare, providers rely on working capital to meet operational expenses such as supplies, utilities and salaries, and to sustain the service capacity on which revenue depends, so that liquidity performs a significant role in profitability (Ndungo, Tobias & Florence, 2016). Healthcare financing, for its part, encompasses the mobilization, allocation and management of financial resources for the delivery of health services, through mechanisms that include loan facilities, health insurance reimbursements and out-of-pocket payments (Al Mustanyir, 2023; Zhou et al., 2022). How the financing a hospital assembles is converted into the liquidity it operates with is therefore a question at the heart of hospital financial management.

The Keynesian liquidity preference theory, which anchors this study, holds that economic units hold liquid assets for transactionary, precautionary and speculative motives (Keynes, 1936). Applied to private hospitals, the theory explains why hospitals maintain working capital as a buffer that enables them to meet recurrent obligations in an environment characterised by uncertain out-of-pocket receipts and frequently delayed insurance reimbursements, and it implies that liquidity mediates the translation of financing into performance.

Contemporary evidence reaffirms the proposition: Marozva (2026) found liquidity to be a pivotal factor shaping the financing and value of listed firms, while Dangs, Ojeka, Uthman and Onmonya (2026) reported that internal liquidity capacity was the dependable driver of return on assets in capital-constrained sub-Saharan African healthcare markets. The resource-based view complements this logic by treating both financing and well-managed liquidity as strategic resources that firms deploy to generate superior performance (Barney, 1991).

The private hospital sector in Kenya offers a fitting setting for examining these propositions. The Kenya Medical Practitioners and Dentists Council licenses 153 private hospitals at level 4B and above (KMPDC, 2023), institutions that face high operating costs, rising demand for quality care and constrained access to financial resources (Nyawira et al., 2022). A significant source of financial strain is the long-delayed collection of hospitalization fees from insurance funds, which is frequently settled in instalments across financial periods, creating cash-flow gaps that disrupt financial planning (Nguru & Ireri, 2022). In such an environment, the manner in which hospitals convert their financing into working capital may determine whether that financing improves financial performance at all.

B. Problem Statement

Although a considerable body of research links working capital management to firm performance, the evidence on its role in the financing–performance relationship in healthcare remains fragmented. Studies of hospitals in middle-income and developed countries have related healthcare financing sources and working capital practices to profitability, liquidity and efficiency (Hsiao & Yip, 2024; Tarzibash & Ozyapici, 2024), and cross-country comparisons confirm that the strength of the working capital–performance relationship differs between developed and emerging markets (Kiyamaz, Haque & Choudhury, 2024). Yet these studies treat financing and working capital as parallel determinants rather than examining whether working capital is the channel through which financing operates.

The mediation evidence that does exist lies outside the private hospital context. Arilyn and Nguisteva (2026) found that working capital management significantly mediated the leverage–performance relationship among listed firms in Indonesia but not in Singapore, underscoring the context-dependence of the effect, while Amos, Au-Yong and Musa (2022) documented the mediating role of finance in the performance of hospital facilities management services. In East Africa, Crammar and John (2021) established that competitive advantage mediated the relationship between working capital management and the financial performance of private hospitals in Western Uganda, but did not test working capital itself as the intervening mechanism between financing and performance. Kenyan studies have likewise addressed adjacent questions, including financial management practices in public hospitals (Muturi & John, 2020) and short-term financing among retailers (Kiarie & Olando, 2021), without estimating the intervening role of working capital in private hospitals.

These conceptual and contextual gaps motivated the present study, which sought to determine the intervening effect of working capital on the relationship between healthcare financing and the financial performance of private hospitals in Kenya. The study tested the null hypothesis (H02) that working capital has no significant intervening effect on the relationship between healthcare financing and the financial performance of private hospitals in Kenya.

II. LITERATURE REVIEW

A. Theoretical Review

The Keynesian liquidity preference theory, propounded by Keynes (1936), anchors the study. The theory holds that economic units hold liquid assets in preference to less liquid ones for three motives: the transactionary motive of meeting day-to-day obligations, the precautionary motive of cushioning against unforeseen contingencies, and the speculative motive of exploiting future opportunities. Applied to private hospitals, the theory explains the maintenance of working capital, proxied by the current ratio, as a buffer that enables hospitals to sustain operations without recourse to costly emergency financing, and it provides the theoretical justification for treating working capital as the intervening variable between healthcare financing and financial performance. Critics observe that the theory may encourage the holding of excessive idle balances that depress profitability, and that it accords limited attention to long-term investment financing (Baumol, 1952; Miller & Orr, 1966); these cautions imply that it is well-managed, rather than merely large, liquidity that should transmit the benefits of financing.

The resource-based view, proposed by Barney (1991), holds that firms achieve superior performance by strategically deploying valuable, rare, inimitable and non-substitutable resources. In this study, both the financing that hospitals mobilize and the liquidity into which it is converted constitute such resources: it is not the possession of financing that matters but the ability to deploy it, through working capital, to sustain and expand service delivery. The theory thus frames the mediation hypothesis in resource terms, with working capital the proximate resource through which the more distant financing resources act.

The pecking order and trade-off theories complete the framework. The pecking order theory of Myers and Majluf (1984) holds that firms exhaust internal funds before turning to debt and, only as a last resort, to equity, which explains the reliance of private hospitals on retained earnings and loan facilities. The trade-off theory (Myers, 1984) postulates that firms balance the benefits and costs of alternative financing sources, including the trade-off between the returns to investing resources and the protection afforded by holding them in liquid form. Together, the theories predict that financing choices will bear on performance principally through the liquidity positions they produce.

B. Empirical Review

Cross-country evidence establishes that working capital is significantly related to firm performance while leaving the mediation question open. Kiymaz, Haque and Choudhury (2024) compared developed and emerging economies and found that the components of working capital were significantly related to performance, with the relationship markedly stronger in emerging markets, but did not treat working capital as an intervening variable. Arilyn and Nguisteva (2026) tested mediation directly and found that working capital management significantly mediated the leverage–performance relationship in Indonesia but not in Singapore, underscoring that the mediating effect is context-dependent and warrants testing in other settings.

Healthcare-sector studies relate financing and working capital to hospital outcomes without isolating the channel. Hsiao and Yip (2024) examined healthcare financing and working capital management in middle-income countries and documented their joint association with hospital profitability, liquidity and solvency, while Tarzibash and Ozyapici (2024) showed that working capital management conditioned the effect of economic policy uncertainty on healthcare organizations in developed economies. Amos, Au-Yong and Musa (2022) found that finance mediated the relationship between service quality and the performance of hospital facilities management services in developing countries. None of these studies, however, tested working capital as the intervening variable between healthcare financing and the financial performance of private hospitals.

The regional evidence closest to the present study is that of Cranimar and John (2021), who examined private hospitals in Western Uganda and established that competitive advantage mediated the relationship between working capital management and financial performance. The study confirmed the salience of working capital to hospital profitability in East Africa but inverted the question of interest here, treating working capital as the antecedent rather than the mechanism. The absence of any study estimating the intervening effect of working capital on the financing–performance relationship among private hospitals in Kenya constitutes the gap the present study fills.

III. METHODOLOGY

The study adopted a positivist research philosophy and a longitudinal panel research design. The positivist paradigm ensured objectivity by relying on quantifiable secondary data and the empirical testing of hypotheses, while the longitudinal design enabled the analysis of relationships over time and the control of unobserved hospital-specific heterogeneity. The target population comprised all 153 private hospitals in Kenya licensed at level 4B and above, made up of 54 level 4B, 90 level 5 and 9 level 6 hospitals (KMPDC, 2023), and a census was adopted because the population was relatively small. Secondary data were collected from the audited annual reports and financial statements of the hospitals for the five-year period from 2019 to 2023, yielding a balanced panel of 765 hospital-year observations.

Healthcare financing was decomposed into loan facilities, out-of-pocket payments and insurance receipts, each measured as the natural logarithm of its total annual value; working capital was measured by the current ratio, the ratio of current assets to current liabilities; and financial performance was measured as the return on assets, as applied by Mwangudza, Jagongo and Ndede (2020). The intervening effect was tested using the four-step mediation procedure of Baron and Kenny (1986) estimated within the fixed-effects framework: Step One regressed financial performance on healthcare financing ($FP = \beta_0 + \beta_1 HF + \epsilon$); Step Two regressed working capital on healthcare financing ($WC = \beta_0 + \beta_1 HF + \epsilon$); Step Three regressed financial performance on working capital ($FP = \beta_0 + \beta_1 WC + \epsilon$); and Step Four regressed financial performance on both healthcare financing and working capital ($FP = \beta_0 + \beta_1 HF + \beta_2 WC + \epsilon$). Mediation exists where the first three steps are significant and the direct effect of financing is reduced or rendered insignificant in the fourth.

Prior to estimation, diagnostic tests for multicollinearity, normality, linearity, heteroscedasticity, autocorrelation and stationarity were performed and confirmed the suitability of the data for panel regression: variance inflation factors ranged from 1.33 to 2.36, the Shapiro-Wilk statistics were consistent with normality, the modified Wald and Wooldridge tests found no heteroscedasticity or serial correlation, and all variables were stationary in levels. The Hausman specification test returned a chi-square statistic of 469.55 ($p < 0.001$), leading to the selection of the fixed-effects model over the random-effects alternative. Estimation was carried out at the 5 per cent level of significance.

IV. RESULTS AND DISCUSSION

A. Descriptive Results

The descriptive statistics presented in Table 1 summarize the characteristics of the study variables across the 765 hospital-year observations, comprising the 153 hospitals observed over the five years from 2019 to 2023. The three financing components are expressed as natural logarithms of their total annual values in millions of Kenya shillings, working capital as the current ratio and financial performance as the return on assets.

The financing variables display comparable log-scale dispersion (standard deviations of 0.413 to 0.420) with pronounced positive skewness (1.28 to 1.35), indicating that a small number of hospitals mobilized considerably larger financing volumes than the majority. Working capital, by contrast, was remarkably stable: the current ratio had a mean of 2.043 (median = 2.043) with a standard deviation of only 0.050, values ranging narrowly from 1.835 to 2.216, negligible skewness (0.05) and a coefficient of variation of 0.02, indicating that the hospitals uniformly maintained current assets at roughly twice their current liabilities. This tight clustering suggests a deliberate and common approach to liquidity management across the sector, precisely the behaviour the liquidity preference theory predicts. Financial performance had a mean of 0.0706 (median = 0.0693), an average return of about 7.1 per cent on assets, with a near-symmetric distribution (skewness = -0.15) and values ranging from 0.0525 to 0.0890.

Table 1: Summary of Descriptive Statistics

Statistic	Ln(Loan facilities)	Ln(Out-of-pocket payments)	Ln(Insurance receipts)	Working capital	Financial performance (ROA)
N	765	765	765	765	765
Minimum	6.240	6.644	7.227	1.835	0.0525
Maximum	8.767	9.294	9.910	2.216	0.0890
Mean	7.052	7.395	7.983	2.043	0.0706
Median	6.955	7.312	7.893	2.043	0.0693
Std. deviation	0.413	0.413	0.420	0.050	0.0071
Std. error	0.015	0.015	0.015	0.002	0.0003
Coeff. of variation	0.059	0.056	0.053	0.024	0.101
Skewness	1.308	1.284	1.349	0.046	-0.146
Excess kurtosis	2.118	2.404	2.493	0.839	-0.780

Source: Research Findings (2025)

B. Hypothesis Testing

The null hypothesis (H02) that working capital has no significant intervening effect was tested using the Baron and Kenny four-step procedure, with the results of the four steps presented in Tables 2 to 5. In Step One (Table 2), healthcare financing had a significant effect on financial performance: the model was significant, $F(3, 609) = 498.60$, $p < 0.001$, with a within R-squared of 0.7107, and loan facilities ($\beta = 0.773$, $p < 0.001$) and out-of-pocket payments ($\beta = 0.013$, $p = 0.003$) were significant predictors, satisfying the first condition for mediation.

Table 2: Step One – Healthcare Financing and Financial Performance

Fixed-effects (within) regression		Number of obs = 765	Number of groups = 153			
R-squared: within = 0.7107, between = 0.6814, overall = 0.1518						
F(3, 609) = 498.60		Prob > F = 0.0000				
Financial performance	Coef.	Std. err.	t	P> t	[95% Conf.	Interval]
Ln(Loan facilities)	0.7734	0.0225	34.33	0.000	0.7291	0.8176
Ln(Out-of-pocket payments)	0.0135	0.0046	2.95	0.003	0.0045	0.0224
Ln(Insurance receipts)	0.0075	0.0047	1.59	0.113	-0.0018	0.0169
_cons	10.4714	0.0897	116.74	0.000	10.2952	10.6475

Source: Research Findings (2025)

In Step Two (Table 3), healthcare financing had a significant effect on working capital, with loan facilities ($\beta = 0.985$, $p < 0.001$) and out-of-pocket payments ($\beta = 0.015$, $p = 0.004$) significant predictors and the model explaining 76.76 per cent of the within-hospital variation in working capital ($F(3, 609) = 670.36$, $p < 0.001$), thereby satisfying the second condition for mediation. The near-unit elasticity of working capital with respect to loan facilities indicates that debt financing translated almost fully into liquidity.

Table 3: Step Two – Healthcare Financing and Working Capital

Fixed-effects (within) regression	Number of obs = 765	Number of groups = 153			
R-squared: within = 0.7676, between = 0.6581, overall = 0.1718					
F(3, 609) = 670.36	Prob > F = 0.0000				
Working capital	Coef.	Std. err.	t	P> t 	[95% Conf. Interval]
Ln(Loan facilities)	0.9852	0.0246	40.05	0.000	0.9369 1.0335
Ln(Out-of-pocket payments)	0.0146	0.0050	2.92	0.004	0.0048 0.0244
Ln(Insurance receipts)	0.0082	0.0052	1.59	0.113	-0.0019 0.0184
cons	9.3759	0.0979	95.73	0.000	9.1835 9.5682

Source: Research Findings (2025)

In Step Three (Table 4), working capital had a strong, positive and highly significant effect on financial performance ($\beta = 4.743$, $p < 0.001$), with the model explaining 64.88 per cent of the within-hospital variation ($F(1, 611) = 1128.74$, $p < 0.001$), satisfying the third condition for mediation.

Table 4: Step Three – Working Capital and Financial Performance

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Fixed-effects (within) regression	Number of obs = 765		Number of groups = 153			
R-squared: within = 0.6488, between = 0.5346, overall = 0.4631						
F(1, 611) = 1128.74		Prob > F = 0.0000				
Financial performance	Coef.	Std. err.	t	P> t 	[95% Conf.	Interval]
Working capital	4.7434	0.1412	33.60	0.000	4.4661	5.0207
cons	5.1687	0.1013	51.04	0.000	4.9698	5.3676

Source: Research Findings (2025)

In Step Four (Table 5), when working capital was entered alongside the financing components, working capital remained strongly significant ($\beta = 0.901$, $p < 0.001$) while the direct effects of the financing components changed markedly: out-of-pocket payments ($\beta = 0.0003$, $p = 0.698$) and insurance receipts ($\beta = 0.0001$, $p = 0.878$) became insignificant, and the coefficient of loan facilities was substantially reduced and reversed in sign ($\beta = -0.114$, $p < 0.001$). The collapse of the direct effects of out-of-pocket payments and insurance receipts once working capital was controlled for, together with the dominant and significant effect of working capital, is the classic signature of mediation and indicates that working capital carried the influence of healthcare financing on financial performance.

Table 5: Step Four – Healthcare Financing, Working Capital and Financial Performance

Fixed-effects (within) regression	Number of obs = 765	Number of groups = 153				
R-squared: within = 0.7117, between = 0.7527, overall = 0.2252						
F(4, 608) = 375.27 Prob > F = 0.0000						
Financial performance	Coef.	Std. err.	t	P> t	[95% Conf.	Interval]
Ln(Loan facilities)	-0.1145	0.0076	-14.98	0.000	-0.1295	-0.0995
Ln(Out-of-pocket payments)	0.0003	0.0008	0.39	0.698	-0.0013	0.0019
Ln(Insurance receipts)	0.0001	0.0008	0.15	0.878	-0.0015	0.0018
Working capital	0.9012	0.0066	136.43	0.000	0.8882	0.9142
cons	2.0218	0.0640	31.61	0.000	1.8962	2.1474

Source: Research Findings (2025)

Taken together, the four steps satisfied the conditions for mediation: healthcare financing significantly affected both financial performance and working capital, working capital significantly affected financial performance, and the direct effects of healthcare financing were greatly diminished when working capital was introduced. Working capital therefore had a significant intervening effect, and the null hypothesis H02 was rejected. The mediation was full in respect of out-of-pocket payments and insurance receipts, whose direct effects became insignificant, and partial in respect of loan facilities, whose effect remained significant but was greatly reduced.

The findings provide strong support for the Keynesian liquidity preference theory, which assigns liquidity a central role in sustaining operations and profitability (Keynes, 1936): healthcare financing translated into improved financial performance largely through its effect on the hospitals' liquidity, so that the manner in

which financing was converted into working capital was decisive for profitability. The full mediation observed for out-of-pocket payments and insurance receipts is intuitive, given that patient payments and insurance reimbursements directly augment current assets, while the partial mediation of loan facilities indicates that debt financing retained an independent influence beyond its liquidity contribution, consistent with the disciplinary and investment roles of debt emphasised by the trade-off theory (Myers, 1984). Empirically, the results are consistent with Cranimar and John (2021) on the salience of working capital to private hospital performance in East Africa, with Arilyn and Nguisteva (2026) on the mediating role of working capital management, with Kiymaz, Haque and Choudhury (2024) on the strength of the working capital–performance relationship in emerging markets, and with Marozva (2026) and Dangs, Ojeka, Uthman and Onmonya (2026) on liquidity as the dependable driver of performance in comparable settings.

V. CONCLUSION

The study establishes that working capital plays a central intervening role in the relationship between healthcare financing and the financial performance of private hospitals in Kenya. Analysis of a balanced panel of 765 hospital-year observations from the 153 level 4B and above private hospitals over 2019 to 2023, using the Baron and Kenny procedure within a fixed-effects framework, confirmed that financing influenced performance largely through the liquidity it created: the direct effects of out-of-pocket payments and insurance receipts vanished once working capital was controlled for, and the effect of loan facilities was greatly reduced. These results elevate working capital from a peripheral consideration to the principal mechanism through which healthcare financing shapes hospital profitability.

Overall, the findings imply that hospitals that convert their financing into adequate and well-managed liquidity are better placed to sustain operations, meet their obligations and achieve superior financial outcomes than those that do not. The evidence supports the Keynesian view of liquidity as a buffer against uncertain receipts and delayed reimbursements, while the stability of current ratios around two to one across the sector suggests that Kenyan private hospitals already manage liquidity deliberately. The decisive question for performance is therefore not merely how much financing a hospital mobilizes, but how efficiently that financing is transformed into working capital and deployed in operations.

VI. RECOMMENDATIONS

In view of the central intervening role of working capital, the study recommends that private hospitals adopt disciplined working capital management practices, maintaining adequate liquidity to meet operational obligations without holding excessive idle balances. Financial managers should establish clear policies on the management of current assets and liabilities and monitor liquidity regularly, since it was through working capital that healthcare financing exerted much of its influence on performance. Hospitals should also strengthen their patient-billing and collection systems, and build robust claims-management capacity, so that out-of-pocket revenue and insurance reimbursements, whose effects on performance operated entirely through liquidity, are converted into working capital promptly and fully.

Policymakers and insurers should reform the claim-settlement process by shortening payment cycles, reducing rejection rates and standardising reimbursement procedures, since delayed settlements impede precisely the liquidity channel through which financing was found to drive performance. Financial institutions should, in turn, design credit products whose disbursement and repayment profiles support rather than strain hospital liquidity. Future research should examine the moderating influence of hospital characteristics such as size and age on the mediated relationship, employ alternative liquidity measures such as the cash conversion cycle, and test the robustness of the mediation using structural equation modelling or bootstrapped indirect effects.

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