AN ETHICAL INVESTIGATION INTO OPERATING PAYING SECTIONS IN MALAWIAN PUBLIC HOSPITALS: THE CASE OF ZOMBA CENTRAL HOSPITAL (ZCH)

MASTER OF ARTS (APPLIED ETHICS) THESIS

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UNIVERSITY OF MALAWI

CHANCELLOR COLLEGE

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By

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Submitted to the Faculty of Humanities in partial fulfillment of the requirements for the degree of Master of Arts in Applied Ethics

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DECLARATION

I, the undersigned, hereby declare that this thesis is my own original work and it has not been submitted to any other institution for examination purposes. Acknowledgements have been duly made where other people's work has been used. I bear the responsibility for the contents of this thesis.

Reuben Kantwanje Alexander

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Full Legal Name

_____

Signature

_____

Date

CERTIFICATE OF APPROVAL

The undersigned certify that this thesis represents the student's own work and effort and has been submitted with our approval.

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Head of Department

DEDICATION

I dedicate this piece of work to my late mother, Mary Unjika, for the love and encouragement to work hard in school.

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First and foremost, I thank the Almighty God for life and granting me the abundant grace to complete the study.

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ABSTRACT

This study is an ethical investigation into operating paying sections in Malawian public hospitals, and focuses on Zomba Central Hospital (ZCH) as a case study. Zomba Central Hospital is one of the hospitals in Malawi where paying sections are run alongside the non-paying sections. Initially, medical services at this institution were for free at the point of consumption. However, a paying wing was later introduced, although it was also suspended along the way. In 2013, the paying wings were re-introduced at ZCH. This study was conducted to investigate whether or not the distribution of resources at ZCH favours the paying section. The study used utilitarianism ethical theory to investigate the ethics of operating paying wings in public hospital of Zomba Central. Face-to face interviews were conducted to two key informants (Chief Hospital Administrator and the In-charge of the Paying Section). Semi-structured questionnaires were used to gather primary data from five nurses and three doctors. Focus group discussions were conducted with four guardians from paying section and eleven from the non-paying section. The findings of the study show that distribution does not favour the paying section. However, it was found that the system is associated with good and bad things. The good things include: the system does not infringe non-paying patients from accessing healthcare; the system helps to realise money that is used to buy medicine, reagents and other necessities at the institution used for the entire hospital, such as renovation of the hospital structures and motivation of all members of staff. The bad things highlighted were that provision of good meals and accommodation favours the paying section only. The study concludes that the system of operating paying wings in public hospitals is ethical under utilitarianism. This is so because the system does not favour the paying wing in the resource distribution. The other aspect is that the system mitigates the financial gaps created by the underfunding of the institutions.

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LIST OF ABBREVIATIONS

CHA	Chief Hospital Administrator
HD	Hospital Director
HIMS	Health Information Management System
HIV	Human Immunodeficiency Virus
ICU	Intensive Care Unit
KCH	Kitwe Central Hospital
MASM	Medical Aid Society of Malawi
MCH	Maputo Central Hospital
MoH	Ministry of Health
OOP	Out-Of-Payment
PFP	Private for Profit
PHA	Principle Hospital Administrator
PNFP	Private Not for Profit
PPIs	Public-Private Interactions
TAH	Tygerberg Academic Hospital
UHC	Universal Health Coverage
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisation
ZCH	Zomba Central Hospital

CHAPTER 1
INTRODUCTION

1.1 Background

The system of operating paying sections alongside non-paying sections in public hospitals has been on the increase in low and middle income countries (McPake, Hongoro & Russo, 2011). McPake et al. (2011) report two main aims for the introduction of such a system. The first one was to provide comprehensive quality health care to affluent people. The other aim has been to generate funds to upset financial woes faced by underfunded public hospitals. The generated funds are also used in retention of medical professionals, subsidisation of the underprivileged population groups and development of novel models of service delivery (Wadee & Gilson, 2007).

Wadee & Gilson (2007) describe paying sections in public hospitals as differentiated amenities which deal with provision of hotel-kind of services to affluent patients through out-of-pocket payment and medical insurance cover. This implies that patients do have the opportunity to choose whether to go to paying or non-paying section. It also implies that the services offered in the paying section surpass, in terms of quality, those provided in the non-paying section. The determinant of choosing the paying section is the ability to pay for its services. This means that paying sections allow patients to access comprehensive medical service delivery.

McPake, Nakamba, Hanson & McLoughlin (2004) describe the system of having paying section in public hospitals as a two-tier charging mode of medical service delivery. This two-tier charging system consists of 'high-cost' and 'low-cost'. The high-cost refers to the paying section while the low-cost refers to the non-paying section (McPake et al. 2004). The main aim of this kind of arrangement is to let the proceeds from the former to subsidise the later (McPake et al. 2004).

Many studies have been conducted on the system (McPake et al. 2004; Wadee & Gilson, 2007 & McPake, Hongoro & Russo, 2011). Some have revealed flaws of the system (McPake et al. 2004 & McPake, Hongoro & Russo, 2011) while others have recommended it (Wadee & Gilson,

2007). The studies that have faulted the system of operating private sections alongside non-paying section argue about its failure to meet the intended purpose of subsidising the non-paying section. This is due to, among other reasons, its failure to generate enough funds to carter for the entire hospital activities (Gilson, 1997); accrual of higher costs of the paying sections that makes realised funds to meet the said costs (McPake, Hongoro & Russo, 2011) and allocation of resources favouring the paying section (McPake et al. 2004).

Information gathered from various studies reveals that many of them took an economic perspective (McPake et al. 2004 & McPake, Hongoro & Russo, 2011). However, very few considered an ethical perspective (Wadee & Gilson, 2007). This study, therefore, investigates the ethics of operating a paying section in public hospitals in the context of resource distribution. That is, the study aims at exploring whether or not resource distribution favours the paying section. The study was conducted at Zomba Central Hospital (ZCH) which is located in Zomba, South Eastern part of Malawi.

1.2 Malawi

Malawi is a landlocked country in Southeast Africa with a population of 17.5 million out of which 84% lives in the rural areas (Government of Malawi, 2019). The country covers an area of 94,552 square kilometres. Malawi's economy is largely based on agriculture and contributes about 28% of the gross domestic product (GDP) which is one of the lowest in sub-Saharan Africa (Global Fund, 2016). This situation is evidenced by the claim that almost more than 50% of Malawi's population lives below the national poverty line (World Bank, 2010). Additionally, Malawi is one of the fastest

-growing populations being rated the 12th position in the world with a yearly growth rate of 3.2% (World Bank World, 2012).

1.2.1 Organisation of Malawi's health sector

Health services in Malawi are provided by three main sectors namely; public, private for profit (PFP), and private not for profit (PNFP) (Makwero, 2018). Public sector provides health services through Ministry of Health (MoH) which provides 60% of the health services in Malawi (National Statistical Offices, 1987). The public health services are also offered through district,

town and city councils, army, police and prisons (Makwero, 2018). The PNF offers its services through private hospitals while PNFP sector renders its health services through religious institutions, nongovernmental organisations (NGOs), statutory corporations and companies (Makwero, 2018).

Public sector delivers its healthcare services for free or almost free because of the bypass fees that are paid in referral hospitals (Oxfam, 2016). Public health services are offered through three different avenues namely; primary, secondary and tertiary levels (Makwero, 2018). According to her, primary care level includes health centres with their clinics, dispensaries and village hospitals which are meant to serve an average population of 10,000 citizens. Secondary care level deals with the provision of health care at a district level, for instance at a district hospital. On the other hand, tertiary care level focuses on delivery of health care services at central hospitals. Currently, Malawi has four tertiary hospitals which include Zomba Central Hospital, Queen Elizabeth Central Hospital, Kamuzu Central Hospital and Mzuzu Central Hospital. Ngalande Banda & Simukonda (1994) reports that the levels are based on the referral role a particular level plays. This means that a patient would first visit the primary level and then get referred to another level if that previous level failed to provide adequate services.

The MoH services and institutions are meant and fundamentally free and depend on funding from government and donor community. Ngalande Banda & Simkonda reports that a big percentage of MoH budgetary vote is spent on health institutions, for instance, over 85% of the MOH budget is spent on hospital and their related health centres.

1.2.2 Zomba

Zomba is the district that is situated in the South-Eastern part of Malawi, Central Africa. It covers an area of 2,363 square kilometres. Zomba became the capital in 1891. The capital was transferred to Lilongwe in 1975 and later became a municipal in 1979. On 9th March, 2008 Zomba was accorded a status of a city. Zomba city is located at the bottom of Zomba Plateau.

Zomba district has a total population of 746,724. The district has one of the central hospitals in Malawi known as Zomba. However, Zomba district has no district hospital apart from health

centres which refer their patients to ZCH. Some districts surrounding Zomba district refer their patients to ZCH. Such districts include: Machinga which has a population of 735,438; Mangochi with a total population of 1,148,611; Balaka with a population of 438,379; and Phalombe which is currently accommodating a population of 429,450 (Government of Malawi, 2019).

1.2.3 Zomba Central Hospital

Zomba Central Hospital (ZCH) is located within Zomba City. ZCH has the capacity of 400 beds. It has four main departments namely: surgery (including male ward and female wards, clinic and 3 operating theatres); adult medicine (including male and female wards, male and female Tuberculosis/isolation wards, a prison ward, medical clinic, Human Immunodeficiency Virus (HIV) clinic, staff clinic), paediatrics (including a medical paediatric ward, a surgical paediatric ward, a nutrition ward, a neonatal ward, a kangaroo baby care unit and the under-five clinic), an eye clinic and gynaecology (including a labour ward, prenatal ward, postnatal ward and gynaecology clinic). The hospital also has a 4bed Intensive Care Unit (ICU), a rudimentary laboratory, radiology department and a physiotherapy unit. Specialists available include 2 general surgeons, 1 anaesthetist, 1 dermatologist, 2 obstetrician/gynaecologists and 1 internist. The hospital does not have a paediatrician at the moment. The hospital also runs a paying section which has male and female wards with 17 beds per ward.

Zomba Central Hospital operates under the guidance of a vision “To be a centre of excellence in the provision of tertiary health services using cutting edge technology in the south eastern zone”. The hospital also conducts its activities with a mission “To provide specialised quality tertiary health care services to patients and clients in the south east zone and beyond”. Zomba Central Hospital, further, delivers its health care services with the purpose of promoting and rehabilitating the health status of patients, clients and communities in the south east zone and beyond by curing and preventing ill health. Additionally, ZCH works under the direction of the motto “Passionate, quality tertiary health care for our clientele”. Finally, ZCH performs its tasks by focus on the core values that include: team work, privacy, informed consent, safety, integrity, reliability, equal opportunities, confidentiality, veracity, infection prevention, accountability, and responsibility.

1.3 Statement of the problem

This study is an ethical investigation of operating a paying section in a public hospital of Zomba Central. There have been debates on the topic of operating paying wings alongside non-paying wings in public hospitals but no conclusive position has been made as to whether it is ethical to employ the system or not. Furthermore, some literature has reported the challenges that the system inflict on the society. These include: favouring resource allocation to the paying section (McPake et al., 2004); promoting inequity between paying and non-paying patients (Eramus, Blaauw & Gilson, 2009); realisation of little proceeds not worthy to offset financial challenges that public hospitals face (Gilson, 1997); and putting a burden of financing public hospital activities on poor people; and taking back of the proceeds to the paying section to meet the accrued high costs thereby failing to subsidise the non-paying section (Oxfam, 2016). Despite all the underscored challenges, some countries still think of either introducing or reintroducing it. Malawi, for instance, re-introduced the system in 2013 after it stopped receiving support from the hospital management and its staff in the early 2000s. In Malawi, provision of free medical services in public hospitals is considered a government responsibility. However, it is a problematic to have paying sections within public hospitals which are supposed to be for everyone and for free. This is so because distribution of resources may be favouring those that pay fees at the paying section. In addition to the highlighted challenges, not many studies have been conducted to explore the ethics of embracing this system since their focus has been on an economic perspective.

1.4 Aim of the study

The main aim of this study is to carry out an ethical investigation into operating a paying section in a public hospital of Zomba Central.

1.5 Research questions

This study was guided by the following main research question, sub-research questions and hypothesis.

1.5.1 Key research question

a) Is it ethically justifiable to operate paying section in public hospitals in Malawi?

1.5.2 Sub-research questions

a) What does the system of operating paying section within public hospitals entail?
b) How is the system of operating paying section implemented at ZCH?
c) What are the merits of having a paying section at ZCH?
d) What are the demerits of having a paying section at ZCH?
e) What are the ethical implications of operating paying section at ZCH?

1.6 Hypothesis

Considering that Malawi's public hospitals are underfunded and that by introducing paying section they aim at offsetting the challenges emanating from the underfunding, I hypothesise that distribution of resources may be favouring the paying section because it is where additional funding for the running of the hospital is expected to come from. Significantly, managers of the hospitals would apply cost-benefit analysis in allocating resources. That is to say, they would allocate more where more revenue is being generated. In addition, significantly, clients of the paying section would expect comprehensive quality services which would be fulfilled through enough allocation of resources. This would influence allocation of resources by favouring the paying section.

1.7 Significance of the study

This study is important because the findings will help to explore ethical issues associated with operation of paying section along with non-paying section. The study will also help to explore the merits and demerits of implementing the system. Besides assisting in exploration of ethical issues; merits and demerits, the study will also uncover the challenges faced by medical professionals, guardians and patients from both paying and non-paying sections. The other importance is that the study may help the management to work out on some of the challenges to make the system work fairly. Additionally, the study may help policy makers in learning some issues that can be looked into when evaluating the system at a national level. Finally, the study may be used as a basis for future studies.

It is important to note, however, that much as the findings of this study cannot be generalised to other public central hospitals in Malawi and other countries beyond, their significance cannot be

underemphasised. The experiences that ZCH faces for having paying wings can provide some lessons to other central public hospitals, both in Malawi and beyond, that are operating paying sections or are considering doing so.

1.8 Dissertation outline

Chapter One: This chapter discusses the introduction, background, problem statement, aim, research questions, hypothesis and significance of the study.

Chapter Two: The chapter articulates the literature review of the study.

Chapter Three: This chapter explains the theoretical framework informing the study.

Chapter Four: This chapter discusses the research methodology of the study. The chapter indicates the research site, sample size, target population, tools, sampling methods and data analysis method of the study. The chapter has also indicated reasons for the choice of the outlined aspects. It is also in this chapter where research ethics and the limitations of the study have been discussed.

Chapter Five: This chapter presents findings of the study. It is also within this chapter where discussion on the findings has been made.

Chapter Six: This is the chapter where conclusion and implications of the study have been made.

1.9 Chapter conclusion

This chapter has introduced the title of the study. It has also explained the study's problem statement, aim, research questions, hypothesis, and significance. The chapter has, finally, presented the layout of the study.

CHAPTER 2
LITERATURE REVIEW

2.1 Chapter introduction

This chapter discusses the relevant information from different sources on the issue of introducing paying section in public hospitals. That is, how they are implemented, their merits and demerits. This is also the chapter where information about the rationale behind introduction of paying sections in public hospitals is exposed.

2.2 Worldview of operating paying section in public hospital

Operation of paying sections in public hospitals is one of the reforms low and middle economic countries have embarked on. Hospital reforms are also advocated by international agenda as one of the elements of new public management reforms (Wadee & Gilson, 2007). Hospital reform takes different forms that include user fees, management autonomy just to mention but a few (McPake et al., 2004). The major aspect of hospital reform that has been embraced by low and middle income countries is that of operating paying sections in public hospitals (Wadee & Gilson, 2007). McPake et al. (2004) describes the system of operating paying section as a two-tier charging structures where paying services are offered alongside free services in public hospitals. This way of providing health services is said to be common in low and middle income countries (McPake et al., 2011). The main aim is to provide high quality services to people who can manage to pay for the medical services. The other rationale behind the system is for revenue generation to fund the under-funded public hospitals to achieve Universal Health Coverage where all people's needs to access health care services is made possible despite the financial challenges one can be in (McPake et al., 2011). Wadee & Gilson (2007) report that paying sections in public hospitals are also referred to as "differentiated amenities" which involve provision of hotel-type of services to patients who can manage to pay through either out-of-pocket or medical insurance. According to them, the system plays a vital role in a number of ways. The paying section generates revenue which helps in the retention of medical professionals and development of new models of service delivery, thereby allowing disadvantaged population groups to easily access better health services.

A number of African countries embrace the hospital reform of operating paying wards in public hospital. For instance, Zambia, through its Kitwe Central Hospital (KCH), operates paying wards along with non-paying wards (McPake et al., 2004). According to McPake et al. (2004), the rationale behind introducing the system is to subsidise the low-cost patients from the revenue generated by high-cost patients. The other aim is to generate revenue to be retained and used by the hospitals themselves. In Zambia, the system is described as a two-tier structure having high-cost and low-cost patients where high cost patients are the paying ones whereas the low cost are those who opt for free health care.

In Zambia, it is reported that the system of having paying wings is not compulsory, meaning that one is free to choose either the paying or non-paying section (McPake et al., 2004). According to McPake et al. (2004), Kitwe Central Hospital introduced a mechanism to allow paying outpatients to jump long queues to get faster services known as "fast-track". McPake et al. (2004) argue that patients opting for high-cost services get the hotel-type of higher quality services. The other advantage of opting for high-cost services, according to them, is that one's time is served as they are quickly attended to. Payment of the high-cost arrangement is facilitated through three ways namely; at the point of use, prepayment and fee-for-service bills or known as medical service scheme. However, the vice of the system at KCH is that it does not serve the intended purpose as the high cost patients are subsidised at the expense of the low cost patients. The other challenge is that resources are disproportionately allocated as they favour the paying patients; for instance, the use of theatre favours the high-cost patients (McPake et al., 2004).

Mozambique is another African country that once embraced the introduction of paying wards in public hospitals. In Mozambique, the paying wards being described as special clinics. The aim was to generate revenue to support the underfunded entire health system. In Mozambique, special clinics were introduced in 1977 at Maputo Central Hospital (MCH) by the ruling FREELIMO party. The initial rationale for introducing the special clinics was to provide quality care for party members and international diplomatic officials. This was the time when doctors and nurses were working in these special clinics outside their working hours at the main hospital. Later, the system grew to the extent that all activities done in the main hospital were also being

offered in the special clinics. The clinics offered an opportunity for patients to be assisted quickly by jumping the long queues available in the main hospital (McPake et al., 2011).

McPake et al. (2011) also argue that special clinics services at Maputo Central Hospital were being offered using their own facilities except for laboratory and surgical services which were being provided from the main hospital. Members of staff were being sourced from the main hospital and they used to work annually in a rotation. McPake et al. (2011), further, argue that health care services of the special clinics bordered the emergency department where non-paying patients who persevered on long queues watched the paying patients receiving treatment faster. This, according to McPake et al. (2011), made the system unpopular in Mozambique leading to its suspension in 2007. The government only allows its employed medical professional to practice in private hospital outside the public hospitals (McPake et al., 2011).

However, the special clinics were not without pitfalls as they failed to subsidise the public clinic because the generated funds were never distributed to the public wards. The other problem was the inequity being promoted between the special clinic patients and the public section patients. Besides, it became problematic to sustain quality demarcation between the two forms of sections. In Mozambique, it also became a challenge to explore the balance of net revenue flows between the special clinics and the public section (McPake et al., 2011). Therefore, this study intends to investigate where the paying section at ZCH is located and if the location has any ethical implications. The study also wants to enquire whether or not the system at ZCH has ever been suspended by the government; and if yes, the reasons for the suspension.

Besides Zambia and Mozambique, South Africa is yet another country that employs a two-tier system of medical care provision. That is, South Africa offers both paying and non-paying medical services. One of its public hospitals where paying system is done is Typerberg Academic Hospital (TAH) (Wadee & Gilson, 2007). The rationale behind the adoption of the approach was to generate money that would help to retain medical professionals through motivation; quality delivery of health services by using novel models and subsidising the poor by allowing them to access quality health care services (Erasmus, Blaauw & Gilson, 2009).

According to Erasmus et al. (2009), South Africa introduced the approach of having paying wings in public hospital. South African government describes the initiative as differentiated amenities which are defined as the provision of quality health care services equated to hotel services through out-of-pocket payment and medical insurance. The motivation behind South African government in venturing into the activity of operating paying wings is the budgetary pressure that emanated from the attempts to redirect resources to primary health care and the constant levels of spending indicated between 1994 and 2005. The other motivator is the government's engagement with private sector in service delivery through Public-Private Interactions (PPIs). Wadee et al. (2003) defines Public-Private Interactions as an arrangement that involves public and private sectors in service delivery. In the context of health, PPIs involve the engagement of private health finance in rendering some support to public health care. In South Africa, paying wings are allocated within the public hospital and doctors work in both wings as part of their normal duties. This implies that no incentives are given for working in the private wings. In these private wings, meals are slightly different from the ones received from the non-paying section. The meals from private wings are of high quality and the patients have that opportunity to demand a particular type of meal. Their Intensive Care Unit (ICU) has specific beds for private patients. The findings of Tygerberg Academic Hospital (TAH) study also indicate that there is no bias in resource distribution towards the paying wings (Wadee & Gison, 2007). However, despite the initial arrangement to have uniform quality services across the board, the uniformity is compromised as evidenced by the slight variations of catering menu provided between the two sets of wards where the paying section is being favoured (Erasmus et al., 2009). It is, therefore, this study's curiosity to investigate whether or not how paying wards at ZCH are run the same way they are done at TAH.

Lewis (2007) suggests that introduction of formal fees in public health facilities is one of the ways of dealing with informal payments also known as under-the-table payments in public hospitals. This is not in tandem with what most literature claims as the reason for introducing paying wings. This is the case because most studies attribute introduction of paying sections in public hospitals to the generation of fund as the main reason for venturing into the exercise. Lewis (2000:1) defines informal payments in two ways. First, as payment to individual and institutional providers, in kind or in cash, which are made outside office payment channels, for

instance, envelope payments to physicians and contributions to hospitals. Second, purchases meant to be covered by a health care system, for instance, the value of medical supplies purchased by patients and drugs obtained from private pharmacies but intended to be part of government-financed health care services. Informal payment is regarded as one of the forms of vices that fall under the category of corruption because the payment is made to individuals who use public office for personal gains. Informal payments in public health facilities are used to jump queues and get high quality services thereby undermining the concept of equity which is the rationale for subsidised public services (Lewis, 2007). So, this study wants to unearth whether or not under-the-table payment is one of the reasons paying sections were introduced at the institution.

According to Lewis (2007) informal payments pose negative impacts towards the poor people. Lewis argues that informal payments cost both inpatients and outpatients. For instance, the costs inpatients incur in informal payments surpass their annual family income. This forces them to sell their household assets and accumulation of debt to get money so that they access quality health services (Lewis, 2000 & Oxfam, 2016). Such kinds of challenges prompted Kyrgyz Republic and Cambodia to introduce official fees in public hospitals as a mechanism to deal with under-the-table payments (Lewis, 2007). These are payments which are defined as unofficial fees made in public facilities where services are offered for free (Killingsworth et al., 1999). Cohen (2012) describes such forms of payment as a 'do-it-yourself' approach which individuals use to be attended to quickly in government hospitals and gets quality services. The countries became successful as the strategy sharply reduced informal payments (Lewis, 2007). This can also be described as formalising of informal payments where fixed prices are set for the services unlike the informal ones which used to be unpredictable. Cambodia, for instance, formalised informal payments by setting fixed prices. This ensured patients of the set fixed prices. It also helped in protecting patients from the unpredictability of hospital fees because informal fees are not fixed (Barber, Bonnet, & Bekedam, 2004).

Lewis (2007) has reported that donors and governments have argued against any form of user fees in the interest of equity in access to health care in public facilities. Lewis (2000) also argues against making of any form of payment to buy public medical services because they compromise

the concepts of access to quality medical care and equity in accessing medical services. According to him, the system of paying for medical services makes them unaffordable and restricts their access to the well-off. This contravenes the principle of Universal Health Coverage (UHC) which advocates that all people should have an equal access to all health services they need such as health promotions, prevention assistance, rehabilitation and palliative care services. That is the equal access should not be compromised by the condition of one's financial status. That is to say, the process of accessing medical services at public facilities should not be the one that exposes the user to financial difficulties (World Health Organisation, 2016). This implies that any forms of payment, whether formal or informal, compromise the concept of universal health coverage.

Despite numerous attacks on any forms of payment to access medical care, Out-Of-Pocket payment is regarded as one of the three main ways of financing health system (Organisation for Economic Cooperation and Development (OECD) (2012). The other forms include revenue from taxes and donor funds. However, Out-Of-Pocket payment faces a lot of accusations arguing that the arrangement poses barriers to people in accessing and using health care services (Njeru & Okello, 2015). There are a number of studies that were conducted focusing on the concept of Out-Of-Pocket payment merely because it is either one of the sources of health care financing system or it acts as a stumbling block to people in accessing health care or realisation of universal health care coverage.

One of the studies on Out-Of-Pocket payment was done by Okello and Njeru in 2015. The study was to do with an investigation into factors affecting Out-Of-Pocket medical expenditure among outpatients in hospitals in Nairobi County. The factors that were targeted include: total income earned by an individual or household; individual's employment status; the level of extended family of an individual, that is, number of dependants for a particular individual; the costs of nursing and medical care services; and accessibility of medical insurance covers. The study revealed that household monthly income earned has a positive association on out of-pocket medical expenditure. This is the case because those whose earned higher income use much of it on out-of-pocket payment. The situation is attributed to their preference for private fee-paying health care facilities. Employment status of an individual has a negative impact on the out-of-

pocket medical expenditure because when one is employed, the employers insure their employees on health insurance covers. It is the insurance that covers medical expenses. High cost of medical services negatively impact the out-of-pocket medical expenditure because an expensive thing is less demanded. Finally, the availability of medical insurance covers negatively affects out-of-pocket medical expenditure because the insurance agencies or companies relieve their clients from out-of-pocket payment (Njeru & Okello, 2015). The implication of the findings is that for one to be able to manage out-of-pocket payment they should have higher income earnings. This means that the arrangement leaves out the poor. Therefore, the study was interested to test whether the system of operating paying section at ZCH leaves out the poor. The investigation was done by exploring the class of people that patronise the system.

Another study was done by Mark Merlis in 2012. The study was entitled "Family out-of-pocket health care spending: a continuing source of financial insecurity." The findings of the study are that out-of-pocket medical expenditure still stands out as one of the main sources of financial insecurity to those who are not covered with health insurances. The findings, further, state that the uninsured are at health risk because they end up foregoing the medical services when need arises (Merlis, 2012). In a related study by Mclntyre, Gilson and Mutyambizi, the three focused on the topic entitled "Promoting equitable health care financing in the African context: current challenges and future prospects". In the study, it was revealed that out-of-pocket medical expenditure is one of the largest sources of financing health systems in African nations despite imposing burdens on the poorest households (Mclntyre, Gilson & Mutyambizi, 2005). The study, further, revealed that donor funds take a vital role in financing health systems and their reliability is always uncertain. The study also found out that revenue from tax plays a bigger role in financing health system of African countries. Therefore, the focus of this study was to investigate whether or not out-of-pocket payment and medical insurance has an impact in financing health system at ZCH.

Malawi, as a country, has not been left behind as far as implementation of the policy of having paying wards in public hospitals is concerned. The implementation of the policy started with all the referral hospitals such as Zomba Central Hospital, Queen Elizabeth Central Hospital, Kamuzu Central Hospital and Mzuzu Central Hospital. The main aim is to generate revenue to fill the economic gaps created by the country's underfunding of health system. However, some

critics argue against this policy as it puts the burden of funding the country's health system to innocent poor Malawians (Oxfam, 2016). For them, the two-tier system accelerates inequality. They argue that though the system is optional, but it is prone to making it biased towards those who can pay for the medical services, thereby leaving poor quality to the poor. The critics, further, argue that two-tier system is incompatible with universal health coverage values which advocate for equal access to health facilities to all. They also argue that the system of having paying wards in public hospitals has the potential of widening the already existing gap between the rich and the poor. For them, free quality health care services can jeopardise this trend (Oxfam, 2016). The critics, further, argue that the system raises minimal revenue to cater for service delivery (Gilson, 1997). For instance, Kamuzu Central Hospital realises an average of 9 percent of its monthly budget while Zomba Central Hospital gets as less as 7 percent (Oxfam, 2016). Such amount of revenue cannot address the problem of underfunding in public hospitals since the paying wards have their administrative costs which cannot be upset by the revenue raised (Cheelo et al., 2005). It is against this background that this study is keen to investigate if the challenges highlighted by Oxfam study are available at ZCH and attributed to the introduction of paying section. The Oxfam study's position about user fees is in line with what the 12th World Bank president Jim Yong Kim claims. The former World Bank Chief argues against user fees as he describes it as a system which does not make sense (Ridde et al., 2014). He, further, labels the system of user fees as unjust and unnecessary because it punishes the poor (Ridde et al., 2014).

The position of both the Oxfam study and the former World Bank Chief is to have free care services at the point of consumption. This position of offering free care medical services is also accommodated in the Ugandan government policy on surgical services delivered at governmental hospitals (Anderson et al., 2017). However, the study conducted at a regional referral hospital in rural south-western Uganda in 2016 shows that undergoing an operation at a government hospital in Uganda results in economic burden to patients and their families (Anderson et al., 2017). This is so because government hospitals in Uganda faces frequent stock-outs and broken equipment. The situation forces them to buy medicine from private pharmacies, thereby increasing their costs on medical services (Anderson et al., 2017).

Running paying sections in public hospitals is one of the forms of user fees (Oxfam. 2016). However, many studies have revealed that this approach is not preferential (Robert & Riddle, 2013) despite the 1987 Bamako Initiative championed by the World Health Organisation and United Nations International Children's Emergency Fund (UNICEF), which advocated for the introduction of user fees in public hospitals as a way of improving the quality of health care services (Watson et al., 2016). For instance, a study conducted in Neno district, Malawi, introduction of user fees proved to be a hindrance to the patronisation of health care services (Watson et al., 2016). The study was trying to examine the impact of user fees on health care services. It was discovered that patronage of health care centres was high during the time that the user fees were removed and lower when they were introduced. Recently, there has been an experience where several African nations have suspended or completely eliminated user fees (Yates, 2009 & McKinnon, Harper, Kaufman & Bergevin, 2015). This is so because the said nations fear that the user fees may act as a barrier to accessing quality health care, thereby interfering realisation of universal health coverage (Yates, 2009; WHO, 2015 & Savedoff, de Ferrant, Smith & Fan, 2012). It is, therefore, from that basis that this study is inquisitive in trying to know user fees that characterise the paying section make people to shun the services offered by the section at ZCH.

Despite the unfavourable conditions that user fees receive in these African nations, there are some people who prefer accessing private health services to free ones. This is evidenced in the study that was conducted in Malawi's cities of Blantyre and Zomba (Makoka, Kaluwa & Kambewa, 2007). The study enquired what provokes the demand for private fee-paying private health entities among formal sector employees in Malawi. The study found that formal sector employees have a preference of visiting private health institutions for health care treatment where health insurance would be utilised. It was also found that lack of knowledge about heath insurances makes people not to be insured, thereby unable to attend private fee paying facility. Besides, it was also revealed that financial challenges pose as a barrier towards subscribing to health insurances and easily get treatment from private hospitals. The implication is that despite the fact that one would argue that user fees have no place in African nations, such as Malawi; there is some demand of it as indicted in this study. This is why the current study is curious in

probing whether or not there is certain group of people who can demand paying medical services despite availability of free services.

Despite the criticisms levelled against operating paying sections in public hospital, underfunding is not the only motivation for Malawi to venture such arrangement. The withdrawal of donor aid by the donor community because of the embezzlement of government money through corrupt practices is yet another source of motivation for Malawi to venture into the system (British Broadcasting Corporation (BBC) News, 2011). The 2013 infamous 'Cashgate Scandal' where a revelation of the plunder of millions of government money was revealed forced donors to cut their aid to Malawi. This was a big blow to the economy of Malawi, Ministry of Health in particular, as Malawi's health spending accounted for as much as 70 percent of the donor aid (Ministry of Health Slides, 2016).

The public hospitals in Malawi, such as ZCH, operate in a society which is directed by legal framework which informs the country's policies. For instance, the Constitution of Malawi section 13(c) obliges the state to actively promote the welfare of and development of the people of Malawi by progressively adopting and implementing policies and legislation aimed at achieving good health (Government of Malawi, 2010:17). That is to say, the state is obliged to ensure provision of adequate health care in line with the needs of the people of Malawi and international standards (Government of Malawi, 2010). As such laws and policies made by the state should ensure that they are in line with the Constitution. Ironically, Malawi's Public Health Act s. 143 allows accommodation of private patients in government hospitals. This is substantiated by its provision of amount of fees to be paid by the private patients (Public Health Act, 1948). However, Malawi's National Health Policy was formulated in line with the Constitution as it is all-encompassing. This is the case because its overall objective is to raise the level of health status of all Malawians (Government of Malawi, 2012).

2.4 Research gaps

Some of the studies in the literature took an economic perspective (McPake et al., 2004 & McPake et al., 2011). Their interest was to assess, between paying and non-paying sections, which section more resources are allocated to. Such studies did not focus on the ethical part of

the system. Much as the studies found that more resources were being allocated to the paying section than the non-paying, there was a need to investigate the ethics of the system. This is so because the system might have been favouring the paying section in the allocation of resources but benefiting the greatest number of people. In this case, one would regard the system of having paying wings in public hospitals ethical. Such being the case it was the interest of this study to investigate the ethics of operating paying wings in a public hospital.

Another aspect is that some studies put much weight in faulting the introduction of user fees by claiming that it acts as a barrier for the poor to access quality health care services (Oxfam, 2016 & Watson et al., 2016). These studies did not investigate the role the proceeds from user fees system does in running the activities of the hospital. This is why this study embarked on investigating the ethics of having paying section in public hospital since it is one of the forms of user fees. This study took that direction because by investigating the ethics of the system the study would be able to explore how the system is run, how the resources are distributed and more important know who are the beneficiaries of the proceeds from the paying section.

The third gap unearthed is that some of the studied research sites were not worth to conclude that user fees were the causative agent for people's failure to patronise the health facilities, for instance, the study done in Neno by Watson et al. (2016). There was a need to conduct such a study at a big public hospital that accommodates more clients are an institution that is able to resource some money, on top of the government funding, on its own for the running their institution. By doing so, the researchers would be able to appreciate whether the user fees were beneficial or not. This is why this study conducted its research at ZCH an institution which receives referrals from health centres in Zomba as well as from district hospitals of Machinga, Mangochi, Balaka and Phalombe. This was necessary because this was the first study to be done in Zomba and Malawi at large to investigate the ethics of operating paying sections in public hospitals.

2.5 Chapter conclusion

This chapter has discussed the literature that talks about introduction of paying wings in public hospitals as a form of user fees. The literature comprises of studies from Malawi and beyond.

The literature also looked at two of the main official documents that guide the running of health issues in Malawi. The documents include Malawi's Public Health Act of 1948 and Malawi National Health Policy of 2012.

CHAPTER 3
THEORETICAL FRAMEWORK

3.1 Chapter introduction

The major aim of this section is to express the theoretical framework that was used in this study. The moral theory that underpins the study is that of utilitarianism. This theory was applied in Section Four (findings and discussion) and Section Five (ethical implications of operating a paying section). The theory is relevant for the study because most government policies are based on utilitarianism, especially in terms of the concepts of consequence and public benefit. The study used this theory to test if the system is in line with some elements of utilitarianism which promote maximisation of people's well-being. It is also important to note that the choice of utilitarianism theory influenced the researcher in selecting the literature reviewed. This was done by incorporating literature that reviews on issues concerning the implementation of user fees in public hospitals; but also focusing on the maximisation of well-being of the greatest number of people.

3.2 General idea of utilitarianism

Utilitarianism is a moral theory that deals with the issues of right and wrong by taking into account the consequences of an act (Mill, 1863). Two of the proponents of the utilitarian moral theory are Jeremy Bentham and John Stuart Mill. The theory is classified into classical and contemporary.

3.3 Categories of utilitarianism

Utilitarianism moral theory is categorised into classical and contemporary. Classical utilitarianism is faced with the practical objection that it is not a useful theory in the moral decision making. On the other hand, contemporary utilitarianism faces theoretical objections where it is challenged that the theory is not in line with moral beliefs in a number of cases.

3.3.1 Classical utilitarianism

Utilitarianism claims to be value-oriented. That is to say, value is an element that qualifies an action to be right (Timmons, 2002). Utilitarianism is said to be consequentialist theory because

the rightness of an action is dependent on facts about the value of consequences of that particular action (Timmons, 2002).

3.3.1.1 Tenets of utilitarianism

Timmons (2002) outlines the tenets of utilitarianism. The first one is that it has a maximising idea of right action, that is, when an individual is confronted with a number of actions, the one that maximises more value than the alternative ones is said to be right. The other tenet is that utilitarianism would consider an action to be right if it promotes the welfare of all the stakeholders involved. This implies that utilitarianism is very much interested in the welfarism of all the people that might be affected by a particular action. Timmons (2002) defines welfarism as the type of value worth to undergo ethical assessment. Universal and impartial are the final tenets of utilitarianism. By universal, Timmons (2002) means that utilitarianism takes into consideration of the value of consequences of actions on all people affected. On the other hand, impartial element means that every individual's value of consequence is taken into consideration. The universalist and impartialist elements are a reflection of Bentham's memorising motto which emphasises the need to include value of consequence of each individual (Bentham, 1781). To sum up, utilitarianism looks at how much value an action would generate. It also considers which action maximises welfarism by comparing with alternative actions by considering all those affected by that particular action.

3.3.1.2 The concept of utility

The notion of utility is a very important aspect of utilitarianism. Timmons (2002) defines utility as values of the consequences of a certain action. In other words, utility means the goodness or the badness of the consequences of an action. He also describes the concept of utility as a net value of the consequences of action. This simply entails that since any action has both good and bad side of it. So, net value is found after doing a cost benefit analysis of consequences of the action.

3.3.1.3 Hedonistic utilitarianism

Hedonistic utilitarianism is a classical idea advocated by Bentham and Mill. The two identify welfarism with pleasure or happiness (Bentham, 1781 & Mill, 1863). This implies that Bentham

and Mill advocate for value hedonism which holds the view that experience and pain is intrinsically good and bad respectively (Mill, 1863).

3.3.1.4 Bentham's felicific calculus

Felicific calculus is the method that Bentham uses in calculating utility to determine whether the values of the consequences of a certain action carried out is good or bad (Bentham, 1789). Bentham's felicific calculus has seven aspects that are used to test the utilities of an action. These include: intensity, duration, certainty and uncertainty, propinquity and remoteness fecundity, purity and extent. The aspect of intensity measures the levels of the goodness and badness of an action. The duration aspect looks at the time frame one is going to face with the experience or pain. The aspects of certainty and uncertainty look at the likelihood of an action to result into pleasure or pain. Propinquity and remoteness deal with how soon or further results of an action are to emerge. Fecundity and purity deal with the possibility of whether the aspects of pleasure or pain will come to pass after an action has been implemented. The two aspects, finally, talk of how many people will be likely affected by the action (Timmons, 2002).

3.3.1.5 Mill's utilitarianism

John Stuart Mill's 1863 work entitled *utilitarianism* is dedicated to two issues namely the idea of welfare and the attempted proof of utility. Mill is very much concerned with these issues in trying to defend the moral theory of utilitarianism (Mill, 1863). Like Bentham, Mill conceives welfare with happiness or pleasure. For Mill, utilitarianism moral theory holds that rightness or wrongness of an action is entirely dependent on the maximisation of the welfare or well-being of those affected by the said action (Mill, 1863). On his attempt to prove the idea of utility, Mill argues that individual's welfare or happiness is intrinsically good for that particular individual. For Mill, general pleasurable experiences tantamount to an intrinsic good for the cumulative of individuals. This implies that welfare or well-being or happiness is the only intrinsic good (Mill, 1863).

3.3.1.6 Practical objections of utilitarianism

Utilitarianism faces practical objections from its critics. The accusations are centred on the idea of utility. The critics question the usefulness of the concept of utility. They question the

practicability of assessing the utility of all the alternative actions before making a moral decision. The critics, further, argue that it is difficult to know how many people might be affected by the particular action chosen. They also charge utilitarianism as a failing moral theory because calculation of utility is very difficult. For them, the principle of utility is just a mere moral criterion and not a decision procedure (Timmons, 2002).

3.3.2 Contemporary utilitarianism

The contemporary utilitarianism faces theoretical objections from its critics. It is also in the contemporary utilitarianism where new versions of utilitarianism, such as rule utilitarianism, non-hedonistic utilitarianism and pluralistic utilitarianism are presented. These are different from the ones advocated by Mill and Bentham in the classical utilitarianism. This is done to respond to the theoretical objections levelled against utilitarianism.

3.3.2.1 Theoretical objections of utilitarianism

The first theoretical objection against utilitarianism is that it is always at odds with moral beliefs in a number of issues. As such, according to the critics, the theory does not qualify to be a correct moral procedure for moral decision making (Timmons, 2002). Utilitarianism is also regarded as being too demanding; requiring a lot of aspects in its determination. They fault the universalsist conception where everyone who is affected with a particular action should morally be considered in determining the rightness and wrongness of an action; and the impartialist conception where every individual must be counted. The universalist and impartialist, put demands on people when making moral decisions because each action has its reasons for engaging in it. This subjects people to a situation with a conflict of interests (Timmons, 2002). The other objection of utilitarianism is the one to do with supererogation actions. Timmons (2002) defines supererogation actions as the ones that go further than the normal call of duty. This is where one takes a risk to do the action. Such actions, according to the critics, might be amongst the alternatives and carrying out of such action might produce the highest utility. However, the challenge is that supererogation actions are not always successful. This is why critics fault utilitarianism of demanding too much from actors. This is also the reason why utilitarianism is regarded as ethics of fantasy because it sets standards of right action that are beyond normal human capability (Mackie, 1977).

3.3.2.2 Rule utilitarianism

Rule utilitarianism is a unique form of utilitarianism that came into play in the 1950s and 1960s with the aim of defending its bedfellow cousin act utilitarianism (Mill, 1863). Rule utilitarianism is considered as unique because it tries to avoid the theoretical objections advanced by the critics of utilitarianism (Timmons, 2002). Act utilitarianism, on the other hand, holds that an act is right if its consequences outweigh the maximisation of well-being of any other act (Eggleston, 2012). The underlying idea behind the view of act utilitarianism is based on two arguments (Timmons, 2002). The first is that the rightness and wrongness of certain actions depend on the use of a correct rule in particular situation when making moral decisions. The other aspect is the moral rule being applied to a situation may be said to be correct if that rule produces the greatest utility as compared to the considered alternatives.

3.3.2.3 Non-hedonistic utilitarianism

Classical utilitarianism conceives welfare in terms of happiness or pleasure and understands that happiness hedonistically. This understanding is based on value hedonism. However, the understanding is highly objected. Because of this, contemporary utilitarianism decides to take a different view by embracing non-hedonistic theory of welfare (Timmons, 2002). One of the examples of non-hedonistic theory of welfare is desire fulfilment theory of welfare. The underlying idea behind desire fulfilment theory of welfare is that what flourishes an individual's life is the fulfilment of their desires, and what makes the life otherwise is the non-fulfilment of the desires. However, desire fulfilment theory is not without criticisms. The theory is challenged because sometimes it is difficult to see how the fulfilment or non-fulfilment of the desire could contribute in any way to the well-being of an individual (Timmons, 2002).

3.3.2.4 Pluralistic utilitarianism

Pluralistic utilitarianism is a form of utilitarianism that tries to respond to one of the theoretical objections of utilitarianism which claims that utilitarian theory is not plausible because it conflicts with considered moral beliefs of people. Pluralistic utilitarianism responds to the objection through a pluralist theory of intrinsic value which is an account of welfare (Timmons, 2002). The proponent of this theory is David Brink (1989). According to the theory, there are three main elements of human that are said to be intrinsically good. Such elements include

insightful pursuit of one's reasonable project; accomplishment of those projects and certain personal and social reconnections such as friend, family relations just to mention but a few (Brink, 1989). One might challenge Brink's theory because it is focusing on personal projects as it might be seen as individualistic. However, it is important to note that by respecting personal projects the notion of respects is also being taken into consideration. And since the notion of respect for persons is a moral one, this follows that Brink's theory is plausible (Timmons 2002).

Utilitarianism is not without competing theories that could be used as alternatives. Some of the competing theories include John Rawls' theory of distributive justice and Robert Nozick's entitlement theory. The theory of distributive justice advocated by John Rawls is grounded in the understanding that the society is a system of cooperation for shared benefit between individuals. This is the reason why conflicts between differing individual interests emerge. So, to address such situations, Rawls argue that principles of justice should describe the suitable distribution of the benefits and burdens of social cooperation (Rawls, 1971).

Rawls further proposes two principles of justice namely; political justice and social justice (Rawls, 1971). On political justice, Rawls argues that each person should have an equal right to the most extensive total system of equal fundamental liberties in line with a similar system of liberty for all. On social justice, Rawls is of the view that social and economic inequalities are to be arranged in such a manner that they provide the maximum benefit to the least advantaged. Rawls, further, argues that the arrangement of the inequalities should be attached to institutions and positions open to all under conditions of just equality of opportunity (Rawls, 1971). This is why Rawls advocates for redistribution of resources as one of the ways to deal with inequalities.

The other competing theory of utilitarianism is Nozick's entitlement theory which focuses on the distribution of justice. Nozick defines justice in three ways. For him, justice involves justice in acquisition. This deals with the process of acquiring property rights that were not previously owned by the concerned individual. Nozick also describes justice as justice in transfer. This definition deals with acquiring of property rights from one person to another through transferring processes. Nozick, finally, defines justice as rectification of justice. This involves the process of

restoring property rights to the right owner, in case they were unjustly acquired or transferred (Nozick, 1974).

Nozick's theory of justice known as entitlement theory claims that whether a certain pattern of distribution is just or not depends entirely on how it came about. For Nozick, justice is about giving respect to people's rights such as right to property and right to self-ownership. For him, people must be allowed to exercise their freedom to decide on what to do with what they own. This entails that people's autonomy must be respected because they are ends-in-themselves. The implication is that taking away property rights from the people in the name of redistribution, as advocated by Rawls, is a violation of their rights (Nozick, 1974).

Despite Rawls' theory of distributive justice and Nozick's entitlement having some elements befitting ZCH study, the researcher opted for utilitarianism ethical theory as a theoretical framework of the study. The theory has been chosen because it is being guided by three plausible ideas. The first of the ideas is the theory's commitment to welfarism or well-being of the individuals. The second idea is that utilitarianism is based on practical rationality when making moral decisions making. The third element that makes utilitarianism attractive and that has also this study attracted is the idea that it is driven by the idea that impartiality is the hub of morality (Timmons, 2002). Since utilitarianism is divided between classical and contemporary, this study employed contemporary utilitarianism because the study is investigating issues that are happening in the contemporary world. The other justification for contemporary utilitarianism is that this form of utilitarianism is able to respond to theoretical objections advanced by the critics of utilitarianism.

3.4 Chapter conclusion

This chapter has discussed moral theory of utilitarianism as the theoretical framework informing the ZCH study. The chapter has also discussed categories of utilitarianism which are classical utilitarianism and contemporary utilitarianism. Contemporary utilitarianism is the version that came in to defend and address objections advanced by the critics of utilitarianism. It is within this chapter where the researcher explains reasons for employing contemporary utilitarianism.

CHAPTER 4
RESEARCH METHODOLOGY

4.1 Chapter introduction

Kothari (2004) defines research as a scientific and systematic search for relevant information on a particular issue or problem. There are methods applied to conduct a research. Bryman (2007) describes research methods as procedures followed in collecting pertinent information on a particular issue. Chinthenga (2019) argues that importance of a research methodology in any study cannot be overemphasised. This is so because research methodology supports the issues dealt with and data collected (Clark, 1984). This study is an ethical investigation of operating paying wings in public hospitals. It is a qualitative study which was conducted at Zomba Central Hospital in Malawi. It used an empirical method of gathering data by employing a case study approach which is regarded as a suitable one in tackling the "how" and "why" questions (Yin, 1994). The research opted for a philosophical method of deductive approach to analyse the data. I shall, first, give a brief description of the empirical method before tackling the method used in analysing the data.

4.2 Research design

Creswell (2009) defines research methodology as strategies and guidelines procedures for carrying out a research that start from broad assumptions to comprehensive methods of data collection and analysis. Creswell (2009), further, argues that when choosing a research design one has to take into consideration a number of aspects such as the character of the research problem being addressed, the researchers' own experiences and the nature of the audiences of the study (Creswell, 2009).

4.2.1 The type of research methodology used

Creswell (2009) discusses three types of research designs namely; qualitative, quantitative, and mixed methods. However, this study employed qualitative method. This is so because the nature of the research problem under research, "investigating the ethics of operating paying section in public hospital", is very much focused to answer "why the system was introduced?" and "how it

is implemented?" So, according to Creswell (2009), the "why" and "how" questions are better answered by using qualitative research approach.

4.2.2 Research approach

Burney (2008) describes a research approach as a mechanism that helps researchers to define and make use of research methodologies effectively. Burney, further, argues that for a study to be conducted in a well-defined way to meet the demands of philosophy, it is imperative to choose a proper research approach. According to Burney (2008), there are two research approaches namely; deductive approach and inductive approach. Deductive research approach involves use of an established theory or hypothesis to resolve the research issues and then tests the theories with the findings of the study (Burney, 2008). In other words, this research approach involves moving from broader generalisation to specific observations of a phenomenon under enquiry. It is also described as top-down approach. This approach follows the following stages: theory, hypothesis, observation, and confirmation (Burney, 2008). One advantage of deductive approach is that different arguments are utilised to give sufficient analysis for a particular fact. The other advantage is that the arguments that are used are based on definite laws, rules and regulations.

On the other hand, Burney (2008) defines inductive research approach as the procedure in which particular concepts are analysed in a broad way. It is also known as a bottom-up approach. The inductive research approach follows the following stages; observation, pattern, tentative hypothesis, and theory (Burney, 2008). Inductive research method gives flexibility to researchers as they do not need a prearranged theory for them to conduct the research (Burney, 2008). This helps the researcher in coming up with alternative explanations on what is being observed (Burney, 2008). However, this study employed deductive research approach since it was simple to apply it to the study; a researcher just needs to have an established theory and apply it to the findings to come up with a conclusion.

4.2.3 Research sites

The research site of this study was Zomba Central Hospital situated in Zomba City, eastern region of Malawi. The site was chosen because, at the time of the study, it was one of the central public hospitals where paying wings are run alongside non-paying ones. The other reason for

choosing ZCH is that it also serves patients as referrals from both the district's health centres as well as other district hospitals from the region such as Machinga, Balaka, Mangochi and Phalombe.

4.2.4 Sample size

The sample size of this study was twenty-five respondents. The sample size was, further, subdivided in the following categories: One respondent was one of the top managers at the institution who was a Chief Hospital Administrator. One respondent was a nurse who, at the time of the study, was working as the In-charge of the Paying Section. Eight respondents were medical professionals working at the hospital whereby three were doctors and five were nurses. All the three doctors were working for both paying and non-paying section while the three nurses and two nurses were working for the non-paying and paying sections respectively. Fifteen respondents were guardians from both paying and non-paying sections who took part in separate focus group discussions. That is, one involving guardians from the paying section and the other for those in non-paying section. Out of the fifteen guardian respondents, four were from the paying wing while eleven were sampled from the non-paying side. The non-paying wing was further divided into Wards 5 and 6, as well as Wards 7 and 8 where six respondents came from Wards 5 and 6, and five respondents from Wards 7 and 8. The paying ward focus group discussion had two male respondents and two female respondents. The non-paying section had one male respondent and five female respondents from Wards 5 and 6, whereas Wards 7 and 8 had five female respondents and no male respondent.

This sample size was reached at because the aim of the study was to investigate the ethics of operating paying sections in public hospitals. The main aspect the study was targeting was the resource distribution. So, the study investigated how resources were distributed between the paying and non-paying sections. This is why ten out of the twenty-five respondents were officials from the hospital because they are the ones who know how resources are distributed. This is the case because resource distribution is an administrative task. The remaining fifteen respondents were guardians. In the paying section, only four were available against six admitted patients; and eleven respondents were from the non-paying section. The guardians were sampled to get information on the resources accessed their patients.

4.2.5 Target population

The target population of this study comprised the Chief Hospital Administrator, In-charge of the Paying Section, doctors, nurses and guardians from both paying and non-paying sections from ZCH. The Chief Hospital Administrator was targeted because he was the one who would be in a position to give why the system was introduced and how resources are distributed between the paying and non-paying sections. The In-charge of the paying Section was also the target of the research because she would be in a position to give information on how the system is implemented. The Chief Hospital Administrator and the In-charge of the Paying Section were the main target group in this study because their involvement would answer the "why" and "how" part of the system. Doctors and nurses were included in order to get information as to whether they received a certain incentive for working for a particular ward. It also comprised of guardians from paying and non-paying sections. The guardians were targeted to explore how their patients were treated in their respective sections.

4.2.6 Techniques used to collect primary data and secondary data

In-depth interviews were used to collect primary data from the Chief Hospital Administrator, the In-charge of Paying Section and the guardians. The in-depth interview helped the researcher to contextualise the case study experience and place it in more of an ethical perspective by responding to the following issues: why the system was introduced at ZCH; ethical principles informing the system; how the system compromises or ensures fair distribution of resources between paying and non-paying sections among others. In-depth interviews with the guardians helped to explore their understanding about the system; how their patients access to the hospital resources; among other issues. However, for the Chief Hospital Administrator and the In-charge of Paying Section, it was a one-to-one interview whereas the guardians were interviewed in a focus group setup. It is important to note that the In-charge of the Paying Section and all guardians allowed their interviews to be audio recorded. However, the Chief Hospital Administrator refused to be recorded. However, he did not give reasons for his refusal to be recorded. Semi-structured survey questionnaires were administered to 3 doctors and 5 nurses (see Appendix 3). Semi-structured survey questionnaire is a data collection tool that contains both open-ended and close-ended questions (Bakuwa, 2015). The questionnaires were administered to nurses and patients to explore: their knowledge on the system of operating

paying wings in public hospitals; if incentives were given for working in the private section among other issues. Secondary data were also collected from relevant books and internet. The books and internet were necessary sources to explore how other countries implement the system.

4.2.7 Breakdown of in-depth interviews

In-depth interviews were administered to the Chief Hospital Administrator and the In-charge of the Paying Section. Focus group discussions were conducted to paying section and non-paying section (Wards 5, 6, 7 and 8).

4.2.8 Sampling methods

The research used purposive sampling technique in choosing the Chief Hospital Administrator, the In-charge of the Paying Section, nurses and doctors. Purposive sampling can be described as a technique which involves a deliberate selection of target population, settings or events to get information (Maxwell, 1996). Purposive sampling was used because the researcher already had in mind the respondents to target such as the Chief Hospital Administrator, the In-charge of the Paying Section, nurses and doctors. The study also used convenient sampling, also known as judgmental sampling, in selecting guardians from paying wards. The sampling technique was also used in identifying the non-paying wards as well as its guardians. This technique is defined as a selection of research participants, settings and events that are readily available (Taherdoost, 2016). Convenient sampling is one of the preferred techniques because it is less costly (Ackoff, 1953). Apart from the minimal costs attached to the convenient sampling, it was also used because guardians are subject to change depending on the condition of their patients which may lead to the discharge from the hospital. Such being the case, it was necessary for the researcher to use a convenient technique to target any of the available guardians.

4.2.9 Data analysis

According to (Soiferman, 2010) choice of an analysis method to analyse qualitative data is based on the philosophical assumptions informing the study, the research questions, and the types of data collected. Analysis also requires a better understanding of the text in order for the researcher to be able to answer the research questions (Creswell, 2009). According to him, there are six different methods of analysing qualitative data. However, this study used one of the six methods

known as interpretive data analysis. This method involves developing of themes that capture the main categories of information and makes an evaluation of the data in an explanatory arrangement (Creswell, 2009).

4.3 Research ethics

The Researcher recognises that ethics is of great importance to any study. Thus, first, the researcher sought permission from the Hospital Director (HD), Dr Mathias Joshua, to conduct a study at ZCH. Informed consent was sought from all the participants before conducting interviews. The researcher briefed the research participants of the rationale behind the study. Informed consent was also sought from the interview participants to record the interviews. Informed consent forms were attached to each questionnaire to give research participants an opportunity to read the consent forms before committing themselves to answer the questionnaires. Participants were further informed of their right to withdraw at any point during the study or skip any uncomfortable question. Data collected and the identity of the participants were treated anonymously.

4.4 Study limitations

As is the case with many studies this study is no exception when it comes to having limitations. Firstly, the researcher was denied an opportunity to audio record the interview conducted with one of the key informants who happened to be the hospital management official. The other limitation is that the researcher did not capture the ages of all the respondents which could help to know the type of responses were coming from certain ranges of age. Further, the researcher had intended to administer questionnaires to four doctors and four nurses. However, because the questionnaires were issued by one of the hospital's official who is the Principal Hospital Administrator (PHA), the latter issued them to three doctors and five nurses. This senior hospital official was entrusted with the task in order to facilitate identification of the doctors and nurses who work in shifts. The arrangement was based on the assumption that he, as a senior official who is ready to face the challenges head-on, was not going to be biased in choosing the doctors and nurses who would provide positive information only. The hospital official was given that task for easy identification of the doctors and nurses who work in shifts. Additionally, key information on how the system operates was given by staff members, and one cannot rule out the

subject nature of the information. The final limitation is that there was poor representation of gender balance more especially in the focus group discussions that were conducted in the non-paying wards.

4.5 Chapter conclusion

This is the chapter where the research methodology employed in undertaking this study has been highlighted. The study used qualitative study which used deep interviews and semi-structured questionnaires in obtaining information. The chapter also highlighted on the research design, study population, sampling technique and sample size, data collection instruments. It is also within this chapter where ethical considerations and limitations were indicated.

CHAPTER 5
FINDINGS AND DISCUSSION

5.1 Chapter introduction

This chapter presents findings of the study as answers to the following research questions: (a) What does the system of operating paying section within public hospitals entail? (b) How is the system of operating paying section implemented at ZCH? (c) What are the merits of having a paying section at ZCH? (d) What are the demerits of having a paying section at ZCH? (e) What are the ethical implications of operating paying section at ZCH?

The study aimed at collecting data at ZCH on the ethical investigation of operating paying section in public hospitals. All the discussions in this chapter are in line with utilitarian framework. Utilitarianism claims that an action is said to be morally right if the net benefits over costs are greatly maximised for all affected as compared with the net benefits of all other alternative choices considered (Bentham, 1781). That is to say, utilitarianism is a moral theory that claims that the moral course of action is the one whose proceeds are of great benefit to all affected by the action. This implies that the way resources are distributed between paying and non-paying section would determine the level of benefits and harms to all affected by the arrangement are.

5.2 The meaning of operating paying section

According to the Chief Hospital Administrator (CHA) at ZCH, operating a paying section in public hospitals entails offering of health care services at a price through either medical insurance or out-of-pocket payment. This is done by giving people freedom of making choice of going either to paying or non-paying section. According to him, the system is informed by the solidarity health principle where the health system is funded through taxation, out-of-pocket payment and different medical insurance covers that people subscribe to. The CHA further reports that funding of public hospitals through taxation is not sufficient to meet all the activities at public institutions such as ZCH. As such, there is need to embrace the system of having paying wings in public hospitals to generate funds that can help to fund some activities at the hospital. The CHA also reported that:

> *Universal health coverage can be achieved through good financing system. Taxation system is not sufficient as it does not look at the specific problem of the patient because funds from taxes can be diverted to other government commitments such as road maintenance.*

This means that achieving a situation where people would access quality medical services regardless of their financial statuses requires enough funding. Taxation is not sufficient in achieving universal health coverage. This is so because money realised from taxation is shared among different public institutions to solve general problems. However, money realised from the paying section tackles the specific challenge which the system is aimed to address.

Additionally, the CHA reported that the system of having a paying section in public hospitals is based on the principle where the rich subsidise the poor. That is to say, the money the rich pay when getting health care services in the paying section also help the non-paying patients through medication and other services provided by the medical professionals. Related to the principle where the rich subsidise the poor, the CHA argues that the system is also based on the principle where the health subsidises the sick. That is to say, when the rich visit the paying wings, they get the help very quickly and go back home to continue working for the growth of the economy of the country. The money paid after getting the services helps the sic to continue getting quality health services.

The findings on the meaning of operating a paying section at a public hospital are somehow different from other studies in the sense that those studies have concrete definitions of the system which is not the case with ZCH findings. For instance, Typerberg Academic Hospital (TAH) study in South Africa defines paying sections as differentiated amenities (Wadee & Gilson, 2007). Another example is Kitwe Central Hospital (KCH) study in Zambia describes the system of operating paying wings in public hospitals as a two-tier charging system where the paying services are called “high-cost services” whereas the free section is named “low-cost services” (McPake et al., 2004). Maputo Central Hospital (MCH), on the other hand, describes the paying section as “Special Clinics” (McPake et al., 2011). The unique thing in the findings of ZCH

study on the meaning of the system is that the CHA reports the principles on which the system of operating paying section at ZCH; a thing which is not explicitly indicated in other studies.

Using utilitarianism on the CHA's arguments that the system is informed by the principle where the rich subsidises the poor and the healthy subsidises the sick, the arrangement can be claimed to be ethical. This is so because at ZCH non-paying patients outnumber the paying ones. So, money generated from the few paying patients helps the many non-paying patients patronising the hospital, thereby maximising their well-being through health care services provided to them.

5.3 The rationale for establishing paying section at ZCH

The CHA outlines the reasons for establishing paying section at ZCH. He reports that the system was established as a response to the call from the middle and high class that had been asking for the reintroduction of paying services after they were suspended. The suspension, according to the CHA, was as a result of failure by government to account for the proceeds of the system which were going straight to Account Number One. This resulted in medical professionals losing interest to serve clients in the paying section. As a result of this, the section could operate for close to a week without a doctor. The other factor that led to loss of interest by the medical professionals to work in the paying section was that they could not see the products of the arrangement as is the case now where some structures are being renovated using the proceeds from the section. The call for the establishment of the paying section can be corroborated by the study that was conducted by Makoka, Kaluwa and Kambewa in Blantyre and Zomba (Makoka et al., 2007). The study's findings indicated that there is a certain section of people, formal employees in this case, that has a preference to receive medical care from private paying section (Makoka et al., 2007). Such being the case, it is not surprising to learn from one of the respondents at ZCH that a certain section of people called for the resumption of paying section activities. It is also important to note the motivation for introducing a paying section at ZCH is quite different from what was the case with Cambodia which was motivated by the rising cases of under-the-table payments. So, to deal with the vice, the country decided to formalise under-the-table payments (Lewis, 2007).

Another reason for introducing paying wings at ZCH, according to the CHA, was to take it as another source of income generating mechanism to top up the funding which comes from Government which is always insufficient. This is a common reason for establishment of the system in many low and middle economic countries. It has been found out by many studies that countries introduced paying wards in their public hospitals to generate funds to be used in the running of the activities because the funding is always insufficient to meet the activities of the hospital (McPake et al., 2004; McPake et al., 2011 & Wadee & Gilson, 2007). The other purpose of the generated money is to subsidise the non-paying section. The assumption is that this would help to achieve universal health coverage.

So, using utilitarianism moral theory, introduction paying wings at ZCH to generate funds to support the hospital's activities is a moral cause because the proceeds are meant to help the entire hospital and not the paying section only.

The other rationale is to deal with the vice of using connections to jump the long queues. Whenever people from the business and working classes visit the public hospitals to seek medical help, they prefer to be assisted as quickly as possible. For this to happen, they make sure that they have links with medical professionals so that anytime they visit the hospital they should be assisted quickly. The introduction of the paying section therefore acts as an alternative to the business and working classes. Instead of queuing on long lines, they should get better and quick treatment from the paying section. According to the CHA, the motivation to introduce the system at ZCH was to curtail practice of jumping the queues and getting medication through connections. The CHA said,

> *Introducing paying section at ZCH is a fair arrangement because those from middle and upper classes get the same quick and better treatment at a fee from private hospitals. So, they would want to get the same treatment at ZCH at the expense of the poor who line up in long queues. So, allowing them to manipulate the poor in that way would be unethical.*

The meaning of this quote is that the wish of people to get medical care services quickly at the expense of those that queue in lines should be paid for. This is also in line with what was found

out at KCH study in Zambia where the system cut the vice of jumping the long queues by introducing a fast-track outpatient paying clinic to allow paying patients to get fast medical services (McPake et al., 2004).

Using utilitarianism ethical theory, such an arrangement is ethically justifiable because the paying patients do not disturb the non-paying patients from accessing health services. It is important to note that the absence of such arrangement could promote the use of connections and under-the-table payment where the beneficiaries were going to be a few, that is, the medical professional and the patient. By having a paying section, medicine that could have been lost through such kinds of connections is safeguarded and money that is paid for the services helps the entire hospital, thereby benefiting a lot of clients. Furthermore, one would argue that introduction of a paying section to prevent well-to-do people getting medical treatment at the expense of the poor who are always many is in line with utilitarianism ethical theory. This is so because the arrangement is trying to protect the poor from being manipulated by the rich in accessing the health care. It is a good arrangement because by cashing on the rich, the money is ploughed back into the health system of ZCH where both the paying and non-paying patients benefit. The arrangement is also in tandem with utilitarianism ethical theory because it cuts the vice of under-the-table payment which encourages siphoning of government medicine for the benefit of the few. That is to say, by curtailing this vice, the arrangement is protecting the stealing of medicine by medical professionals to assist their friends, thereby making medicine available in the hospital to be accessed by the both non-paying and paying patients.

5.4 Implementation of the system of operating paying section at ZCH

To get information on this theme two respondents, who were the key informants in this study, were targeted and these are the CHA, the In-charge of Paying Section, doctors and nurses. This was so because the former, during the time of this study, was the one responsible for the administration of hospital activities carried out at paying and non-paying sections. The latter was targeted because she was the one responsible for the affairs happening within paying section during the time this study was being carried out. Doctors and nurses were targeted because they are also a form of resources (human resource) but they also provide services to patients.

5.4.1 General implementation of paying section at ZCH

The CHA reports that the system offers hotel-type of services where good accommodation and meals are provided. When people report at the hospital for registration of their diseases, they have the option to choose to go to either the paying or non-paying section. He also reports that a patient who is admitted to the paying section can opt out of this section and go to the non-paying section. The finding at ZCH that paying section offers hotel-type of services is also found in other reviewed studies such as TAH study and KCH study (Wadee & Gilson, 2007 & McPake et al., 2004). However, what happens on registration of patients is not indicated in other studies. The other unique thing with ZCH study is the information that indicates that a paying patient can opt out and go to a non-paying section for any other reasons. This information is not indicated in other reviewed studies.

Using utilitarianism ethical theory, provision of good accommodation and meals to paying patients is ethical because they are the services they pay for. The clients are motivated to patronise the paying section to get such kind of services. As such, their patronisation of paying section brings money to the institution which helps both paying and non-paying patients, thereby promoting the well-being of the greatest number of people.

5.4.2 Positioning of paying section at ZCH

The paying section is positioned within the hospital structure. It is adjacent to non-paying wards. This positioning is in line with the one adopted by other public hospitals as explained by the reviewed studies, for instance, MCH and KCH hospitals (McPake et al., 2011 & McPake et al., 2004). However, what differs between ZCH and MCH is that the later positioned its paying section within the hospital but near patients' registration room where people were able to see paying patients being helped quickly whilst they were still queuing for the same services. This is what prompted the suspension of operating paying wings in public hospitals. However, the positioning of the paying section at ZCH is in such a manner that a patient from non-paying ward cannot see anything happening in the paying section.

Using utilitarianism theory, the positioning of ZCH paying section is ethical because it is not isolated from the main hospital to enable both paying and non-paying sections to be using same

resources such as medicine, laboratories, theatres and others. This entails that patients from both sections are treated equally, hence the system's ethicality.

5.4.3 Distribution of resources at ZCH

According to the CHA, resources are distributed fairly. He claims that same doctors and nurses work in both paying section and non-paying section. He further claims that patients from both sections use the same health facilities of the institution such as labour ward, laboratory, ICU ward, theatre and X-ray department. This was corroborated by the In-charge of the Paying Section though she indicated that the paying section has its own pharmacy. The issue of fair distribution of resources was also supported by all the doctors and nurses that were interviewed. When the researcher asked them this question; "Describe how resources are distributed here at ZCH?" All of them argued that there is fair and equal distribution of resources. This is how one nurse responded to the question: "*Resources are distributed equally only that in paying section, there are usually fewer patients*. Another doctor responded that "*resources are distributed fairly and equally based on the need of the department or section*."

The responses given by the nurses and doctors indicate that there is no section that is favoured in terms of resource distribution. According to utilitarianism theory, this is ethical because the equal distribution of doctors and nurses to both paying and non-paying patients helps to promote the well-being of the greatest number of people.

The sharing of some of the health facilities between paying and non-paying patients is also indicated in the study conducted at MCH especially on laboratory and surgical services only (McPake et al., 2011). This is so because at MCH, the paying section was using its own facilities except for laboratory and surgical services (McPake et al., 2004). The sharing of human resource such as doctors and nurses between paying and non-paying sections at ZCH is similar to what is indicated in the TAH study where doctors and nurses work in both wings as part of their normal duties (Wadee & Gilson, 2007). However, ZCH findings show that sharing of Intensive Care Unit (ICU) beds differs from what is contained in the TAH study. This is so because TAH shows that there are wards in the Intensive Care Unit specialised for paying patients which is not the case with ZCH where ICU beds are for all patients from both sections.

Using utilitarianism ethical theory, the sharing of resources between paying and non-paying patients at ZCH is an indication of impartial treatment of paying and non-paying patients. Impartiality is a core value of utilitarianism theory (Timmons, 2002).

It is important to note that there is a correlation between the distribution of resources, such as nurses or doctors, and service provision in both paying and non-paying sections. This is so because working in the paying section does not attract any incentives. As such, allowing nurses and doctors to work in both sections promotes equal access to medical care services to all patients regardless of being paying or non-paying ones (See Appendix 8).

5.5 Merits of having paying section at ZCH

According to the CHA, the system helps the hospital to generate money to fill the gaps that are created by underfunding of the institution. Taxation is the main source of funds that help to run the activities of the hospital. The paying section helps to supplement government funding. There are situations where medicine and other necessities run out of stock at ZCH. It is this money realised from the paying section that helps to buy medicine and reagents used in laboratory and x-ray departments and used by both sections. These medicine and reagents are bought from private pharmacies. By doing that, it entails that the paying section at ZCH subsidises the non-paying section. The finding is different from what MCH study in Mozambique (McPake et al., 2011) and KCH study in Zambia (McPake et al., 2004) explored. The two studies explored that the purpose of introducing paying sections in public hospitals to subscribe the non-paying section fails to be realised.

The In-charge of the Paying Section reported that part of the realised money is also used to pay subscription fee to Malawi Aid Society of Malawi (MASM) for all members of staff. The subscribing of members of staff to medical scheme helps them to patronise the paying section. The aspect of being subscribed to MASM also helps to cut the vice of stealing medicine at the hospital. This is so because members of staff sometimes steal medicine to help themselves or their sick relatives. So, instead of stealing medicine from the hospital, they just register as sick persons to get the medication and help their relatives. The claim of subscribing members of staff to medical scheme was corroborated by another key informant the Chief Hospital Administrator.

This is one of the unique findings of ZCH because no other study amongst the reviewed literature has indicated this kind of gesture where members of staff are subscribed to medical insurance.

In this case, utilitarianism theory is applied in a number of ways. First, subscribing all members of staff from both sections to a medical scheme motivates them, thereby working to the satisfaction of the patients. The motivated members of staff do not help only those in the paying section but also those admitted in the non-paying section, thereby promoting the well-being of the greatest number of patients. The other way is that by subscribing members of staff, it enables them to patronise the paying section of ZCH a thing which could be difficult if they were not on medical scheme. Patronisation of the paying wing helps the section to generate money which is ploughed back and help in the running of the hospital activities, thereby benefiting patients from both sections and the entire hospital at large. This entails that the greatest number benefits from the system such as members of the staff, the patients and the entire hospital activities. These arguments are worthy to brand the system ethical. Further application of the theory is based on the system's ability to cut the vice of stealing medicine by subscribing members of staff to medical scheme. The medicine that is saved here is used by both paying and non-paying sections, thereby flourishing the health of many, hence ethicality of the system.

The In-charge of the Paying Section, further, reported that 40% of the realised money is shared among all members of staff regardless of which department they work for or position they hold. She said: "*The money is shared equally regardless of cadre"*.

The response means that the money is shared equally to every hospital staff, that is, whether that member of staff is a doctor or a messenger. This is another form of motivation to the members of staff through the shared money, thereby working diligently for the betterment of the patients from both sections. She also reports that the remaining 60% goes to government where it helps in other government commitments. This entails that proceeds from the paying section do not help only within ZCH, but do go beyond the institution, thereby promoting the well-being of many, such as members of staff, patients from both sections and many more outside the hospital. The money also helps in renovating hospital structures. For example, the Endoscopy department of

the hospital was renovated using money realised from the paying section. The Endoscopy department is one of the units introduced in Malawian central hospitals to deal with both upper and lower gastrointestinal tests (Howson, 2010). The endoscopy unit at ZCH is used by all patients from both sections. This is yet, another unique finding from ZCH which is not available in any of the reviewed studies.

The claim that part of the money realised from the paying section is shared equally amongst members of staff was supported by one of the junior staff who works as a messenger in one of the offices at ZCH. In his support for the claim he said:

> *It is true that 40% of the money realised from the paying section is distributed to every member of staff equally and regardless of the section one is working for. We receive this money twice a year, that is, June and December. Whenever these months are approaching, every member of staff is geared to receive a certain amount of money from management. This arrangement was made public to the members of staff during one of the meetings we had organised by the management when the system of having paying section at ZCH was being revamped.*

The messenger's response gives a conviction that indeed part of the money (40%) realised from the paying section is shared equally amongst members of staff at ZCH. The conviction is emanating from the fact that evidence was obtained from one of the senior members of staff (In-charge of Paying Section) and one of the junior members of staff (messenger).

Using utilitarianism ethical theory, the sharing of part of the proceeds from the paying section is ethical. This is so because, in the first place, the money is shared among all members of staff from the entire hospital and not only those from the paying section. Secondly, the money acts as a motivating factor to the staff, thereby influencing them to work hard for the betterment of the patients from both paying and non-paying sections. By doing that, it is the greatest number of people that benefit from the staff's motivation.

The CHA also reported that the system helps to reform rude nurses. These nurses are allocated to the paying section where they reform because there they interact with paying patients who retaliate to any element of rudeness.

The other distinctive merit of the system that was supported by all the respondents from the paying section was that the system helps to provide quick and quality service delivery. This was evidenced by the positive responses made by all the interviewed guardians from the paying section. This is how one guardian responded to the question on their take on the advantages of the paying section; "*It is a good arrangement because good meals, accommodation and comprehensive quality care are provided*."

This response from the guardian of the paying patients entails quality service provision at the paying section. The other guardian added: "*Here, we have good toilets and bathrooms and there is availability of warm water."*

This response also supports the claim that paying section at ZCH is accorded with quality services. The claim that paying section provides better quality services is supported by most of the studies that have been reviewed (McPake et al., 2004; McPake et al., 2011 & Wadee & Gilson, 2007).

Using utilitarianism theory, the provision of better quality services, good meals and accommodation acts as a driving force for people to keep on patronising the paying section, hence generation of more money to cater for the services at the hospital. These services benefit both paying and non-paying patients.

The other merit of being admitted to the paying section as reported by the In-charge of the Paying Section is about good environment since the beds are smart and covered with curtains to ensure privacy of patients; a patient can have two or three guardians; the section has a pharmacy that runs from Monday through Sundays; guardians have the freedom to ask about the procedures taken on their patients; and patients have the freedom to know the procedures and explanation of the results. Using utilitarianism theory, the system favours the few people by

allowing their pharmacy to operate throughout the week including weekends and leaving the majority having a holiday of visiting their pharmacy. These are some of the findings that are unique to ZCH study as there is no study amongst the reviewed ones that has indicated similar findings.

Using utilitarianism, the findings can be said to be another driving force for people to patronise the paying section, thereby allowing hospital management to be cashing in on them. The generated money is, further, used for running the activities of the hospital which, in turn, maximise the well-being of the majority of patients.

Additionally, the Principal Hospital Administrator (PHA) argued that the paying section at ZCH facilitates smooth operations of hospital activities through its proceeds, for instance, the helps in paying rentals for doctors' houses, paying suppliers and other necessities. He, further, argued that the monthly budget allocation of K60million (7.2billion per year) is insufficient to meet the demands for the smooth running of the institution. The PHA also claimed that the treasury is the account holder of the budgetary money. As such ZCH as an institution does the paper work such as preparation of vouchers to pay suppliers, landlords for the doctors' houses and other creditors. However, according to him, release of cheques from the treasury offices takes longer to the point that some creditors begin to push for their money or intending to evict the tenants (doctors) from the houses. To avoid such situations, management uses money from the paying section in paying the creditors to ensure smooth running of the hospital.

Using utilitarianism ethical theory, operating paying section at ZCH can be argued to be ethical. This is so because the money from the paying section is able to facilitate running of the hospital activities in the time when the management is waiting for the treasury to process cheques for payment. So by using money generated from the paying section, doctors are not embarrassed from being evicted from the rented houses, thereby maintaining their provision of health services to all patients from both paying and non-paying sections at the institution. As a result, the well-being of the greatest number of patients that patronise ZCH is promoted. It is also important to note that by using the money to pay the hospital's suppliers makes them (the suppliers) to keep on supplying the institution with the necessities used for the running of the hospital. As a result,

running of the activities at the hospital that help to promote the well-being of the greatest number of patients at the institution is not disturbed.

It is also important to note that the findings from the ZCH's accounts department indicate that tangible revenue is generated from the paying section. This makes the institution's ability to facilitate hospital activities at the time when the allocated budget (about K60, 000,000.00 per month) is yet to be given to the institution through giving out of cheques by the treasury. It was found out, for instance, that the paying section generates annual average revenue of K105, 708,055.00. The annual average is based on the findings on the 2016/2017, 2017/2018, and 2018/2019 financial years, the paying section generated revenue amounting to K64, 897,596.00; K111, 280,996.00; and K140, 945,573.00 respectively. This money is generated from people that patronise the paying section. It was found out from the hospital's Health Management Information System (HIMS) department that the average number of people that patronise the paying section per month is 215.

5.6 Demerits of having a paying section at ZCH

The CHA conceives the system of operating paying section in a public ward as an arrangement without disadvantages. For him, the only disadvantage that comes to his mind is that the system makes those in the paying section as rich and those in the non-paying poor. Such a kind of a position was also experienced when the researcher was interviewing the In-charge of the Paying Section who only highlighted the challenges faced when discharging the duties within the section. The failure by the two hospital officials (CHA and In-charge of the Paying Section) to say more on the disadvantages of the system can be claimed to be a ploy not to disclose the system's weaknesses. For the In-charge of the Paying Section, the only challenge influenced by the institution is failure to provide the paying section with its own laboratory, x-rays and labour wards. The other challenges are influenced by the clients of the paying section. In her reporting, she argues that the patients and guardians become so rude where they insult medical professionals by claiming that they can pay them. The rude behaviour extends to the relatives who visit their patients at any time without considering a visiting hour schedule. The patients, too, cause challenges to the working staff by choosing the type of medicine which they feel

could heal their sicknesses. This is a challenge because the behaviour undermines the expertise of medical professionals.

One of the main problems advanced by the respondents from the paying section (guardians) was the tendency by the hospital management to charge meals in addition to the accommodation. Almost all the respondents argued that they prefer if people could be given an opportunity to choose whether to be taking meals provided by the hospital or not. The other challenge raised was the unavailability of some facilities (such as laboratory, X-ray department, theatre and labour ward) within the section. Their worry was that if they are to access services from these facilities, they have to travel from where the paying section is situated to the above outlined facilities. One of the female guardians from the paying section expressed her concern by saying:

> *It becomes a big challenge by us, women. When we are expectant and it is time to deliver, we have to travel from here (the paying ward) to the labour ward. It would have been better if the section had its own such kind of facilities for us to access them easily in the time of need.*

In the quote the female respondent meant that the paying section's failure in having their own facilities such as labour wards causes panic among pregnant women during their due time to deliver. The arrangement may be seen as unethical to paying patients because that might disturb their quick receipt of medical services which is their aim of patronising the paying section. However, it can be argued that by using utilitarianism, the arrangement is ethical because many people patronise the non-paying section as compared with the paying section. So, by putting place an arrangement where patients from both sections should use same facilities at the hospital, the management is not leaving out the greatest number of people in accessing quality medical services.

The respondents from the paying section also raised the concern of not being prioritised when accessing these facilities. Two of the four guardians claimed, *"When you go to the X-ray department, we are never considered first as paying patients. We have to queue on the long lines with non-paying patients."*

The respondents who made the above quoted statement meant that whenever they are using the hospital facilities such as X-ray, theatres and others, they are never prioritised as paying clients. However, taking utilitarian perspective, the arrangement is ethical because by prioritising the paying patients who are always in minority would entail leaving out the non-paying patients who are usually in majority.

Another interviewee outside ZCH, who once visited the paying section at ZCH to access medical services, concurred with the claims made by respondents from the paying section and said: *"It is true that the paying patients are not prioritised. Sometimes, medical professionals make their considerations by treating ten non-paying patients then take one paying patient"* (Personal communication, June 19, 2019).

This means that being a paying client is not a guarantee for one to be prioritised in being attended to by the medical professionals at ZCH.

In responding to these claims, the In-charge of Paying Section said it is ZCH's policy to have both paying and non-paying patients access the same above mentioned facilities. She said:

> *This is the case because this is a public hospital and the facilities were meant for the non-paying patients. So, it would be unethical to be prioritising the paying patients at the expense of the non-paying patients because the hospital's policy is that patients from both sections should have equal access to the facilities.*

The above response entails that the ZCH's policy advocates for equal access to facilities at the institution.

The findings of ZCH on the demerits of having a paying section in public hospital are not similar to the changes highlighted by many of the reviewed studies. Most of the studies reviewed indicate that the resource distribution favours the paying section (McPake et al., 2011). The other challenge advanced by those studies is that the rationale of having the paying section to subsidise the non-paying section is not realised (McPake et al., 2004). Among the reviewed studies, it is

only the TAH study that indicates that the distribution of resources does not favour the paying section.

All guardians interviewed from non-paying section highlighted a number of challenges that emanate from the system. One guardian from guardian from non-paying Wards 7 and 8 observed that the system makes her to hold a belief that the paying section is favoured. Two of the six guardians from non-paying Wards 5 and 6 reported the challenges they face; these include bad toilets and bathrooms. They also argued that men and women use the same toilets and bathrooms. On a daily basis, they claimed, they start queuing for the bathrooms as early as four o'clock in the morning. These findings, too, are not available in all the reviewed studies, hence their uniqueness to ZCH study.

By using utilitarianism ethical theory, it shows that at ZCH the facilities are such that toilets and bathrooms do not meet the demand as it is the case with the paying section. As such, it can be claimed that the arrangement of failure to provide enough facilities to the non-paying patients who are always many infringes the ethical principle of utilitarianism to promote the well-being of the greatest number. This is the case because the people's desires in the non-paying section are not fulfilled. Failure to fulfil one's desires is unethical according to Brink's desire fulfilment theory (Brink, 1989).

Some of the interviewed guardians from the non-paying section also argued that the security guards ill-treat them by not allowing them to enter into the wards once they have sneaked out to buy their patients some commodities. They are usually told to wait for visiting hour. The respondents from Ward 5 and 6 also queried the tendency of ward cleaners who force the guardians to be cleaning the toilets and bathrooms. Here, it also means that the management of ZCH workers such as cleaners differs from section to section. What is being portrayed here is that cleaners from the paying section are closely monitored to ensure cleanliness of the section. However, this is not the case with the non-paying section. This information, too, is not available in the reviewed studies.

Using utilitarianism, the arrangement of the management by focusing on the paying section in ensuring cleanliness and leaving out non-paying section is not in line the principle of maximising the well-being of many, hence this is unethical.

The situation experienced by the non-paying patients from their respective wards is an indication that the allocation of some facilities such as toilets and bathrooms are not in line with the demand. This is different from the paying section which usually accommodates few patients thereby allowing for easy access to such facilities. The situation also shows that ward cleaners from the non-paying section do not care about the clients of the section unlike those from the paying section. This can be the case because cleaners from the paying section might fear being rebuked by the clients. This argument corroborates with what the CHA reported on rude nurses who, he claimed, are sometimes sent to work in the paying section as a way of reforming them. The CHA had this to say, when he was asked about the merits of having a paying section in public hospitals,

> *Here at ZCH, paying section acts as a place where rude nurses are reformed because they cannot be rude at the paying wards as they are with the non-paying wards. This is so because they fear being rebuked by the paying clients.*

The CHA's sentiments meant that sometimes the institution uses the paying section as a reformatory area for rude medical professionals.

This finding of ZCH study was not available in the studied literature.

5.7 Ethical implications of operating a paying section at ZCH

This section analyses ethical implications of operating paying section at ZCH. The analysis focuses on how the system promotes or compromises the notions of social justice and entitlement.

5.7.1 The notion of social justice

Baldry (2010) defines social justice as a systemic and structural arrangement that aims at achieving equality as a core political and social value. Chipkin and Meny-Gilbert (2013) discuss

three elements of social justice. The first one is social justice as a distributive question. Miller (1991) writes that social justice involves distribution of benefits and burdens among members of the community. The other element is social justice as fairness. According to Jost and Kay (2010), social justice deals with a fair allocation of rights, benefits and burdens in the economic, political and social spheres. The last element of social justice is the State. Since social justice involves fair allocation of rights, burdens and benefits among members of the society, there is need for a social justice organisation to deal with the process (Chipkin & Meny-Gilbert, 2013). This entails that the social justice organisation should be the State. According to Chipkin and Meny-Gilbert (2013) the state should be at the centre of the whole process of ensuring realisation of social justice. Miller (1991:6) supports the idea of placing the state at the hub of the process social justice as he writes "theories of social justice propose legislative and policy changes that a well-intentioned state is supposed to introduce".

5.7.1.1 Distribution of doctors and nurses

The first aspect looks at the distribution of resources between the paying and non-paying sections. The findings (from the Chief Hospital Administrator, In-charge of the Paying Section, the five nurses and three doctors) indicate that resources are distributed fairly. For instance, the doctors who work in the non-paying section also work in the paying section. The nurses are rotated every two years. This was explored when the Chief Hospital Administrator was responding when the researcher indicated that he wanted to administer questionnaires to two nurses and two doctors from both paying and non-paying sections. The Chief Hospital Administrator responded by saying, *"We do not have doctors or nurses working for specific section, say paying or non-paying section. Doctors and nurses working in non-paying section also work in the paying section".*

The CHA's response means that doctors and who work in the non-paying section also offers their services in the paying section.

The implication of doctors working in both paying and non-paying sections is that there is a fair distribution of resources to patients from both sections. It also implies that every patient has an equal opportunity to access the expertise of the doctors regardless of whether one is in the paying

or non-paying section. Such a way of distributing resources, further implies that the poor who patronise the non-paying section are not left out; in as far as accessing health care services is concerned. This is the case because despite their failure to access the paying services, they are able to access similar services as those accessed by the paying patients.

Equal access to health care services regardless of whether a patient is from a paying or non-paying section is manifested from what the In-charge of the Paying Section said. She said that they have full time nurses and one full time clinician, *"But for surgical, gynaecological and orthopaedic cases, we call clinicians and doctors from those departments."*

The response from the In-charge of the paying section means that the paying section at ZCH does not have its own specialists of surgical, gynaecological and orthopaedic cases. As such, the specialists are called from the non-paying section which acts as their base.

The In-charge of Paying Section, further says, *"Whenever we want the doctor and if he/she is with a patient from the non-paying section, they finish with that patient then come to the paying patient."*

The latter response of the In-charge of the Paying Section means that a specialist cannot abandon a non-paying section patient for a paying one. He/she would rather finish working on the non-paying patient then attend to the paying patient.

The implication of the two statements is that priority for one to be attended to by health professionals does not require one to be in the paying section. The other implication is that the purpose of paying to get quicker services at ZCH is compromised because no priority is given to the paying patients. This may negatively affect patronage of the paying services thereby reducing revenue to the hospital which helps to fund some of the activities at the institution. So, such kind of a situation may negatively affect the greatest number of non-paying patients who are admitted at the institution. This is the case because the non-paying patients depend on the free services whereas the paying patients may go to other private hospitals and get quality services.

5.7.1.2 Double-payment of paying patients

It can be argued that paying patients pay twice for the medical care in public hospitals. They pay through tax (Value Added Tax, Income Tax and Pay as You Earn) as well as out-of-pocket or medical insurance cover. This arrangement can be argued to be unjust to the paying patients because the services that are meant to be free or being paid for through tax, others are asked to pay for them. However, the claim of injustice is illogical because according to the system of running the paying wings in the public hospitals, it is optional to go either to the paying or non-paying section. The argument of injustice would have been valid if the clients were being forced to patronise the paying section. Making the paying system at ZCH optional implies that the one opting for the paying services is doing so not to get different medical care services but rather good meals and accommodation. This is the case because medical care services offered in the paying section are similar to those being provided to the non-paying patients.

5.7.1.3 A Compromise of quick and quality service delivery to paying patients

The fair distribution of resources between paying and non-paying patients at ZCH, where they all queue for same theatre, labour, X-ray, laboratory and ICU services, may imply a delay in accessing health care services by the paying patients. The paying clients sacrifice their money by patronising the paying section to get quicker services. Making an arrangement, for instance, where both paying and non-paying patients should be using same beds allocated to ICU ward may delay the former in accessing ICU services in a situation where the later have occupied all the beds in the ward. This would compromise the essence of being a paying patient which is to get quicker and quality services.

5.7.2 Entitlements

The Cambridge Dictionary (1995) defines entitlement as having the right to do or to have, or the right to do or have something. *The Oxford Dictionary* defines the word "entitlement" as the fact of having the right to something; the amount to which a person has a right; and a belief that one is inherently deserving of privileges or special treatment (Murray 1884). Patients and guardians in both paying and non-paying sections have some entitlements. This section analyses how the system of operating a paying section promotes or compromises patient's and guardian's entitlements in both sections of the hospital.

5.7.2.1 Right to quality and nutritious meals

All patients have a right to nutritious food (Wejesinghe & Fernando, 2017). Hospital meals form a fundamental element of healthcare to hospitalised patients (Wejesinghe & Fernando, 2017). Provision of nutritious food to inward patients should be a hospital's priority because a large number of hospitalised patients are dependent solely on hospital food (Wejesinghe & Fernando, 2017). Nutritious food is vital for patients as it helps to regain strength and get healed (Murphy, (2017).

Patients in both sections at ZCH, too, need quality food to nourish their sick bodies. According to the Chief Hospital Administrator, the meals are provided by external contractors known as Tasty Catering Solutions. However, the food provided at the paying section is of better quality as compared to the one that is given to the non-paying section. This is evidenced by the information the Chief Hospital Administrator gave that *"Nursing and medical services provided at the paying section are also done at the non-paying section. The only difference is that at the paying section, quality food is provided."*

The response was also supported by the In-charge of the Paying Section and all the four respondents interviewed as guardians of the paying patients. This entails that inward patients from paying section are better fed than those in the non-paying section. This leads to malnutrition in non-paying patients. The disparity in food distribution is also indicated in TAH study (Wadee & Gilson, 2007). The disparity implies that non-paying patients are exposed to malnutrition condition. Malnutrition in patients leads to a number of challenges. These include delayed healing, higher mortality, just to mention a few (Wejesinghe & Fernando, 2017). Therefore, by giving quality and nutritious food to the paying patients and leaving out the non-paying ones, the system compromises utilitarian's principle of impartiality. However, this assertion can be counter argued by claiming that the paying patients are given better meals than those given to non-paying patients because the former pay for it. It is ethical to give the paying patients the type of meals they pay for.

5.7.2.2 Right to health

According to the Covenant that was adopted by the United Nations General Assembly in its resolution 2200A (XXI) of 16 December 1966, but entered into force in 1976 and ratified by 157 states in 2007; one of the aspects of the right to health is that it contains entitlements that include: access to essential medicines, equal and timely access to basic health services, just to mention a few. The paying section at ZCH seems to support this arrangement by the United Nations through its realised funds which help to buy some necessities of the general hospital. These necessities bought by the realised money according to one key informant (Chief Hospital Administrator) include medicine, reagents (chemicals used to clean x-rayed pictures), and many more.

According to the theory of utilitarianism employed in this study, the system of operating paying wings at ZCH maximises the well-being of the greatest number. This is so because the medicines and reagents bought help patients from both paying and non-paying sections.

5.7.3 Ethical justification of operating a paying section at ZCH

The findings of the study indicate that there are a number of aspects that show that running a paying section at the public hospital of Zomba Central is largely ethical. The first aspect is that having the paying section at ZCH does not, in any way, disturb the non-paying patients from accessing the needed and required medical treatment. This is so because the findings reveal that doctors at ZCH work in both sections. The other reason is that no incentives are given for working in the private wings. If incentives were being given, one could argue that the doctors are motivated by the incentives to work in private wings. The study findings have also revealed that whenever there is a need for a certain doctor or clinician in the private wings, they call him or her from the related department such as gynaecology, surgical and orthopaedic. It has, further, been revealed that if these experts are busy working on a patient from the non-paying wards, they never leave that patient in order to attend the paying patient. This means that they make sure that they finish working on that particular patient then move on the paying client. This entails that being a paying patient does not guarantee one to be prioritised in accessing medical care services. The final reason that shows that operation of paying section does not disturb free patients from getting medical care is the fact that patients from both sections queue to access

health services from X-ray, laboratory, and theatre departments. There is no prioritisation of paying patients when accessing medical services from these departments.

The other aspect is that part of the money realised from the paying section is used to buy the hospital's necessities (such as medicine, reagents and others) which are used by both paying and non-paying sections. This means that the gap that is created by underfunding of the hospital is sometimes not felt because of the money realised from the paying section. Operation of public hospitals with scarce resources is a daily situation. Having an initiative of generating funds to facilitate some of the hospital's activities is worth recommending. The arrangement also means that the poor who patronise the non-paying section are taken care of by the paying section through its proceeds.

Besides the paying system's failure to disturb the non-paying patients from accessing medical services and its ability to generate money to buy some necessities; 40% of the money is equally shared among all the members of staff from the hospital across the board. That is, from both sections without regard of one's position at the hospital. This implies that the Hospital Director and the cleaner get the same share and this is done every six months. This can be a motivating factor to the staff and medical professionals in particular who mostly shun public health institutions for private entities. Related to the motivating issue, part of the realised money is paid to MASM as a subscription fee for all members of staff at ZCH. This, according to the findings, reveals that it helps the staff to patronise their paying section thereby plough back the money to the activities of the hospital. It has also been found that subscribing members of staff to MASM helps to cut the vice of members of staff stealing medicine from the hospital. This is so achieved because whenever members of staff are in need of medicine for them or their relatives, they just register as sick people to get the type of medication needed at that material time. This tends to be a plus to the institution because, through this, the hospital is able to save medicine by cutting the vice of theft of medicine. Furthermore, if the medicine stocks ran out, the hospital is able to replenish by buying using money realised from the paying section.

The final aspect that makes the system of operating a paying section at ZCH largely ethical is that 60% of the money realised from the section goes to government's account number one. The money is either given back to the hospital in a form of funding or given out to other institutions

to meet some government commitments. The money is also used at ZCH to work on some structures, for instance, Endoscopy department was renovated using money from the paying section. This entails that the paying section at ZCH is beneficial to both the hospital and beyond.

5.8 Chapter conclusion

This chapter has presented the findings and discussion on different themes of the study. The discussion was based on utilitarianism ethical theory. The presentation of the findings and discussion gives a pointer to the conclusion and implications presented in the next chapter.

CHAPTER 6
CONCLUSION AND IMPLICATIONS

This study set out to carry out an ethical investigation into operating a paying section at Zomba Central Hospital. The system of having paying sections in public hospitals is defined as differentiated amenities aimed at providing high standard of health care services (Wadee & Gilson, 2007). The key research question that guided the research was "is it ethically justifiable to operate paying section in public hospitals?" That key research question was addressed by answering the following sub-research questions: (a) What does the system of operating paying section within public hospitals entail? (b) How is the system of operating paying section implemented at ZCH? (c) What are the merits of having a paying section at ZCH? (d) What are the demerits of having a paying section at ZCH? (e) What are the ethical implications of operating paying section at ZCH?

The sample size of this study was twenty-five respondents. These included one hospital administrator, one paying ward in-charge, three doctors and five nurses, four guardians from paying section and eleven guardians from non-paying section. The literature review indicated that the system of operating paying wings alongside non-paying wings in public hospitals is growing in low and middle income countries.

The moral theory that informed the study was utilitarianism. Beauchamp (1982) describes utilitarianism as the most influential theory as compared to other ethical theories that focus on measuring the worthiness of actions by their results. There are two main categories of utilitarianism namely; classical utilitarianism and contemporary utilitarianism. The common denominator of the classical utilitarianism and contemporary utilitarianism is their advocacy on the claim that wrongness and rightness of an action is determined by the results produced for the general well-being of all the parties affected by the particular action. However, this study was grounded in contemporary utilitarianism. All the research questions of the study were answered in chapter four.

The statement of the problem of this study was that the system was perceived to be a source of many challenges. Firstly, the allocation of resources was viewed to have favoured the paying section because it was where more proceeds emanate from. The system may also promote inequity between paying patients and non-paying patients. Besides, operating paying wings may realise little proceeds that may be unable to offset financial challenges met by public hospitals. The system is, finally, perceived as a mechanism used to put the burden of financing public hospitals on poor people. The significance of the study was to explore ethical issues associated with having paying wings in a public hospital of Zomba Central. The other significance may be appreciated from the fact that this may be the first study to take ethical perspective because most of them have been taking an economic angle. As such, other researchers may use this study as their point of departure and references for future studies.

The findings show that the arrangement of operating paying wings alongside non-paying wings has its benefits and flaws. The benefits centre on the arrangement's ability to generate funds which help to buy some necessities that help to run the hospital such as medicine, reagents, just to mention but a few. The generated funds also help to motivate their members of staff by paying subscription fees for their medical schemes and paying them biannual allowances. The findings indicate that the arrangement plays a vital role in ensuring the availability of things that constitute healthcare services for all patients from both sections such as medicine, reagents in x-ray department, motivated health personnel, and many more. This entails that the system does not benefit only those who patronise the paying section, but also the non-paying clients. This is in contrast to the general perception of non-paying clients that the arrangement does not benefit them. Almost all the guardians of the non-paying section showed their disapproval of the arrangement of operating paying wings in a public hospital like Zomba. This thinking is based on the idea that the source all the health care services provided by the hospital is government funding. Such line of thinking does not accommodate the fact that sometimes government resources fall short of supply. This is where the proceeds from the paying section become the corner stone of the activities at Zomba Central Hospital.

The other benefit is that 40% of the generated money is equally shared amongst all members of staff from both sections regardless of their position at work. The remaining 60% is deposited into

government's account number one where it is given back in form of funding or helps in meeting other government commitments. Some hospital structures at ZCH, such as endoscopy department, have been renovated using money from the paying section. The flaws of the system emanate from the way some services are provided by favouring paying section, for instance, allowing two or three guardians per patient, provision of pharmaceutical services throughout the week including the weekends, and others. The other challenge associated with the system is the favouring of the paying patients in providing them with quality meals and good accommodation. This is evidenced by the sentiments of one of the key informants, the CHA who reported that there are times at ZCH when they run out of medicine and reagents. So, according to him, the hospital uses the proceeds realised from the paying section to buy such necessities. This key informant also reported about the accommodation challenges the staff working at ZCH face. The accommodation challenge discourages experts from working at ZCH. According to this key informant, the hospital use part of the proceeds to pay for accommodation. So, the availability of accommodation and some form of motivation to the staff attract the experts to work at the hospital. These medical experts benefit both paying and non-paying patients. The findings also indicate that distribution of resources does not only favour the paying section as evidence shows that all patients from both paying and non-paying sections queue for same health facilities at the institution.

The implications of the findings are that the system of operating a paying section at ZCH allows the rich to subsidise the poor. This is done by paying at the paying section where the hospital management use the proceeds in buying necessities at the institution. It can also be implied that the rich subsides members of the staff at the institution through money they receive every six months as a motivation to staff. The other implication is that the rich are punished twice in paying for the medical services. That is to say, the rich pay for the services through tax (Value Added Tax, Income Tax, and Pay as You Earn Tax) and direct payment made at the point of consumption of medical services. However, it is important to note that double payment made by the paying patients through tax and direct payment is optional. Besides the aforesaid implications, allowing both paying and non-paying patients to queue for same services destroys the whole purpose of paying to get quicker services.

In a nutshell, this dissertation argues that it is ethically justifiable to run paying wings alongside non-paying wings in a public hospital. This is so because of the significant role the paying section plays to the entire ZCH. The other justification is that the system also benefits non-paying patients who outnumber the paying ones, hence promotion of the well-being for the greatest number of people. The highlighted flaws exposed by the guardians of the non-paying patients cannot be attributed to the system of running parallel paying wings at ZCH, but rather to the insufficient funding the institution is provided with. Operation of paying wings has been seen as a viable initiative to address the problem of scarce resources the institution faces. The initiative can also be argued as one way of achieving self-dependency thereby graduating from depending on donors.

6.1 Suggestion for further study

This study focused on one central hospital in Malawi, thereby making it difficult to be generalised. Therefore, it is suggested that future researchers could broaden the scope by taking into account all the central hospitals in Malawi and beyond to explore if what was found at ZCH is also experienced in those other hospitals.

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APPENDICES

APPENDIX 1: FACE-TO-FACE INTERVIEW WITH CHIEF HOSPITAL ADMINISTRATOR

QUESTIONS

1. What does the system of operating a paying section at ZCH entail?
2. Why was the system introduced at ZCH?
3. What main legislation, policies and ethical principles inform this system of operating paying section in public hospitals?
4. How is the system implemented here at Zomba Central Hospital?
5. How does the implementation process of the system enhance or compromise fair distribution of resources between paying and non-paying sections?
6. In your assessment, what are the ethics and vices of this arrangement?
7. What is your final word on the discussion?

THANK YOU SO MUCH FOR YOUR TIME

APPENDIX 2: FACE-TO-FACE INTERVIEW WITH IN-CHARGE OF THE PAYING SECTION

QUESTIONS

1. What does the system of operating a paying section at ZCH entail?
2. How is the system implemented in your section?
3. What services are offered in your section but not available in the non-paying section?
4. Which class of people patronises your section?
5. In your opinion, what are the ethics and vices of this arrangement?
6. What is your final word on the discussion?

THANK YOU SO MUCH FOR YOUR TIME

APPENDIX 3: SEMI-STRUCTURED INTERVIEW FOR DOCTORS AND NURSES WORKING IN EITHER PAYING OR NON-PAYING SECTION AT ZCH

Instructions

This questionnaire should be answered by doctors who are sampled to answer questions on

a) Tick wherever applicable
b) No names should be indicated, only use numbers
c) Only doctors and nurses working in either paying or non-paying section are eligible for this study.

SECTION ONE

Doctor ☐

Nurse ☐

A. What does the system of running paying section along with non-paying section at ZCH entail?

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……

…….....

B. Which section do you work for:

i. Paying ☐

ii. Non-paying ☐

iii. Both ☐

C. What incentives, if there are any, are given for working in the section ticked above?

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D. Describe briefly how resources are distributed to your section.

……

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…….....

E. How flexible is your section in allowing patients to demand for a particular treatment or call for the doctor's/nurse's attention?

……

……

……

F. In your opinion, how ethical or unethical is the arrangement of having paying section in a public hospital like ZCH?

……

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……

……

G. What is your final word on the discussion?

……

……

THANK YOU SO MUCH FOR YOUR TIME

APPENDIX 4: FOCUS GROUP DISCUSSION GUIDE FOR GUARDIANS OF PATIENTS FROM PAYING SECTION

1. Kodi mukudziwapo chani pa zachiringanizo chokhala ndi mbali yolipira ndi yaulere pano pa chipatala cha boma cha ZCH?
2. Kodi mumachiona bwanji chilinganizo chokhala ndi mbali yolipira ndi yosalipira mzipatala zaboma chino cha ZCH kumbali yofikira thandizo la zaumoyo labwino?
3. Kodi ubwino ndi kuipa kwa chilinganizochi nkotani?
4. Ndi chifukwa ninji munaganiza zopita mbali yolipira osati yosalipira?
5. Mungatifotokozere bwanji za thandizo lomwe limaperekedwa mbali olipira ya chipatalachi kumbali yakukhutitsidwa kapena kusakhutitsidwa?
6. Ndi zinthu ziti zomwe mungasangalatsidwe zitamachitika kapena kuchotsedwa kumbali yolipirayi? Ndipo, chifukwa ninji?
7. Mawu anu omaliza pa zokambiranazi ndi otani?

ZIKOMO CHIFUKWA CHA NTHAWI YANU

APPENDIX 5: FOCUS GROUP DISCUSSION GUIDE FOR GUARDIANS OF PATIENTS FROM NON-PAYING SECTION

1. Kodi mukudziwapo chani pa zachiringanizo chokhala ndi mbali yolipira ndi yaulere pano pa chipatala cha boma cha ZCH?
2. Kodi mumchiona bwanji chilinganizochi kumbali yofikira thandizo labwino la zaumoyo?
3. Kodi ubwino ndi kuipa kwa chilinganizochi nkotani?
4. Ndi chifukwa ninji munaganiza zopita mbali yaulere osati yolipira?
5. Mungatifotokozere bwanji za thandizo lomwe limaperekedwa mbali yaulere ya chipatalachi kumbali yakukhutitsidwa kapena kusakhutitsidwa?
6. Ndi zinthu ziti zomwe mungasangalatsidwe zitamachitika kapena kuchotsedwa kumbali yolipirayi? Ndipo, chifukwa ninji?
7. Mawu anu omaliza pa zokambiranazi ndi otani?

ZIKOMO CHIFUKWA CHA NTHAWI YANU

APPENDIX 6: A LETTER OF INTRODUCTION

PRINCIPAL
Prof Richard Tambulasi, B.A (Pub Admin), BPA (Hons), MPA, Ph.D

Our Ref: MA/PHIL/20/03/2019
Your Ref

CHANCELLOR COLLEGE
P.O. Box 280, Zomba, Malawi
Telephone: (265) 01524 222
Fax: (265) 01 524 046
E-mail: principal@cc.ac.mw

21st March, 2019.

TO WHOM IT MAY CONCERN

INTRODUCTION LETTER: REUBEN ALEXANDER

This serves to introduce **Reuben Alexander**, a student registered with the University of Malawi, Chancellor College pursuing Master of Arts in Applied Ethics.

As a requirement for graduating, he is supposed to conduct research leading to a dissertation. The title of the research he is conducting is: *Ethical Investigation on operating paying section in public hospitals in Malawi: The case of Zomba Central Hospital.*

As part of his research, Reuben will be required to collect empirical data. Data collection tools have been vetted by the Department of Philosophy and they have been deemed to adhere to ethical standards. In addition research findings will only be used for academic purposes and to inform policy.

Assistance rendered to him will be highly appreciated.

If you have any question on his research or reports of unethical standards during his data collection process please do not hesitate to contact the undersigned on mobile phone +265997467877 or email yndasauka@cc.ac.mw or the Postgraduate coordinator, Department of Philosophy on mobile phone +265991214677 or email smalewiuja@cc.ac.mw.

Yours sincerely,

DR. Y. NDASAUKA
HEAD OF PHILOSOPHY DEPARTMENT

Cc: Dean of Humanities
Dean of Postgraduate Studies
Dr. J. Bakuwa (supervisor)

APPENDIX 7: LETTER OF APPROVAL

C/O Chancellor College,
P.O. Box 280,
Zomba.
Cell: 0888919281/0999319281
Email: bah-74-11@cc.ac.mw or ma-aet-11-17@cc.ac.mw

Reuben Alexander
Approval is granted

The Hospital Director,
Zomba Central Hospital
P.O.Box 21,
Zomba.
22nd March, 2019.

DIRECTOR ZOMBA CENTRAL HOSPITAL 03 APR 2019 P.O. BOX 21, ZOMBA

Dear sir/Madam,

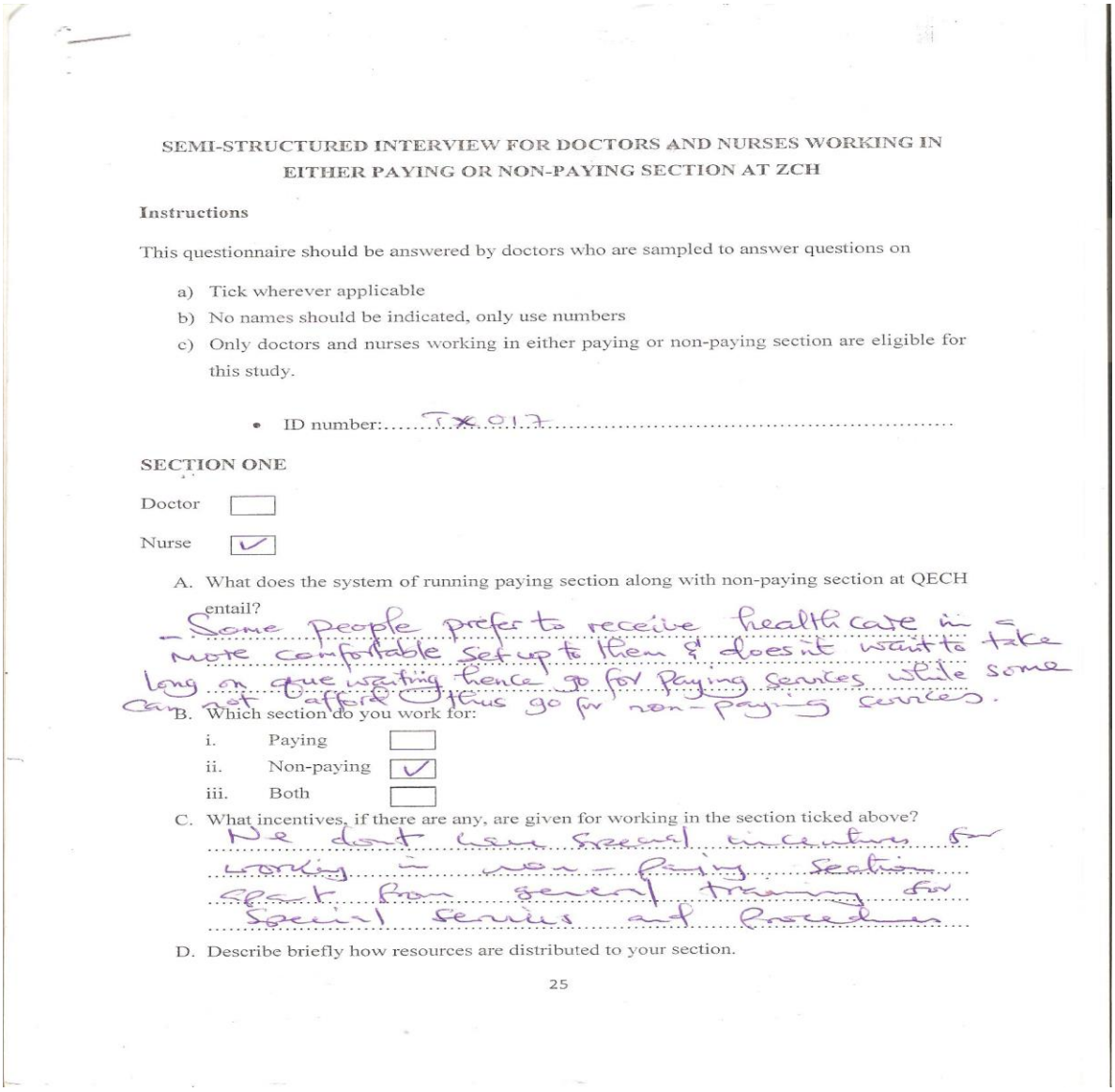
REQUEST TO CONDUCT A STUDY AT ZOMBA CENTRAL HOSPITAL ON THE TOPIC ENTITLED "AN ETHICAL INVESTIGATION INTO OPERATING PAYING SECTION IN PUBLIC HOSPITALS IN MALAWI: THE CASE OF ZOMBA CENTRAL HOSPITAL (ZCH)"

I, humbly, write to request for a permission to conduct the above captioned study at your institution where I intend to approach the hospital administrator, head of paying section, two doctors from paying section and two doctors from nonpaying section, two nurses from paying section and two nurses from non-paying section, and guardians from both paying and non-paying section. The results of the study will help to increase board of knowledge as well as help government to know the ethics and vices of the system thereby being in a position to work on the vices to make the system ethical.

The protocol has been approved by Chancellor College's Philosophy Department of the University of Malawi. All necessary legal and ethical considerations will be adhered to. Attached herewith, is an introduction letter from Chancellor College.

Yours Faithfully,
Reuben Alexander.

APPENDIX 8: SAMPLED COMPLETED QUESTIONNAIRES



SEMI-STRUCTURED INTERVIEW FOR DOCTORS AND NURSES WORKING IN EITHER PAYING OR NON-PAYING SECTION AT ZCH

Instructions

This questionnaire should be answered by doctors who are sampled to answer questions on

a) Tick wherever applicable
b) No names should be indicated, only use numbers
c) Only doctors and nurses working in either paying or non-paying section are eligible for this study.

- ID number: TX017

SECTION ONE

Doctor ☐

Nurse ☑

A. What does the system of running paying section along with non-paying section at QECH entail?

- Some people prefer to receive healthcare in a more comfortable set up to them & doesn't want to take long on queue waiting thence go for paying services while some cannot afford & thus go for non-paying services.

B. Which section do you work for:

i. Paying ☐
ii. Non-paying ☑
iii. Both ☐

C. What incentives, if there are any, are given for working in the section ticked above?

We don't have special incentives for working in non-paying section apart from general training for special services and procedures

D. Describe briefly how resources are distributed to your section.

25

Resources are distributed fairly and equally based on the need of treatment (Section)

E. How flexible is your section in allowing patients to demand for a particular treatment or call for the doctor's/nurse's attention?

It is within their right for the Patient to demand service and Service Provider they wish and our section is flexible to that

F. In your opinion, how ethical or unethical is the arrangement of having paying section in a public hospital like ZCH?

Its Ethical because its gives the community the chance to choose the Service of their interest without Preventing those in un-paying Service (Section) from getting the right treatment

G. What is your final word on the discussion?

Its a welcome idea to have Paying Section at the institution as a Means for the hospital to Manage itself

THANK YOU SO MUCH FOR YOUR TIME

SEMI-STRUCTURED INTERVIEW FOR DOCTORS AND NURSES WORKING IN EITHER PAYING OR NON-PAYING SECTION AT ZCH

Instructions

This questionnaire should be answered by doctors who are sampled to answer questions on

a) Tick wherever applicable
b) No names should be indicated, only use numbers
c) Only doctors and nurses working in either paying or non-paying section are eligible for this study.

- ID number: 1025

SECTION ONE

Doctor ☑

Nurse ☐

A. What does the system of running paying section along with non-paying section at QECH entail?

It is moving well because paying and non paying are receiving same treatment and care. Same drug (drugs)

B. Which section do you work for:

i. Paying ☐
ii. Non-paying ☐
iii. Both ☑

C. What incentives, if there are any, are given for working in the section ticked above?

In general there is a money incentive calculated every 4 months which is given to all staff of Zomba central Hosp. It is a flat rate which rises or falls when income fluctuates.

D. Describe briefly how resources are distributed to your section.

25

The resources are shared equally from pharmacies in both sections. When some items are out-stock wait for the stock to come.

E. How flexible is your section in allowing patients to demand for a particular treatment or call for the doctor's/nurse's attention?

According to what we have; Services, medication and counselling is the same in all the sections.

F. In your opinion, how ethical or unethical is the arrangement of having paying section in a public hospital like ZCH?

People themselves, have welcome the idea they flexible to either use paying services or non paying services as they wish. This time there is a choice to themselves.

G. What is your final word on the discussion?

Malawi needs allow other district hospital to access paying services and non-paying services. They should choose for themselves.

THANK YOU SO MUCH FOR YOUR TIME