ETHICAL EVALUATION OF PRIORITY SETTING PRACTICES AT ZOMBA CENTRAL HOSPITAL IN MALAWI

MASTER OF ARTS IN APPLIED ETHICS THESIS

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UNIVERSITY OF MALAWI

CHANCELLOR COLLEGE

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MASTER OF ARTS (APPLIED ETHICS) THESIS

By

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DECLARATION

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

AGATHA MAGOMBO

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Signature

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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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DEDICATION

I dedicate this piece of work to my Mother, Rhoda, for thus far the Lord has brought us.

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ABSTRACT

The conditions under which organisations operate in the twenty-first century environment have become complex owing to a number of factors. Most organisations are forced to operate on serious budget shortfalls, a situation which has necessitated prioritising activities. The health sector is no exception. In line with this, the Ministry of Health (MoH) in Malawi adopted the process of priority setting in its hospitals so as to ensure efficiency and effectiveness in the distribution of resources. This study evaluated the extent to which the process of priority setting at Zomba Central Hospital, ZCH, adheres to ethical requirements. Specifically, it examined the degree to which the priority setting practices at this hospital can be said to be ethically justified by comparing the practices against the tenets in the ethical framework known as accountability for reasonableness (A4R). To attain its objectives, the study employed a qualitative case study research design where data was collected through in-depth interviews, focus group discussions (FDGs) and document reviews. The study identified three priority setting processes that are practised at ZCH, namely; planning and budgeting, medicine selection, and nurse allocation. The study revealed that priority setting practices at ZCH contain some ethical aspects that are in tandem with the A4R framework. However, the processes do not completely adhere to the requirements of the accountability for reasonableness when setting its priorities. The study, therefore, concludes that the A4R framework is indispensable in both examining ethical aspects of priority settings as well as in averting problems arising from a weak ethical base. It also reflects on areas for further research, to enhance strategies that can help inculcate ethical culture in the Malawian health delivery system.

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LIST OF ABBREVIATIONS

AH:	Allied Health
A4R:	Accountability for Reasonableness
CATS:	Clinical Activity Target Setting
CHIP:	Central Hospital Implementation Plan
CPSRN:	Canada Priority Setting Research Network
DoH:	Department of Health
DTC:	Drug and Therapeutic Committee
EVAR:	Endovascular Aneurysm Repair
FGD:	Focus Group Discussion
HICs:	High Income Countries
ICU:	Intensive Care Unit
LMCs:	Low and Middle -Income Countries
MDGs:	Millennium Development Goals
MoH:	Ministry of Health
NLHS:	National List of Health Service Priorities
OPD:	Out Patients Department
P&T:	Pharmacy and Therapeutic Committee
PBMA:	Program Budgeting and Marginal Analysis
RHA:	Regional Health Authority
UHN:	University Health Network
WCH:	Women and Children Hospital
ZCH:	Zomba Central Hospital

CHAPTER ONE
INTRODUCTION

1.1 Background

The role priority setting plays in any twenty-first century institutional environment cannot be overemphasised. According to Kenny and Joffers (2007), priority setting is always at the centre of determining what is important, a situation that is particularly true for healthcare delivery where priority setting involves making distributional decisions, which inherently includes limiting access to some health services (Moody, 1991). Priority setting has therefore been recognised as a key determinant of success in healthcare delivery (Barasa, Clearly & Molyneux, 2017). Kenny and Joffers (2007), therefore conclude that priority setting as a process should be given special attention, implying an intrinsically normative ethical process.

Owing to a number of reasons, most notably, scarcity of resources and concerns about equity in the distribution of services, as well as who is receiving health care, health systems across the world are entreated to prioritise health services (Bate, Donaldson & Murtagh, 2007). However, health care systems encounter a number of challenges mainly because of imbalances between allocated resources and demand for health services. In the end, priority setting becomes complex and difficult especially because central to this process is the art of making decisions, and juggling competing value-laden choices (Daniels, 1994). In such a setting, decision-makers lack consensus over exact values to guide their decisions as demand often outstrips available resources. This leads to challenges in setting the priorities right.

According to Waithaka, Tsofa, and Kabia (2018), priority setting in the health system should be considered as occurring at all levels—macro (national), meso (hospital) and micro (clinician) levels. Despite this, research on priority setting in health care delivery has largely focused on the macro and micro levels, at the expense of the meso or hospital level (Barasa, Clearly, Molyneux & English, 2017). This oversight has led to a number of

frustrations as far as efforts to improve health service delivery are concerned. First, it has deprived the efforts of evidence of priority setting especially in the context of decentralisation (Maluka, 2010). This should be understood in the context that decentralisation is at the centre of most health system reforms where hospitals are critical in the delivery of healthcare services and control of significant resources (Waithaka, Tsofa, Kabia & Barasa, 2018).

Additionally, hospitals are charged with the daunting task of managing and allocating resources to different departments, services as well as patients. Understanding how hospitals ethically set their priorities and the factors that influence their allocation of resources is, therefore, imperative. This is because priority setting decisions contribute to the sustainability of strained pools of resources, therefore playing a critical role on issues of access to needed health services.

1.2 Problem statement

Malawi is a low and middle-income country (LMCs) facing severe resource constraint, which makes it practically impossible for adequate resources to be allocated in hospitals. Scarcity of resources raise ethical questions, for example, how limited healthcare resources should be allocated. Priority setting becomes imperative because it guides resource allocation in a manner that respects resource constraints. This is because, in theory, priority setting is a systematic approach to a fair and just distribution of the limited resources to fashion the best healthcare system possible (McKneally, Dickens & Meslin, 1997).

However, anecdotal evidence at ZCH suggests that priority setting takes place implicitly. As a result, allocation of limited resources seems to involve prioritising interventions without use of what is described as explicit normative framework; that is, the use of rationing principles or specific instructions provided to guide decision-making process. This type of prioritisation may lead to ethical dilemmas.

Addressing priority setting and ensuring legitimacy in the processes are necessary for developing fairer methods for allocation of scarce healthcare resources. This requires optimal tools and processes that draw on the best local evidence, as well as those that guide decision-makers to identify, prioritise and implement evidence-based health interventions for scale-up and delivery. Such approaches should embrace ethical considerations and should also acknowledge the fact that setting priorities involves value choices of different stakeholders. The purpose of this study is to evaluate the extent to which priority setting practices at ZCH can be deemed to be ethically justified in the context of accountability for reasonableness (A4R) as advanced by Daniels and Sabin (2002).

1.3 Main research question

To what extent do priority setting practices at ZCH comply with established ethical standards such as those in Daniels and Sabin's accountability for reasonableness ethical framework?

1.4 Sub research questions

1. Who is /are involved in priority setting practices at ZCH?
2. What are the areas of focus in priority setting at ZCH?
3. What criteria are associated with priority setting at ZCH?
4. What ethical aspects are present in priority setting processes at ZCH?
5. What are the outcomes of priority setting practices at ZCH?

1.5 Rationale

This study is important because scarcity of resources in most developing countries, for example, Malawi, has made priority setting an imperative venture. Additionally, considering the role that hospitals play in the delivery of healthcare services and the relatively high cost of operating hospitals, there is a need to address priority setting at this level as it is a key determinant of health system performance. The study, therefore, seeks to understand how ZCH management and staff set their priorities and the factors that underline such practices.

This study also stands to help identify the strengths and weaknesses of the practices which can inform the design of interventions for improvement. The logical and transparent appeals that are identified in this research will determine normative principles guiding policy makers both at ministry and hospital levels in their choice of intervention. Lastly, there is a dearth of literature on hospital priority setting especially in Africa. This study therefore will stand out as one of the pioneers as far as examining priority setting practices at the hospital level in Malawi is concerned. Other researchers may therefore use it as a platform for further research.

1.6 Structure of the thesis

The thesis comprises seven chapters. The first chapter introduces the research by providing the background to the study, the problem statement, research questions and the rationale of the study. Chapter Two presents the literature review, while Chapter Three discusses the theory that guides the study. Following this, chapter Four provides the research methods that are used in this study. Chapter Five presents the findings of the study and Chapter Six provides a detailed discussion of the findings. Finally, Chapter Seven provides the conclusions, implications, areas for future research and limitations of the study.

CHAPTER TWO
LITERATURE REVIEW

2.1 Chapter overview

This chapter delves into research work in the terrain of priority setting within the hospital level. This involves defining and explaining what is known about priority setting processes, the criteria that influence these practices and how the context of the hospital affect priority setting practices. These scholarly works provide information on the main objective of the study which is to evaluate the extent to which priority setting practices at ZCH can be said to be ethically justified as compared by the A4R framework.

2.2 Process of priority setting

The term "priority setting" in health care is used interchangeably with rationing (Klein, 1998). However, other scholars make a distinction, they define rationing as decisions that affect individual patients at the point of delivery (micro level) and priority setting as distribution decisions made at the macro and meso level, which involve clear and direct limits on access to care or, simply, a process of determining how health care resources should be allocated among competing programs or individuals (Martin & Singer, 2000). The literature in this thesis will focus on the meso level of priority setting.

From the literature, the process of priority setting at hospital level is dependent on the priority setting activity. Kapiriri, Norheim, and Martin (2007) conducted a study on healthcare priority setting in Ontario (Canada), Norway and Uganda at the three levels of decision making. The researchers evaluated the description using the framework for fair priority setting, accountability for reasonableness to identify lessons of good practices.

The study found that, at the meso-level priority setting, decisions were made by hospital managers and were based on national priorities, guidelines and evidence. They also observed that hospital departments that handle emergencies such as surgery were prioritised. In the same vein, upon evaluation of the process with the accountability of

reasonableness framework, the findings revealed that medical evidence and economic criteria were thought to be relevant, while lobbying for resources was thought to be irrelevant.

Kapiriri, Norheim and Martin (2007) also observed that the process of priority-setting lacked clear and effective mechanisms for publicity. Similarly, in terms of revisions of decisions, formal mechanisms which followed the planning hierarchy were considered less effective while informal political mechanisms were considered more effective. When the process was compared between, Canada and Norway, on one hand, and Uganda, on the other, it was established that revisions were more difficult in Uganda. This is because Canada and Norway had patients' relations officers to deal with patients' disputes. As for enforcement, leadership for ensuring decision-making fairness was not apparent.

The limitation of the study by Kapiriri et al (2007) was that it did not capture the views of members of the public. However, the ZCH case study incorporates within its scope this aspect of capturing the views of members of the public through focus group discussion (FGD) with the guardians in order to validate the findings, with regards to their role in priority setting.

Studies on the process of priority setting at meso-level have generally found that, within the hospital, priority setting is seen to be dominated by hospital administrators or managers, with some hospital settings reporting minimal involvement of frontline practitioners. Reasons for the minimal involvement of practitioners include: time constraints and lack of interest (Kapiriri & Martin, 2006).

Recently, power imbalances between stakeholders have also been found to be a major influence in the priority setting process in hospitals (Barasa, Clearly & English, 2016). Power differences exist when some actors in the priority setting process have the capacity to influence priority setting outcomes more than others. This results in, among other things, perceptions of unfairness and reduced motivation amongst hospital staff. It also puts to question the legitimacy of priority setting processes in these hospitals. This occurs

given that hospital decision-making environments tend to be hierarchical and politically complex (Gibson, Martin & Singer, 2005).

Insights on the process of priority setting as far as fairness in the process is concerned were at the heart of a study conducted by Martin, Hollenberg and Mac Rae (2003) in Toronto, Canada. Using the case study method and accountability for reasonableness as an ethical framework, the researchers sought to evaluate the process for improving the fairness of priority setting in hospital drug formulary. The findings of the study showed that decision making for new technologies and medicines often began with clinician interest and initiative. Suggestions for new technologies and medicines were, thereafter, processed through three possible channels. It is not in the interest of Martin et al. (2003) study to look at all the channels. However, of interest is the observation that, for medicines, these suggestions were often presented to an assessment committee which employed selection criteria to make decisions about their selection and inclusion in the hospital formulary.

The primary limitation of the study by Martin et al. (2003) is generalisability. In other words, it would not make academic sense generalising the results of this study to other hospitals since it was context specific. Similarly, the goal of ZCH study is not to generalise the findings, but it seeks to provide a rich description of context-specific phenomena that have independent, valuable and significant meaning so that some hospitals may learn from them.

Other important findings on the process of priority setting come from Waithaka et al. (2018) who carried out a qualitative case study approach to examine the planning and budgeting processes in two counties in Kenya. In that study, data was collected through in-depth interviews of senior managers, middle-level managers, frontline managers, and health partners, as well as through document reviews. The study revealed that the planning and budgeting processes in both counties were characterised by misalignment and dominance of informal considerations in decision making. When the process was

evaluated against consequential conditions, it was found that efficiency and equity considerations were not incorporated in the planning and budgeting processes.

According to the findings from the Kenyan study, stakeholders deemed to be more satisfied and understood the planning process better than the budgeting process (Waithaka et al. 2018). The reason for their understanding lay in the fact that, against procedural conditions, the planning process was more inclusive, transparent, and stakeholders therein were more empowered than was the case with the budgeting process.

Among the pertinent problems pertaining to the process, the study identified ineffective use of data, lack of provisions for appeal and revisions, and limited mechanisms for incorporating community values in the planning and budgeting processes. The limitation of the study by Waithaka et al. (2018) is that it did not include non-participant observations of the planning and budgeting processes. This ZCH case study, however, includes members of the public (guardians) in order to accord the research the rigour it deserves.

Martin, Shulman, and Santiago-Sorrell (2003b) also conducted a study to evaluate the priority setting element of a hospital's strategic planning process at Sunnybrook & Women's college health sciences centre. The study used a qualitative case study and the process was evaluated against the conditions of accountability for reasonableness ethical framework. The findings revealed that, to a large extent, the hospital's strategic planning process met the conditions of accountability for reasonableness. The reason could be owing to a number of factors. Among others, it could be because the hospital had based its decisions on reasons that the participants felt were relevant to the hospital, or even that the process, decisions, and reasons were well communicated throughout the organisation.

The study by Martin et al. (2003b) had many limitations, however, worth mentioning is that, being the first study in the process of evaluation and improvement in priority setting at the hospital level, the study failed to examine the consequences of the recommended changes (evaluation with A4R framework). It will be important in the current study to

continue the case study through subsequent budget cycles to evaluate the effect of A4R on priority-setting at the hospital.

On decision making, as regards technology, Danjoux, Martin, and Lehoux (2007) argue that, for technologies such as surgical, decision making depended on the level of capital investment required. The study set out to evaluate the decision-making process for the adoption of new technology for repair of abdominal aortic aneurysms (Endovascular Aneurysm Repair (EVAR) in an academic health sciences centre to better understand how decisions are made for the introduction of surgical innovations at the hospital level.

Danjoux et al. (2007) used a qualitative case study and accountability for reasonableness was used as a conceptual framework. Among the important findings were that the decisions made in priority setting involved very few stakeholders and that there were limited internal communications made prior to the adoption of the technology. The researchers also found that there were no formal means to appeal the decisions which were made.

Like many studies before it, Danjoux et al. (2007) was limited in that it had relied on results from the case study which represented findings from an academic health sciences centre, which may not be generalizable to other hospitals. To ensure wide acceptability and generalizability, the current research considers it useful to study a different setting using the same framework.

Additionally, Greenberg, Peterburg, and Vekstein (2005) studied on technology that required low capital investment. The researchers had embarked to map the function of hospital decision-makers within the area of new technology assessment and adoption, and to examine relevant considerations, sources of information and decision-making processes in the adoption of a new technology. To achieve this, they mailed a questionnaire to hospital executives and referred to (i) considerations for and against the adoption of new technology, (ii) the decision-making process and (iii) information sources used in the decision-making process.

Greenberg et al. (2005) found out that decision making for the adoption of a new technology was made by departmental heads. However, they observed that, when a proposed technology was associated with significant capital investment, final adoption decisions were made by the Hospital Manager or Chief Executive Officer. In some hospitals, technology assessment committees had the responsibility of evaluating and making decisions about the adoption of new technologies. However, the findings of this study were not based on optimal sources of information. To address this challenge, the current study conducts a document reviews which are relevant to ZCH case study to make sure the results of the study are optimal besides conducting in-depth interviews. These will include the minutes from previous hospital priority setting meetings for two financial years (2016 – 2017 and 2017 – 2018). The researcher will also review documents that will be recommended by the key informants.

Gordon, Kapiriri, and Martin (2009) used a case study involving key informant interviews and document review to evaluate priority setting in an acute care hospital in Argentina. The study used accountability for reasonableness, ethical framework for fair priority setting. The findings of the study show that priorities were primarily determined at the Department of Health (DoH). The committee which was supposed to set priorities within the hospital was found not to have much influence in the priority setting process. The decisions were based on government policies and objectives, personal relationships, as well as economic, political, historical and arbitrary reasons. Decisions at the DoH were publicised through the internet.

It was also established that, apart from the tenders and a general budget, details of hospital decisions were not publicised. This was beside the fact that the process was also said to provide an accessible but ineffective forum for appeals. This was exacerbated by the absence of quality data, a situation which provided loopholes for the use of informal or subjective considerations in the priority setting process.

Although Gordon et al. (2009) have made important contributions on priority setting through that study, their findings are limited in the sense that they were specific to the

institution under study. This current study however seeks to make its findings as relevant to the local setting as widely applicable as possible, so that other hospitals may learn from them.

In a qualitative study whose objective was to assess the priority setting process and its implication on availability of emergency obstetric care service in Malindi, Kenya, Nyandieka, Kombe, Ng'ang'a, Byskov, and Njeru (2015) found that the priority setting process was greatly restricted by guidelines and limited resources at the national level. The study also revealed that relevant stakeholders including community members were not involved in the priority setting process, thereby denying them the opportunity to contribute to the process. However, the study was limited because the study was conducted at the lower level of the referral health system, as such it did not capture all the priority setting processes and challenges associated with the practices. In contrast, this present study is conducted at a referral hospital whose findings can apply more widely to the lower hospital levels.

In another study, Greenberg, Siebzehmer, and Pliskin (2009) examined the legitimacy and fairness of the process of updating the National List of Health Services (NLHS) in Israel. The study assessed the priority setting process for compliance with the four conditions of accountability of reasonableness outlined by Daniel and Sabin in 2002 (relevance, publicity, appeals, and enforcement). These conditions emphasise transparency and stakeholder engagement in democratic deliberations.

The study reported that the availability and quality of information for decision making had a significant influence on priority setting practice. Priority setting decision- makers (twenty representatives from MoH, Ministry of finance, Health plan, and experts in economics, and members from the public) generally lacked sufficient and reliable information that can guide them when making decisions about setting priorities. Lack of information also resulted in assessments being conducted after technologies had already been adopted and widely used.

Studies have also been made on the role of quality information in priority setting. On this, a study conducted by Madden, Martin, and Downey (2005) revealed that decision-makers felt that the availability of quality information about appeals processes would improve decision-making in the priority setting process in a number of ways. These include enhanced data and information, increased perceived fairness and increased participation. The study had a number of objectives, including to evaluate priority setting in the context of a hospital priority setting, and, to evaluate the use of an appeals process. This was also a qualitative case study, making use of accountability for reasonableness ethical framework.

Some scholars, for example, Hisarcikillar, Woozageer, and Moatari-Kazerouni (2016); Sibbald (2008); Sibbald (2009), have expressed reservations with the findings for the simple reason that it had failed to evaluate the consequences of priority setting decisions. Besides, it is said that the participants of that study might have been influenced by a social desirability bias. Thus, participants may have opinionated statements that they thought the researcher wanted to hear rather than the actual events. To avoid similar pitfalls, the ZCH study takes into consideration the importance of studying the actual operational decisions that follow each priority setting initiative.

Another recurring theme in literature on priority setting is the issue of actors, and their power and interests. Actors (stakeholders) in the priority setting process include national and regional health policy-makers and planners, local politicians, donor organisations, community members, patients, hospital administrators or executives, departmental heads, and frontline practitioners (non-managerial clinical and non-clinical staff working directly with clients). The involvement of national and regional health policy-makers is dependent on where the policy-making authority was vested.

An important study on the question of actors, and their power and interests is that by Barasa et al. (2016). The purpose of their study was to examine the influence of power relations among different actors on the implementation of priority setting and resource allocation processes in public hospitals in Kenya. The study employed a qualitative case

study design and data was collected through a combination of in-depth interviews of national level policymakers, hospital managers, and frontline practitioners in the case study hospitals (n = 72); review of documents such as hospital plans and budgets; minutes of meetings and accounting records; and non-participant observations in the sampled hospitals over a period of 7 months (p. 3).

The results showed that the interaction of actors resulted in an interface between stakeholders who were involved in priority setting. These were senior managers and middle level managers, non-clinical managers and clinicians, and hospital managers and the community. However, this study was limited in terms of sampling in that it lacked wide representation. The current study addresses this shortfall by taking a more practical approach that should ensure a sample that is a representative of different cadres of hospital staff as well as members of the public as research participants.

Literature on power shows that power in decision-making is derived from several sources. For example, a study by Gordon et al. (2009) revealed that actors with control over the budget had more power and, thus, more influence over priority setting decisions as well. A related earlier study had also shown that senior hospital managers exercised more power over decisions compared with other hospital managers and frontline practitioners by their position as senior managers (Gibson et al., 2005). This concurs with Gordon et al. (2009) who reported that hospital executives in Argentina did not consult the hospital management committee when requesting additional staff allocations.

Additionally, Gibson, Martin and Singer (2005) unearthed power struggles between management and frontline workers, with managers reluctant to share the responsibility of making choices when setting priorities. The researchers found that actor power, which was derived from the possession of specialised skills and certain personal characteristics, was also exercised. However, decision making for a new surgical technology in Canada witnessed increased tension and conflict between surgeons and radiologists over the leadership of the process.

Similar conflict had also been reported in other scholarly studies. In a study by Astley and Wake-Dyster (2001), for example, found out that there was a conflict between professional groups in hospitals, manifested through competitive and defensive tactics rather than collaborative behaviour. Astley and Wake-Dyster (2001) were seeking an explanation on priority setting process during reallocation of resources to maximise health outcomes within budget reductions. The approach the researchers had followed is often criticised for lacking benchmarking data from other hospitals which is said to have resulted in an insular focus to clinical costing review. The present study overcomes this challenge by considering document reviews to validate the findings of the study.

Gibson et al. (2005) had also considered the question of power and persuasion. The study found out that two decision-making systems were in conflict in hospitals. The decision-making systems in question were the 'medical-individualistic' decision system and the 'fiscal-managerial' decision system. These are the same decision-making systems Greer (1985) had identified. Thus, while clinicians, who subscribe to the 'medical individualistic', decision system, were concerned with individual patient outcomes, administrators/managers, who subscribe to the 'fiscal-managerial' decision system, were concerned with the implications of decisions on the budget.

These findings were corroborated a few years later by Danjoux et al. (2007) and Gordon et al. (2009). However, Gallego, Taylor and Mc Neill (2007) observed that such conflict tended to be more evident in scenarios where decisions affected identifiable patients, such as medicines selection processes. Gibson et al. (2005) study concluded that although different actors often have varying values, actors with greater persuasive skills have greater power to influence the planning process.

The question of patient and public engagement in the process of priority setting has also been of interest. In a study whose purpose was to describe evidence that exists in relation to patient and public engagement priority setting in both ecosystem and health research, Manafo, Petermann, and Vandall-Walker (2018) found that engaging the public and patients in priority setting made the process successful.

In the study, Manafo et al. (2018) also gave the reason why hospital managers tend to side-line community and patients during the process of priority setting. Their explanation is that decision-makers tend to harbour a perception that community and patients lack understanding of medical issues. Years earlier, Martin et al. (2003) and Mauluka (2011) had proffered similar reasons when explaining why decision-makers side-line patients and community members during the process of priority setting.

In his study meant to strengthen fairness, transparency, and accountability in health care priority setting in Tanzania, Mauluka (2011) had gone further, observing that, despite the rational rhetoric on civic participation in literature on decentralisation, practice at the district level involved little community participation. Mauluka's findings did not give an official profess by government that the planning and priority setting process in the context of decentralisation are done in line with the principles of public participation, democracy, transparency, and accountability. The current study considers public and patients engagement an important component in any process of priority setting for efficient and effective healthcare delivery.

Zulu, Michelo and Msoni (2014) also considered the issue of fairness in priority setting and resource allocation. They conducted a qualitative study which focused on local perceptions and practices of fair priority setting (baseline study) and accountability for reasonableness-based intervention were used (evaluation study). The study was carried out at district level in Kapiri-Mposhi, Zambia.

Important gaps were identified in terms of experiences of stakeholder involvement and fairness in priority setting processes in practice. The evaluation study also revealed that a transformation of the views and methods regarding fairness in priority setting processes was ongoing in the study district, and this was partly attributed to the accountability of reasonableness framework-based intervention. Despite the rich evidence the study had demonstrated, the research was fraught with some pitfalls. This was mainly due to the fact that, although an effort had been made to include informants from many levels of decision

making in the district, the study did not include experiences of community members, an aspect this current study considers critical.

2.3 Criteria used in priority setting

Barasa, Molyneux, and English (2015) categorise various criteria in the priority setting process into two broad classes, namely formal criteria and informal criteria. On one hand, formal criteria are objective criteria that, at least on paper, hospitals claim to use in priority setting. These could be classified as health criteria, economic criteria, and administrative criteria. On the other hand, informal criteria refer to subjective considerations that influence priority setting practices in hospitals (Barasa et al., 2015).

Formal criteria

Using the formal criteria in allocating budgets to departments and health services, the first main health criteria used are the perceived medical need in the hospital's catchment area. Kapiriri and Norheim (2004) demonstrated that disease prevalence in the hospital's catchment area was considered in making decisions about what services to offer. This study was meant to explore stakeholder's acceptance of the criteria for setting priorities for the health care system in Uganda.

Although the study by Kapiriri and Norheim (2004) had revealed important insights on formal priority setting in a hospital setting, their research is criticised for lack of rigour (Barasa et al., 2016). The reason is that, although they had distributed self-administered questionnaires to health workers, planners and administrators working at all levels of the Ugandan health care system, and also to members of the public, the list of criteria that was used was not exhaustive. This is because they had not made use of additional important criteria. The current study, however, attempts to explore these additional criteria as used in priority setting at hospital level.

Later, in a study aimed at describing a strategy which could be used to improve priority setting in developing countries, Kapiriri and Martin (2007) discussed the prominent featuring of the rule of rescue whereby emergencies received high priority in setting

hospital priorities. However, on health technology assessments and medicines selection, the study found that criteria included effectiveness, safety, ease-of-use and capacity of staff to employ the technology, patient benefits in terms of health outcomes, and the nature of the technology or medicines. The latter was described in terms of whether it was a proven, new or an investigational therapy. Proven therapies were often preferred.

Additionally, Valdebenito, Kapiriri, and Martin (2009) revealed that the burden of disease was found to be an important formal criterion used in setting hospital priorities. The aim of the study was to evaluate using qualitative case study the use of an ethical framework 'accountability for reasonableness' in setting hospital priorities in Chile. The findings on the burden of disease mirror those by Barasa et al. (2015); Barasa et al. (2017); Godwin and Frew (2013) and Robinson, Williams, and Dickinson (2012).

The study also revealed that although it was difficult to achieve fair priority setting because there was no clear process targeted for the improvement of strategies, efforts to make the priority setting fair in that context was evident. The study by Valdebenito, Kapiriri, and Martin (2009) was limited in that there was no literature that described actual priority setting in a mixed public and privately funded health care system, such as the Chilean Health Care System.

Another study on formal priority setting had centred on economic criteria. The economic criteria under consideration had included historical budgeting, revenue-generating potential, budget impact and costs to patients when setting hospital priorities. Martin et al. (2003), for example, conducted a study whose purpose was to describe the process of priority setting for new drugs in a hospital formulary and evaluate it using a leading conceptual framework for healthcare priority setting (Daniels and Sabin's accountability for reasonableness).

In the study, Martin et al. (2003) had used a qualitative case study of priority setting for new drugs in a hospital formulary. It involved three primary data sources: key documents (e.g. minutes of Pharmacy & Therapeutics Committee (P&T) meetings), interviews with

key informants (e.g. P&T committee chair) which were audiotaped and transcribed, and observations of group deliberations (e.g. P&T meetings).The study found that cost-effectiveness of an intervention played a role in setting priorities. The study suffered generalisability shortfall, however, as those results were not generalisable to other hospitals. Despite this, the findings by Martin et al. (2003) were later corroborated by those by Cromwell, Peacock, and Mitton (2015); Maluka (2011); Robinson, Williams, Dickinson, Freeman and Rumbold (2012) who established cost-effectiveness and affordability as important criteria for setting priorities.

Another group of scholars, namely Bukachi et al. (2014); Nyandieka et al. (2015); and Robison et al. (2012) have studied formal priority setting by considering administrative criteria. These administrative criteria included strategic alignment and alignment with regional/national priorities, policies and objectives. These researchers established that administrative criteria were equally important when setting priorities. Their findings corroborated those by Gordon et al. (2009) who had evaluated priority setting in an acute care hospital in Argentina, using accountability of reasonableness as an ethical framework for fair priority setting.

The study by Gordon et al. (2009) had used a case study involving key informant interviews and document review. Besides stressing the importance of administrative criteria as a formal approach to setting priorities, the study identified two weaknesses with the administrative criteria. The first problem was that the committee which was supposed to set priorities within the hospitals was taught not to have much influence. Secondly, there were no clear mechanisms for appeals and leadership to ensure adherence to a fair process. This current study takes into consideration these weaknesses for robust results.

Related to administrative criteria as a tool for priority setting in the healthcare delivery, priority setting in developed countries hospitals is also guided by organisational strategies, goals, and vision. One example is the study conducted on priority setting in three teaching hospitals in Canada by Gibson, Martin, and Singer (2004). The study had aimed to set priorities in health care organisations by considering the criteria, process, and parameters

of success. The researchers had used questionnaires that were administered at the three priority setting workshops for board members and senior leadership at three health care organisations to assist in developing a strategy for fair priority setting.

Gibson et al. (2004) identified a range of criteria, providing insight into the competing goals at play during the process of priority setting. The research established that decisions were made based on local strategic fit as well as academic commitment and research focus, and that hospitals seemed to favour innovation in health technologies which provided perceived competitive advantage over other hospitals. These findings illuminate the complex challenges faced by decision-makers in managing scarce health care resources.

It should be pointed out that, although the approach by Gibson, Martin, and Singer (2004) was based on the notion that priority setting requires a normative grounding in procedural justice such as accountability for reasonableness (A4R), this does not mean that the findings are normatively right for clinical service priority setting in all health care. Additionally, very little has been reported from the perspective of hospital administrators. This current research considers that facet as well.

Prestige is another consideration when setting priorities. Kapiriri and Martin (2006) found that though the formal criteria of need determined that the paediatric department which received almost 40% of the hospital emergencies be given higher priority, the surgical department was, in fact, given greater priority because of its perceived prestige. These findings were limited in that they may not be generalisable.

Informal criteria

Apart from the formal criteria which are used in setting hospital priorities, informal criteria are also used in decision making (Barasa et al., 2015). These include political interests, regional health managers' interests, donor interests or perceptions, and professional experience and expertise. These appear to be more perverse in lower and middle-income countries (LMICs) compared to high-income countries (HICs).

Maluka (2010) conducted a study in Mbarali District in Tanzania to describe the process of setting health care priorities. The descriptions were evaluated against accountability for reasonableness. The findings of the study were that even though Malaria was the leading cause of morbidity and mortality, a shift in political priority to HIV/AIDS meant that the latter got more funds. This was thought to be due to, among other things, the fact that the LMIC settings were characterised by lack of quality evidence in priority setting. These findings mirror Bukachi et al. (2014) who reported political interest to have a role in priority setting.

Furthermore, personal relationships and mutual benefit, lobbying, level of ambition and bargaining ability of departmental heads and political interests among actors often dominate priority setting decisions, especially in developing countries. For example, a study by Gordon et al. (2009) at a hospital in Argentina revealed that allocations depended on whether the hospital managers and departmental heads enjoyed good relations and the potential for mutual benefit between them. Besides, given that decision making was centralized, priorities were aligned to meet the political goals of local politicians rather than the health needs of the population. However, the study findings were limited in that they were specific to this institution and the participants involved. The current study, therefore, aims to describe the actual priority setting whose lessons can be used in many hospitals.

2.4 Context of priority setting

Various studies have described decision space as one of the considerations in setting priorities in a context specific environment. According to Bossert (1998), decision space refers to the range of effective choices or discretion that local authorities or institutions are allowed by central authorities.

Bossert and Beauvais (2002) reviewed the experience of decentralisation in four developing countries—Ghana, Uganda, Zambia, and the Philippines. The study found that decision space for hospital priority setting was influenced by the structure of the health

system and the nature of the priority setting activity. Although Bossert and Beauvais have given the research community a lot of insight on decision space, their study was limited in that it focussed on decentralisation programmes primarily on shifting resources and authority from the central authority to local management institutions. In this way, it has limited applicability to the institutional level of the hospital setting. This is also true when one considers the fact that, as far as decentralisation is concerned, different contexts present different results.

According to Kapiriri et al (2007), in countries like Canada and Norway where the health system is significantly decentralised, hospitals tend to have greater decision-making latitude than in countries such as Chile where they have a less decentralised health system. Thus, Kapiriri et al. (2007) conclude that priority setting at the hospital level in countries like Chile tend to be guided predominantly by national decisions with little discretion at the hospital level. These sentiments were later corroborated by Valdebenito, Kapiriri & Martin (2009).

Resource gap is another context specific factor that has been considered in priority setting (Barasa et al., 2015). Literature shows that the reality of constrained resources compels decision-makers to tackle the issue of healthcare rationing. In Australia, for example, shrinking healthcare resources resulted in vigorous debate about the need for ethics and possible methods for cost containment and rationing of health services (Gallego, Taylor, Mc Neill & Brien, 2007).

The observation on Gallego et al.'s (2007) study is that they had not done a robust random sampling which would reduce the question of bias. Another limitation of the study weighs against the study's use of the survey technique with its inherent weakness on limitation of the wording of questions and therefore the quality and amount of data. The present study addresses this matter through use of in-depth interviews and random sampling.

Earlier, Kapiriri and Martin (2006) had also conducted a study on resource gap. The objective of their study was to describe priority setting in a teaching hospital in Uganda

and evaluate the description against accountability for reasonableness ethical framework. The study reported that an increasing budget deficit led to the capping of budgets and the introduction of line budgeting which reduced the flexibility of priority setting. In the same way, a recent study by Barasa et al. (2017) concurs with the findings in Kapiriri and Martin (2006). Thus, Barasa et al. (2017) observe that hospital financing arrangements also play a key role in determining priority setting practices in hospitals.

According to Barasa et al. (2017), hospital financing arrangement influences the process of priority setting in two ways, namely through the conditions associated with the financing sources, and through the incentives engendered by financing arrangements. The researchers gave the example of Chile where there is a mixed publicly and privately financed healthcare system. Barasa et al. (2017) observed that owing to this mix, hospitals were required to employ guidelines that aligned their priorities to those prescribed by both systems.

Similar observations had been made earlier on in a study by Valdebenito et al. (2009). Additionally, the process of priority setting can also be influenced by funding arrangements. According to Danjoux et al. (2007), hospitals which are funded by a global budget are less willing to fund incremental use of new technology compared to hospitals funded under different models, such as a fee for service.

Some studies have considered the role organisational culture plays in the process of priority setting. Generally, such studies have revealed that two aspects of organisational culture seem to be crucial enablers of systematic priority setting processes. The said aspects are, first, the importance attached to the use of evidence, and second, the openness to consultative and deliberative processes (Astley and Wake-Dyster, 2001). For example, in Chile, a country with a history of dictatorship and military rule (then), a government culture that discouraged disagreement was said to have impeded the implementation of an appeals and revisions process (Valdebenito et al., 2009).

Literature on leadership and priority setting shows that, within hospitals, leadership emerges as one of the key factors influencing the process of priority setting. In Canada, a study on the role of leadership in priority setting reported that leaders are expected to foster goals and a vision for the hospital; create alignment between goals, vision, resources, skills, actors and processes; develop and maintain relationships among actors; embody and promote desired values; and establish an effective process for priority setting (Reeleder, Martin & Keresztes, 2005).

By the same token, a qualitative study by Gibson, Mitton, and Martin (2006) found that although some stakeholders may attempt to game the priority setting process, fairness can be enforced by strong executive leadership to ensure conformity to a fair process. The study had aimed at establishing whether programme budgeting and marginal analysis contributes to a fair priority setting.

The study is criticised for its failure to answer the question whether substantive justice is achievable using programme budgeting and marginal analysis (PBMA). Besides, the study failed to examine the ethical values implied in the economics of priority setting. The current study addresses these concerns by answering the question of the achievability of substantive justice because the framework is grounded in justice theories. This also makes it possible for the study to examine ethical values which are key to fair priority setting practices.

2.5 Chapter summary

This chapter has defined priority setting process, how priorities are set at the hospital level and the factors that affect the same. Literature has revealed that priority setting at the hospital level is particularly important, given the prominent role the health sector reforms play towards decentralised health systems. It has also emphasised the need for continuing scholarship on the subject, especially since not much has been done with regard to research in Malawi.

CHAPTER THREE
THEORETICAL FRAMEWORK

3.1 Chapter overview

This chapter is about the theoretical framework used in this study, which is accountability for reasonableness. It is divided in seven sections. First, the section presents the general definition of accountability for reasonableness. The second section presents the notable changes in the A4R. The empirical experience with A4R will be presented in the third section. Fourthly, the description, evaluation and improve use of the A4R will be presented. This is followed by a discussion on other philosophical approaches that are used to set priorities and allocate resources in health care system. However, the researcher found the philosophical approaches narrow to be used in the current study based on the reasons that are given. The sixth section of the chapter compares the two frameworks, justifying why this research has adopted the former. Finally, a summary of the chapter is presented.

3.2 Accountability for reasonableness defined

Accountability for reasonableness (A4R) is the idea that the reasons or rationales for important limit-setting decisions should be publicly available (Daniels & Sabin, 1998). It is an ethical framework for priority setting that aims at ensuring that the process towards setting priorities is fair and that the decided-upon priorities are based on reasons that are communicated to all relevant parties involved (Daniels &Sabin, 2000).

Accountability for reasonableness was developed by Daniels and Sabin in the late 1990s in the context of U.S Health Maintenance Organisations when public accountability became a battle cry of health care reform. Since then, A4R has been used nationally and internationally, at all levels of the health system, to evaluate the legitimacy and fairness of priority setting (Daniels & Sabin, 1997). The framework has also been used to study

actual priority setting processes, so it is relevant to real-world priority setting (Ham & McIver, 2000).

A4R is a theoretical framework for a deliberative consideration of documentation and values (Daniels, 1997). The core idea of this framework is that decision-makers must justify their decisions in a reasonable and relevant way when it comes to priority-setting decisions in health care. The assumption is that, with a fair process of setting limits, decision-makers become more accountable for the decisions they make (Melsether, 2014).

Another important assumption in the accountability for reasonableness framework is that, if decisions are based on qualified and evidence-based research, decision-makers can defend their actions and answer critical questions (Daniels & Sabin, 2008). This can therefore help to make it appear that the decision-makers are indeed accountable for their decisions. However, the main reason for developing A4R was not to make decision-makers accountable for their choices, but to enable people to understand why, and under what conditions decisions that affect them are made.

Daniels and Sabin (2002) argue for four conditions that must be present for a decision to be reasonable. The four conditions are; the relevance condition, the publicity condition, the revision and appeals condition, and enforcement. Relevance requires that decisions are founded in the values of all concerned stakeholders. In practice, this means that all relevant stakeholders (managers, clinicians, patients and affected others) have the chance to participate in the process. This implies that there is respect for differing views and divergent opinions and preferences. In this case, the debate must be based on clear arguments, and all actors involved must be given the chance to have a voice.

Another condition which is supposed to be met in the priority setting process is publicity. Daniels and Sabin (2002) posit that the condition of publicity demands that priority setting decisions and reasons behind them are transparent and are made public. Practically, this can be done, for instance, through open meetings, diffusion of meeting agenda and minutes, and other communication processes.

The third condition which is called appeals or revision requires that priority setting stakeholders be given the opportunity to appeal against the decision, propose revision and receive a reasoned response (Daniels & Sabin, 2002). Appeals and revision condition implies that all stakeholders affected by the decisions have a voice and are effectively heard and that a procedure for revision is ensured.

Finally, enforcement as a fourth condition in A4R, aims to ensure that the first three criteria/ conditions of relevance, publicity, revisions /appeals are adhered to (Daniels & Sabin, 2002). This final condition is commonly referred to in the literature as the leadership of the accountability for reasonableness framework process. This is because arrangements must be made to ensure that there are one or more legitimate bodies which are able to ensure procedures for continuous application of all the four conditions among the stakeholders including the public (Daniels & Sabin, 2002).

3.3 Notable changes in accountability of reasonableness framework

Martin et al. (2003) has shown that since the creation of accountability of reasonableness framework, several studies have suggested changes and additions, while others have combined the framework with new knowledge to advance new concepts for priority setting. In combining information about how data is gathered with the concepts of A4R, Singer, Martin, Giacomini and Purdy (2000) proposes what is referred to as a diamond model for priority setting comprising six elements, namely: institutions, people, factors, reasons, process, and appeals. The scholars suggested this model be used in priority setting of new technologies specific to cancer and cardiac care.

In another study, Gibson et al. (2005) proposes empowerment as a fifth condition to the framework. The researchers argue that the procedural condition of empowerment requires that several steps be taken into consideration to optimise effective stakeholder participation and minimise the impact of power differences in the decision-making context. This enforcement condition is qualitatively similar to those in Daniel and Sabin (1997) in that it functions at the same level of generality, and provides normative guidance that can apply across health care settings.

Additionally, Gibson et al. (2006) highlight that the four conditions of A4R are never meant to be exclusive and exhaustive. They argued that there is room for more conditions that can be added to the framework, which can also provide guidance in achieving legitimate and fair priority setting. Since Daniels and Sabin developed A4R in the context of US private managed care organisations, their fourth condition focused on public or voluntary regulation as a means of enforcement. However, Reeleder et al. (2005) suggest that the term 'leadership' more accurately portrays the task of enforcement, since leadership is an enabler of the other three conditions of A4R.

It is evident from the changes that a number of procedural conditions are desired in decision making for healthcare resource allocation. Drawing from this, the researcher propose the following five procedural conditions as key in evaluating priority setting processes in this thesis:

Condition (1) Stakeholder engagement; literature strongly suggests that policy making processes and specifically priority setting processes are deemed to be fair and legitimate partly when the relevant stakeholders are effectively involved in the process. Specifically for priority setting, these relevant ranges of stakeholders include administrators/health managers, front line practitioners (nurses and clinicians), patients and the community.

Condition (2) Empowerment; that the engagement of stakeholders should be such that they have the power to contribute to and influence decisions. Given the existence of power differences among actors in healthcare organizations (Gibson et al. 2005), mechanisms should be there to minimize the effect of this power difference. These include for example giving each stakeholder equal opportunities to participate at different stages of the decision making process such as setting agenda, developing procedural rules and selecting the information that will be considered in decision making, clearly defining and enshrining the role of the each stakeholder in priority setting rules and guidelines, ensuring accessibility of relevant information to each stakeholder to reduce information asymmetries and ongoing rather than one off or infrequent engagement of stakeholders since it has been shown that ongoing engagement builds trust over time.

Condition (3) Transparency; given that priority setting is a political process that affects a wide range of actors, the accountability and legitimacy of the process is enhanced by transparency. The procedures, decisions and reasons for the decisions should ideally be accessible to all stakeholders and communicated to them as well.

Condition (4) Appeal /revisions; the priority setting process should be dynamic enough to allow for appealing and revisions of decisions in the face of new information. To facilitate this, the process should have a provision for appeals to decisions.

Condition (5) Implementation; priority setting processes should ultimately result in the accountable implementation of decisions. That is a legitimate priority setting process should provide mechanisms for an assurance that the other five conditions are met.
Drawing from this review, the proposed procedural conditions were used for evaluating priority setting practices at ZCH.

3.4 Empirical experience with accountability for reasonableness

In literature, priority setting has been described and evaluated using A4R as a conceptual framework to guide research (Gibson et al., 2005). These studies have shown that A4R can provide helpful guidance for leaders engaged in the process of priority setting. Most such research has been conducted in Canada, through the Canadian Priority Setting Research Network (CPSRN). For example, Martin et al. (2003), in their study aimed at describing and evaluating hospital strategic planning in the context of operational planning, used A4R and found that the organisation partially met all four conditions of A4R. To improve future priority setting iterations, they developed and suggested eight key recommendations for improvement, including allowing participants more time to process information, developing a coherent and comprehensive communication strategy, and developing an appeal (or revision) mechanism.

Earlier, Martin et al. (2002) demonstrated that decision-makers from the Cancer Care Ontario Policy Advisory Committee for the New Drug Funding Program and the Cardiac Care Network of Ontario Expert Panel on Intracoronary Stents and Abciximab (a

glycoprotein IIb/ IIIa inhibitor) believed that there were two primary elements to fairness in priority setting: a fair process and recognition that fairness is relative. In this study, they developed eleven (11) elements of fair priority setting, which they related to the four conditions of accountability for reasonableness.

Other significant research that has relied on A4R includes that of Mitton, Mc Mahon, and Morgan (2006), who used it to empirically investigate the fairness of centralised drug review processes in four countries (Canada, the UK, Australia, and New Zealand). The three researchers found that each country needed to improve the fairness of their processes and that stakeholder engagement ought to have been part of that. Mitton et al. (2006) concluded that it is essential for limit-setting decisions to be publicised, that proper mechanisms be established in order to ensure fair processes and formal mechanisms for appeals, and that revisions be upheld.

Reeleder et al. (2005) studied reports by the CEOs of Ontario hospitals on the fairness of priority setting within their own institutions. The study survey had CEOs (or designates) evaluate their current priority setting activities against A4R. Their most prominent finding was that improvements to the area of leadership would result in more of an impact than improvements to other areas.

It should be pointed out that Byskov, Maluka, and Marchal (2017) argue for the need for global application of the accountability for reasonableness to support and improve sustainable outcomes. They believe that A4R provides a means for better and more sustainable choices on health for all and for everyone in line with the Sustainable Development Goals. A4R is, thus, ready for universal application combined with close monitoring, frequent reviews and research.

3.5 Describing, evaluating and improving priority setting with accountability for reasonableness framework

Accountability of reasonableness can be used as an evaluation framework to describe, evaluate and improve priority setting in real-world contexts. Among the proponents of the

approach that seeks to describe, evaluate and improve priority setting are Martin and Singer (2003). The scholars used the approach to capture and share lessons for improving priority setting all over the world. According to Martin and Singer, by improving means making priority setting more legitimate and fair. This approach allows for collaborative work between stakeholders (scholars and policymakers) to gather and share systematic evidence as a basis for improving priority setting in various health care contexts (among which Ministry of Health, Regional Health Authority (RHA), hospitals and clinical programmes).

The approach is also used as a constructive, practical and accessible improvement strategy that is both research-based and normatively and empirically grounded (Martin and Singer, 2003). Kapiriri and Martin (2007) highlighted the benefits of this approach. For them, the approach operationalises the vague notion of evidence-based policymaking; opens the 'black box' of priority setting in a health system and reveals how decisions are made; and creates an environment in which difficult priority-setting decisions can be accepted by the public.

3.6 Theories of justice and resource allocation

Different philosophical approaches emphasise different values and conclusions on how to allocate healthcare resources and set priorities. These are libertarianism, utilitarianism and egalitarianism. These theories focus on justice and have hence been called theories of justice (Beauchamp & Childress, 1989). Each of these philosophical theories, however, argues for different distributive principles for the allocation of health care resources. However, the research found them narrow to be applied in a real life context as will be presented below.

3.6.1 Libertarian theories of justice

Under the libertarian view, individuals themselves are responsible for their own health, their own well-being and fulfilment of their life plan (Nozick, 1994)). Therefore, everyone pays for their own individually experienced healthcare needs, directly or indirectly

through private healthcare insurance. There is no need to contribute to the healthcare needs of others.

According to Nozick (1974), government action, in this case, is only appropriate for protecting the entitlements and rights of its citizens rather than being responsible for the re-distribution of the health resources. Much of the American health system operates in this way. However, an important problem is that when every individual determines what he /she needs, collective choices about the limitation of the total healthcare budget must be made.

3.6.2 Utilitarian theory of justice

Utilitarian theory suggests that resource allocation decisions should create the greatest good for the greatest number of people as part of maximising value. Macklin (1987) argues that utilitarian type of distributive justice is an obligation of the theory that involves trade-offs between risks and benefits (p.149). To put this into practice in the health care setting, one must be able to decide what good we should be maximising, whether we can measure it and how we can balance the quality of a good with the quantity of that good.

However, questions which ought to be asked are whether we are to maximise health outcomes, which will almost certainly mean unequal distribution of health care; whether the best will be done to maximise access to health care; or whether we are to satisfy people's needs for health care. Daniels (1985) argues that the role of the health care system is to protect an individual's share of the normal opportunity range, both by curing disease and preventing disease. It is the range of opportunities that are being maximised (p.140).

To implement a utilitarian theory, we face dilemmas over what to maximise and the calculation of the greatest number. Veatch (1994) contends that although utilitarian theory may appear to support the wide distribution of low tech preventative health services, it may also support very expensive high technology procedures which are evolving, based on their likelihood of benefit to future generations. Another problem is quality versus quantity of what constitutes 'good' if we are to use utilitarian principles to ensure just

distribution of resources. Longer life of poorer quality may not necessarily be preferable to a shorter life of high quality. In trying to spread health resources to the greatest number might not work since, in practice, goods cannot be minimised to some groups to an unacceptably low quality.

3.6.3 Egalitarian theories and resource allocation

The egalitarian theory holds that morally similar individuals should be treated similarly. Honderick (1995) argue that egalitarian theories of justice explore what are morally relevant grounds for equality and differences (p.248). In the distribution of health resources, there is a need to consider the goal of distribution, that is, whether equal distribution or equal outcome is to be achieved. This is important to translate the theory into practice. If distributive equality is the goal, there is a need to decide what aspects of health care we are equally distributing. If outcomes are the goal, there is a need to consider whether we are trying to satisfy peoples' needs or their desires. This is so because people can be given equality of opportunity or equality of resources, but that still will not translate into equal outcomes.

With the diversity of human conditions, in practical terms, total equality is not possible. Therefore, the practical aim is to reduce the inequalities as much as possible. However, that will mean deciding what are the morally relevant characteristics that need to be equalised and whether there are some differences between people that we do not need to equalise. Equality of outcomes will necessitate unequal distribution. This can be easily recognised in an example where quality of life is what is being equalised. The implementation by the society of an egalitarian concept of justice could be overwhelming unless a minimum requirement can be determined.

3.7 Accountability for reasonableness and the Zomba Central Hospital study

All the normative approaches presented in this section describe what ought to be done while from the reviewed literature, all empirical studies describe what is being done. However, there remains a lack of consensus on an appropriate approach to successful priority setting. This is because defining successful priority setting is a challenge, and no

framework exists to characterise it. In the midst of this lack of consensus, one ethical framework has surfaced as an important guide to achieving a legitimate and fair priority setting. This framework is the accountability for reasonableness (A4R), which focuses on the goals of legitimacy and fairness (Daniels & Sabin, 1997). Legitimacy and fairness are two desirable goals of a priority setting process.

The ethical framework (A4R) can be used by decision-makers and leaders in their organizations, and it can also be used as an evaluation tool. A4R's philosophical (and normative) grounding coupled with its empirical application make it an important contribution to the current understanding ZCH priority setting. Even more importantly, the four conditions of A4R are possible candidates for defining successful priority setting. It is for this reason that accountability for reasonableness was chosen as a theoretical grounding used in the present study.

3.8 Chapter summary

This chapter set out to define the theoretical framework used in this study. It achieved this by providing a general presentation of 'accountability for reasonableness' as an ethical framework for priority setting. It then discussed the theories of justice as other philosophical approaches to resource allocation and priority setting. Owing to a number of reasons, the discussion has found theories of justice inadequate as a framework for resource allocation, hence the choice of the accountability for reasonableness framework.

CHAPTER FOUR
METHODOLOGY

4.1 Chapter overview

This chapter presents the methods used to examine priority setting practices at ZCH. The chapter begins with an examination of the study design, method, a description of the selection of the case and participants, data collection procedures, and data management and analysis processes. The chapter also considers the steps that were taken to ensure that the study adhered to principles of research ethics. Finally, a summary of the chapter is presented.

4.2 Research design

This research sought to evaluate the extent to which priority setting practices at ZCH are said to be ethically justified according to accountability for reasonableness ethical framework by Daniels and Sabin (1997). To answer the research questions, this study employed a case study design. Yin (2014) defines a case study as an empirical inquiry that investigates a contemporary phenomenon (the 'case') in-depth and within its real-life context especially when the boundaries between phenomena and context are not clear (p.16).

There are several features of the case study approach that informed its adoption for this ZCH study. First, the case study approach is considered suitable for inquiries of phenomena that are highly contextual and where the boundaries between what is being studied and the context are blurred. This makes case study approach suitable for the ZCH study as priority setting practices in hospitals are highly context- dependent. This has been observed by several authors including Kapiriri and Martin (2010).

Additionally, the case study approach is useful in building an understanding of the contextual influences which are on the phenomena of interest (Yin, 2014). Thus, case studies always involve relating events or actions to their contexts, which may be local or

global, political, economic or social, and are useful in seeking to reach a deeper understanding of how wider forces are manifested.

Second, case studies are considered suitable in examining and unpacking power dynamics as well as the role of values in social processes (Flyvbjerg, 2001). This emphasises the suitability of this approach to the study of priority setting processes at ZCH given that actor power, interests and relations have been shown by the literature to significantly influence priority setting processes (Barasa et al., 2016).

Third, case study design is appropriate for the ZCH study, since priority setting in healthcare is regarded as complex social phenomena. Shayo, Mboera and Blystad (2013) argue that priority setting is considered a complex social process that confronts decision-makers with significant theoretical, political and practical obstacles. This often involves a range of actors with varied values that are brought to bear in decision making (p. 273).

Flyvbjerg (2001) observes that social processes are complex and unlikely to yield universal truths or accurate predictions. An appropriate analysis should, therefore, aim to develop concrete, context-dependent knowledge. Finally, case studies are also suited to obtaining multiple perspectives and experiences of a wide range of different stakeholders (Yin, 2015).

4.3 Research method

This study employed qualitative research. Creswell (2007) defines qualitative research as a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. The process of such kind of research involves emerging questions and procedures, data typically collected in the participant's setting, data analysis inductively building from particulars to general themes, and the researcher making interpretations of the meaning of the data.

The advantage of conducting a qualitative study at ZCH includes the flexibility to follow unexpected ideas during research and the ability to explore processes of priority setting

practices effectively. Second, the method is the most suitable for this type of investigation because of the type of questions the study intends to address (what and how health priorities are set and put into practices). Third, the newness of the research topic under investigation and its complexity makes qualitative method suitable for the study (Creswell, 2007).

Additionally, the qualitative method has been chosen because it is the most widely used methodology for analysing priority setting practices in healthcare institutions. This is emphasised by Martin and Singer (2003) who recommend that an important initial step of a strategy to improve priority setting involves describing the actual priority setting in a context using qualitative case study methods (p. 64).

4.4 Research site

The study site of this research was ZCH. According to Gawa, Reid, and Edginton (2011), ZCH is one of the tertiary hospitals and referral centres for primary and secondary health institutions in Malawi. Even though there is no official organogram at this hospital, observations and discussions with hospital managers and staff implied the existence of a management structure which was highly hierarchical. At the lower level are the hospital implementers (nurses and clinicians) and non-health staff (support staff). These two groups are answerable to heads of their respective departments.

There are also heads of departments who are middle level managers for clinical departments (e.g. paediatrics, dental, obstetrics and gynaecology), wards (e.g. adult male, adult female and paediatrics), non-clinical departments (e.g. pharmacy, transport, catering and laboratory) and support departments (e.g. accounts, human resource, procurement and maintenance) and are answerable to the three senior hospital managers, namely, the hospital director, the principal hospital administrator and the hospital nursing officer in charge.

The Hospital Director is the chief executive of the hospital and is responsible for the overall running of the hospital. The hospital administrative officer oversees all the hospital

non-clinical departments. The chief nursing officer in charge oversees the nursing department and hence all nursing ward-in-charges. The rationale behind the selection of this site was that the site was convenient for the researcher.

4.5 Sampling method

Purposive sampling procedure was used to select the respondents of this study. The purposive sampling method is one in which only a few members of the population who have characteristics related to the study are sampled. Laerd Dissertation (2012) contends that the main purpose of the sampling technique is that the people who have been selected for the study have been selected with the motive that those people who are unsuitable for the study have already been eliminated. Therefore, only the most suitable candidates were chosen. With this sampling procedure, the process becomes less time consuming and the results are expected to be more accurate than those achieved with alternative forms of sampling.

4.6 Study participants

The selection of participants for interviews included individuals who had in-depth knowledge of the identified priority setting activities, as well as those who took part in, implement or are affected by the priority setting activities. The sample included decision-makers. These included seven (7) core management team members. These are responsible for financial planning, governance and accountability. These were selected because they are the key designers of priority setting at this hospital.

Six (6) middle level managers who are responsible for designing and monitoring staff activities were also considered. They comprised two (2) head of departments, two (2) unit matrons and two (2) ward-in-charges. These were selected because they are fully involved in the priority setting process. The study also considered eight (8) implementers of priority setting practices. These included four (4) nurses and four (4) clinicians of different wards. These were selected on the basis that the researcher regarded them as the implementers of priority setting.

Thirty six (36) members of the public (guardians) who are the primary beneficiaries of the priority setting practices were considered for the focus group discussions. These discussions were conducted in four (4) different wards at the hospital, namely; the maternity, children's, male and female wards. These focus groups consisted of eight to ten (8-10) beneficiaries (guardians) per group and were selected randomly at the time of the hospital visit. The guardians were selected because they are the beneficiaries of priority setting processes; hence they are affected by the outcomes of the processes.

4.7 Data collection methods

In-depth interviews (one-to-one interviews), focus group discussions were used to collect primary data in the study site mentioned above, ZCH. Secondary data was collected from relevant books at the University of Malawi library, relevant documents at ZCH and from the Internet. The data collection methods were selected partly for their utility in achieving both breadth and coverage across issues of interest, and the depth of coverage within each (Ritchie & Lewis, 2003).

4.7.1 In-depth interviews and focus group discussions

Interviews and focus group discussions were used to obtain in-depth information about ZCH priority setting practices from the perspectives and experiences of the hospital decision-makers, hospital implementers, and hospital beneficiaries. Those identified as possible interviewees were invited to take part in the study after the purpose of the study had been explained to them, and after they had provided written, informed consent.

Consent was sought for the use of a digital tape recorder to allow the whole interview to be captured (and later transcribed) while the interviewer and the research assistant took notes. Each interview and focus group discussion lasted between 30 and 45 minutes. In-depth interviews and focus group discussions employed guiding questions that were informed by the accountability of reasonableness theoretical framework.

The author endeavoured to conduct interviews and focus group discussions at the convenience of the interviewee and at a place that created room for confidentiality to be

preserved to ensure that the interviewee felt comfortable. However, this was not always possible. In some instances, the researcher had to conduct interviews in busy outpatient areas or wards since some staff could not find time to leave their working areas. In these circumstances, interviews were sometimes disrupted by noise and the fact that staff often had to attend to urgent requests from other staff and clients in the middle of the interview.

4.7.2 Document reviews

The researcher reviewed documents which were relevant to the priority setting activities selected for the study. These included the Health Sector Strategic Plan 11 (2017 – 2022) and minutes from previous hospital priority setting meetings. The minute documents which were selected were for two financial years (2016 – 2017 and 2017 – 2018). The researcher also reviewed documents that were recommended by the key informants, for instance, the Central Hospital Implementation Plan (CHIP).

4.8 Data management and analysis

All recorded interviews and focus group discussions were transcribed using Microsoft Word, 2010. All notes were taken during interviews, documents review, and voice recorders were stored while in the field and even after fieldwork, to ensure participant confidentiality. Data were analysed using thematic analysis. This involves identifying connections between the data collected and a pre-determined thematic framework by sifting, sorting, coding and charting collected data (Richie & Spencer, 1994). This approach was adopted to provide findings and interpretations that are relevant. This took five (5) steps to complete the analysis as suggested by Richie and Spencer (1994), namely: familiarisation, development of a thematic framework (through coding), open and axial coding, charting and finally, mapping and interpretation.

4.8.1 Familiarisation

Given that data was collected by the researcher, prior knowledge had to be developed as well for analytic interests and thoughts on the data. However, to gain a deeper familiarity with the data, the researcher actively and iteratively read through the interview, FGD's transcripts and document review notes at the analysis stage while searching for meanings,

patterns, ideas, and potential themes. Some potential themes identified included; criteria and process. This phase included taking notes on ideas for coding, which the researcher would then go back to in the subsequent phase.

4.8.2 Development of a thematic framework

The second step involved the development of a thematic framework which took the form of a coding tree. The development of this framework was informed by the study's theoretical framework and the initial thoughts and ideas that emerged from the data.

4.8.3 Open and axial coding

The next step involved the production of codes. Coding is regarded as part of data analysis (Miles & Huberman, 1994) as it involves identifying, organising and labelling chunks of data in meaningful groups (Tuckett, 2005). The researcher coded the data in two steps, namely, open and axial coding. In open coding, the transcribed data was read and then fractured by identifying chunks of data that related to a concept or idea (for example, not being included). In axial coding, similar ideas and concepts were organized into overarching thematic categories (for example, blaming managers for their exclusion in priority setting activities).

4.8.4 Charting

In this step the coded data was charted, a process that entailed the reorganisation of coded data to allow the identification of emerging themes (Ritchie & Spencer, 1994). This involved reading through coded data under each category of the thematic framework and summarising the ideas, supported by quotes from the data. Charting was followed by a thematic approach (Richie & Spencer, 1994) where individual themes were described across respondents or categories of respondents. This process resulted in summaries of ideas on each thematic heading drawn from all data sources (interviews, FGD's, documents, and notes).

4.8.5 Interpretation

In this step, the charted data was examined under each thematic category. According to Ritchie and Spencer (1994), this interpretation of the data entailed identifying key concepts and explaining relationships between these key concepts.

4.9 Ethical considerations

Before the commencement of the study, approval was obtained from the Head of the Philosophy Department at the University of Malawi, Chancellor College, and from the ZCH Director. At the time of the first contact with the study hospital, the researcher clearly explained the purpose and procedures of the study to all participants before conducting interviews, focus group discussions and obtaining documents for review. All study participants were above 18 years of age. They were informed that their participation was voluntary and that they could decline or withdraw from the study at any time without consequences. This was explained in the informed consent forms which were always signed by participants before conducting any formal interviews and discussions.

For the protection of hospital and individual participants' confidentiality, the collected data were made anonymous by ensuring that names of hospitals and individual participants were not recorded. Thus, in reporting results from the hospital, codes rather than the actual names were used. Where participants were unwilling to be tape- recorded, the researcher took notes of their responses.

Given that the study was non-experimental, it was unlikely to cause any physical harm to participants. It was also explained to the participants that while the study had no direct benefits to them, the results would provide a useful basis for potential policy interventions that might improve the way ZCH set priorities and manages resources. Consequently, this would improve the performance of the hospital in delivering care and meeting the needs of the community it serves.

4.10 Ethical evaluation

All the transcribed data and document reviews were evaluated using A4R framework. The ethical evaluation is regarded as a multi-step process (Sibbald, 2008). The first step was to pose questions that attempted to operationalise each proposed condition (stakeholder engagement, stakeholder empowerment, transparency, appeals/revision and implementation) of the accountability for reasonableness ethical framework used in this thesis. For the researcher, this step involved proposing indicators for the tool derived from the conceptual framework. The indicators were mapped into the ethical and practical goals of priority setting, specified in qualitative dimensions of priority setting, and related to both the procedural and substantive dimensions of priority setting.

The next step involved formatting the data according to the questions in order to determine which would be best for each. The third step was to revise each of the questions within their format. The draft tool was subjected to a cyclical process of proposing evaluation indicators and refining them based on the feedback received from stakeholders. The final evaluation tool was revised twice more throughout the research; first through face and content validity testing, and second after the actual empirical application (‘ease of use’ through the pilot test).

4.11 Chapter summary

This chapter has outlined the design and approach that were adopted in carrying out this study. The case study design was adopted given its suitability for exploring complex social processes. In terms of the study site, ZCH was selected as a case for the study. The chapter has also described the procedures that were used in collecting data, including in-depth interviews, focus group discussions and document reviews.

CHAPTER FIVE
FINDINGS OF THE STUDY

5.1 Chapter overview

This chapter presents the findings of the study whose objective was to evaluate the extent to which priority setting practices at ZCH could be said to be ethically justified according to accountability for reasonableness framework. The chapter is organised into five sections according to the research objectives. The first section presents the understanding of priority setting from the respondents' viewpoints. The second section presents focus areas of priority setting at ZCH. The current criteria guiding the setting of hospital priorities will be presented in the third section. Fourthly, a presentation of ethical aspects in the priority setting practices is presented. Finally, the outcomes of priority setting are also presented**.**

The study aimed at collecting data that was relevant to the ethical evaluation of priority setting practices. In this light, the accountability of reasonableness ethical framework guided the researcher to gather the data that was relevant and suitable for the study. The target study participants included the decision-makers (clinical and non-clinical managers), implementers (clinicians and nurses) and the beneficiaries (guardians).

5.2 Understanding of priority setting

The majority of respondents understand priority setting to mean addressing the most pressing issues first while other things can wait, as expressed by Decision-maker 7 in the following response: *"*For me, priority setting in a setting like Malawi where we have limited resources is focusing on the needs that are urgent; these are areas that have the greatest impact on the health of Malawians*".* This echoes Beneficiary 2 in FGD who said that "Priority setting is taking care of the essential things first based on what this hospital can afford and achieve, while others can wait".

5.3 Focus areas of priority setting at Zomba Central Hospital

There are three focus areas of priority setting at ZCH. These were examined in the context of the planning and resource allocation (or budgeting), medicine selection and nurse allocation.

5.3.1 Planning and budgeting

The findings show that the process of planning and budgeting follows some key steps. It starts with the preparation of the hospital implementation plan. The head of each department outlines priorities and the activities to be undertaken under each of the priorities. This is followed by the setting of one-year targets for each major health problem. After this, the core management team prepares the final central hospital implementation plan (CHIP) and budget, taking into consideration cost-saving measures. The finalised plans are then sent to the MoH for approval as reported by a key informant—decision maker 1:

> We do yearly budgets but we are funded monthly. In our budgeting, we plan what kind of activities we are going to do the following year through the heads of departments. Once we have done the planning, the director approves and we send them to the Ministry and the Ministry consolidates them and sends them to Treasury. Treasury sends that budget to Parliament. Parliament must approve. Once Parliament has approved, it becomes a law.

Within ZCH, the planning and budgeting process is reported to be inclusive and it is led by the hospital's core management team whose chair is the hospital Director. The team also includes hospital implementers. This was expressed by Decision-maker 4 who stated that "All individuals working at this hospital are involved and invited—physicians, midwives, nurses, etc. Priority setting processes go beyond the involvement of professionals and the leadership. I write the final report on priorities".

However, some respondents stated otherwise. They felt that the process of planning and budgeting was not fully inclusive. Much as the planning of activities depended on and are dominated by the head of departments, the findings revealed that the departmental heads who are the experts were not sufficiently involved in the actual budgeting meeting. As Decision-maker 7 put it: "Now the ceilings are there to go and revisit what we planned, and they take a small number of people leaving out key people who are very technical and yet having a bunch of administrative people"

Some decision-makers felt that the implementers at this hospital were reluctant to participate in priority setting activities due to either time constraints or lack of interest in managerial tasks. As Decision-maker 2 says: "We are all invited yes but a lot of nurses and clinicians do not attend these meetings … some because they are on hospital calls (duties) while others are just not interested." This corroborates with what Implementer 2 reported as to what makes them lose interest in the process: "The planning and budgeting meetings are meant for the administration people. Every time you hear the administration is away for budgeting, we nurses are not involved."

Document reviews stress the importance of inclusion of members of the public (community) in the planning and budgeting process for a fair priority setting. However, this is not the case at ZCH as Decision-maker 1 observes: "No community views are incorporated in the planning and budgeting process at this hospital because we are a central hospital. The district hospitals are responsible for obtaining community view". This is in line with what Beneficiary 3 in FGDs observed: "I have been to this hospital many times, and I have never heard that people are involved in the planning and budgeting. We don't even know who does the budgeting, maybe the doctors or the administration".

5.3.2 The medicine selection process

Another priority setting activity that happens at ZCH is the medicine selection process. Medicine selection, according to the respondents, refers to the decision-making process

that determines the type and quantities of medicines that will be procured and made available at the hospital. This was a response from Decision-maker 3 who noted:

> We select essential medicines which we think as a hospital will satisfy the health needs of a larger population. The Ministry provides with us the essential packages that are tallied to the essential medicine, but we do order outside the essential medicines as some medicines are context-dependent.

The medicine selection is done by a committee called the Drug and Therapeutic Committee (DTC). The DTC is a multi-disciplinary committee whose role is to guide on medicine management issues at the hospital. Other roles include formulary management, a process whereby decisions are made about which drugs should be made available to the hospital and monitoring the use of medicines at the hospital.

The patron of the committee is the hospital Director and the chair is supposed to be a pharmacist or somebody from the clinical side. During the time this study was being conducted, the DTC was headed by the head of the Theatre Department. The other members of the committee consist of the chief pharmacist, another pharmacist as the secretary, the chief nursing officer, the chief accountant who presents how much the hospital has been allocated for medicine, heads of departments (Surgical, Medical, Dental and Dermatology), the nursing in-charge for Paediatrics and the nursing in-charge for Out Patient Department (OPD). This is explained in the following excerpt by Decision–maker 8:

> For the medicine selection, we have a drug and therapeutic committee. I am a member of that, so that committee sits, and it also involves heads of departments. So that committee decides, so I present what I want in my department through that committee and they proceed, and the accountant is also there to tell us how much money we have, and the pharmacists are the ones who do the ordering, so we can tell them I want such and such drugs in my department.

This is in tandem with a response from Decision-maker 3 who observed that, “I will come with a list and present it to the committee to say these are the things I have observed … I have noticed that we are using these drugs most, so they agree, or we make amendments as a team.”

5.3.3 Hospital nurse allocation process

The final priority setting that was examined at ZCH was nursing allocation. Nursing allocation, according to the respondents, refers to the decision-making process for the allocation of nursing staff to the different service delivery departments of the hospital. According to one of the decision makers, public hospitals in Malawi are provided with nursing staff by the MoH as expressed in this statement by Decision-maker 6:

> The MoH is responsible for the remuneration of nursing staff in all public hospitals. The number of nurses sent to public hospitals by the MoH is determined by the workload of the hospital. This workload formula considers the hospital bed capacity, admission, and outpatient visit numbers as well as guidance from the MoH norms and standards for health service delivery.

The respondents also argued that while the MoH is responsible for allocation of nurses, hospitals in Malawi are responsible for this allocation across departments within the hospital. However, there are no guidelines on the process of nurse allocation within hospitals. Nurse allocations occur in the form of reshuffles.

This study further found out that one of the hospital managers is the main actor in nurse allocation decisions. Other actors who were involved in the process were the matrons and the in-charges of different wards. This corresponds with what Implementer 1 said: “The manager herself does the nursing allocation. She consults with other actors surrounding her.”

5.4 Criteria guiding current priority setting at Zomba Central Hospital

Priority setting requires that one take into consideration various factors when determining the issues to give a higher priority. Several formal and informal criteria are used in the process of priority setting at ZCH. According to Waithaka et al. (2018), formal criteria are objective criteria that are used explicitly to set priorities while informal criteria refer to subjective considerations that influence decision making (p. 740). The formal criteria at ZCH included health, workload, and experience which also include economic and historical criteria. However, lobbying, bargaining, and personal relationships were featured prominently as informal criteria.

The health factors that are used to set priorities at ZCH include the disease burden, disease incidence and prevalence. As one Decision-maker 3 recounts:

> Our guiding principle is how much is needed by the end user…this is determined by which drugs are used faster, and which ones are slow moving…we also look at the attendance register as what kind of diseases are affecting us more.

Morbidity, severity, and impact of disease are also considered important as expressed by one of the middle-level Decision-maker 11:

> Actually, they (all disease areas) are all critical, but we need to break down these issues into the specific intervention areas that need more priority, like malaria…is it the drugs? Is it the prevention? We, therefore, have to go down and break down the activities. We see which of them are more important in that section so that we allocate funds to the activity that is going to make a bigger impact than the other one.

The key informants and FGD participants were all in agreement that the danger which a disease poses, in addition to it being part of the bigger global initiatives such as the Millennium Development Goals (MDGs), was also a factor that those involved in priority

setting used in deciding the priorities of the hospital. This is expressed in the following excerpt by Beneficiary 3: “They set diseases and treatments according to what disease is considered globally or nationally.”

Within the hospital, some respondents reported that their decisions are also influenced by the available resources. For instance, how much the hospital has been allocated shaped what can be done as explained by a middle level manager in the following sentiments by Decision-maker 4:

> The funds are few; we need to give them a priority. And we neglect the other areas. Somebody might even judge us wrongly and say we have neglected the other areas. That’s true. But when we get adequate funds we will get there.

This concurs with what another Decision-maker 3 reported:

> We need to consider cost as we set the priorities. We must weigh that yes, we have a burden, the drug is available, but now let’s look at our resources; how much has been allocated to us…can we go through the financial year with such kind of medication.

Historical budgeting was featured prominently among the criteria used to allocate budgets and medicines across departments. Historical budgeting according to the respondents refers to an estimated income and expenditure that is created on the basis of previous set priorities. The respondents reported that departments often received the same budgetary and medicine allocation as previous years’ budgets as expressed in this excerpt by Decision-marker 2: “We consider what was allocated last month…how much did we allocate for electricity, fuel or water? If we managed to run the hospital…then it’s okay to allocate the same and sometimes with a little surplus”.

The workload is also used to set priorities. The respondents noted that workload at ZCH is determined by the nature of tasks routinely performed in a specific area, and the level of effort required performing the tasks. For example, the general feeling by the respondents was that Maternity and the Intensive Care Units have a higher workload than other general wards because of the nature of tasks carried out in these areas. This is clearly expressed by Implementer 6 as follows: "So the maternity workload is high. Also, the maternity unit has more wards in one unit: there is the labour ward, antenatal ward, postnatal ward…So, maternity always has more nurses."

The sentiments by Decision-maker 6 are in tandem with what was termed by the respondents as 'the rule of rescue consideration' which resulted in more nurses being allocated to maternity and theatre units than to other departments. This was captured in the following response by Hospital Implementer 12:

> In the intensive care units (ICU) and maternity, you may have one patient but because the patient is very critical it requires a lot of work. Then in other places like the paediatric ward, you may have a big number of patients, but most of the children are with their mothers. So, the mothers help with some of the tasks like feeding.

The training or expertise of nurses also influenced their allocation to departments. At ZCH, an attempt has been made to align nurses' training specialisation with their assigned departments. For example, nurses who have specialised in paediatrics have been deployed to the Paediatrics ward, and those that have specialised in critical care have been deployed to the Intensive Care Unit. This is supported by the following statement by Decision-maker 6:

> The qualifications and training also affect where the nurses are allocated. For example, if somebody is trained in theatre or in intensive care nursing, definitely I won't put them in maternity; I'll put them in theatre or ICU,

respectively. But the general areas like the general wards I just put any qualified nurse.

However, there are times at ZCH when the allocation of nurses is influenced by special requests and personal preferences of individual nurses. Sometimes nurses request to be assigned to a department because they are interested in gaining experience in that specialty. This agrees with what Implementer 1 argued: "I asked the bosses to put me at the maternity because I did not undergo midwifery training; I want to gain experience".

Apart from the formal criteria, several informal criteria influenced the allocation of resources across the departments at ZCH. The informants felt that lobbying and bargaining ability had a direct influence on whether their department got allocated resources. It was reported that departmental heads that have negotiation powers are rewarded with allocations. This is expressed in the following statement by Decision-maker 5: "Some departments seem to always get resources even outside the budgeting meeting…it all depends on how convincing the head of the department presents directly his proposals to the Manager".

5.5 Ethical aspects in priority setting at Zomba Central Hospital

According to the framework used in this study, the processes through which priorities are set should fulfil the following procedural conditions: (a) relevance (stakeholder engagement), (b) publicity (transparency), (c) appealing and revising decisions (cases of disagreements) and (d) enforcing decisions (implementation). This section is organised based on these parameters, but it also considers the ethical aspects of efficiency and equity that were prominently featured in the responses.

5.5.1 Stakeholder engagement

On the issue of stakeholder engagement, the study at ZCH revealed that this varied across priority setting activities. While the planning and budgeting processes are supposed to be aligned, the respondents reported that in practice they are not. The reason for the misalignment was the fact that the two processes are conducted and driven by different

sets of stakeholders. Much as the planning process is more inclusive, the budgeting (actual allocation) process is not inclusive as reported by Decision-maker 7:

> According to ZCH, the core people we rely upon for identification of hospital priorities are the heads of department, but I understand last week the hospital has gotten the budget slings and people have gone to Mangochi to revisit the plans. I have heard how they are taking a bunch of administrative people leaving out the heads of departments who are technical …So, we do not know what they will take out because the heads of departments are not there.

The medicines selection process was rated second in terms of stakeholder engagement. The results show that there had been an improvement in terms of stakeholder engagement as compared to the previous years as reported by Decision-maker 3:"We used to be a quorum of nine but this time we can reach fifteen because we are trying to involve more people". However, findings from the study indicate that the nurse allocation was the least inclusive process. This is clearly expressed in the following statement by Implementer 4: "The main actor is the manager, and her deputy".

However, in all these activities, community members are not included in priority setting processes as the mechanism was said to be impossible. This was attributed to, among other things, the context of the hospital which was said to have affected the mechanism of obtaining community views. Being a referral hospital, the catchment area is so wide and this makes it difficult to obtain representatives from all communities. As such, the hospital managers think that community views can be obtained at the district hospital rather than the central hospital.

Second, the respondents were of the view that, given that community representatives would be beholden to the senior hospital managers, their role in hospital priority setting would be seen merely as that of rubber-stamping hospital decisions since they would hardly question or contribute to hospital decision making. This is expressed by Decision-

maker 1 in the following statement: “We tried a long time ago to incorporate the community…only to find out that the members present were always from Zomba…This did not give us an equal representation of our catchment area”.

This was corroborated by the hospital beneficiaries who argued that they were not involved in the priority setting process. This lack of involvement contributed to their lack of knowledge of the priority setting process as reported by Beneficiary 3 as follows: “We are not involved in these meetings and I think it is only the hospital practitioners who are involved”.

5.5.2 Stakeholder empowerment

According to the respondents, stakeholders are said to be empowered if there are opportunities for them to voice their opinions, and when these opinions are considered and potentially incorporated in decisions. The level of empowerment was found to be different among stakeholders across the three priority setting practices. While decision-makers reported being empowered in decision-making processes, the implementers (nurses and clinicians) appeared to have a low level of empowerment. They attributed this to lack of training in the said topic as was reported by Implementer 2 who said that, “Not everyone is conversant with priority setting guiding principles, as in how the priorities should be set, on what criteria…We are invited, yes, but we lack knowledge on how to contribute because we have not been trained”.

5.5.3 Transparency

The extent to which priority setting practices are transparent varies across the three priority setting activities that were examined at ZCH. The medicines selection process was reported to be more transparent than were the budgeting and nursing allocations. The respondents attributed this to the fact that the hospital has managed to develop a medicines formulary (a must-have list/ wish list) which meant that hospital decision-makers and the implementers have access to information on what medicines have been selected for use at the hospital. Lists of medicines that have been procured are available at any given time in the hospital and are circulated to the different clinical departments.

Furthermore, during meetings, attendees are shared the rationales behind the medicine selection. Therefore, it was generally felt that the medicine selection process is transparent. This is expressed by Decision-maker 5 in the following statement: “Medicine is treated differently; you cannot use drug money for anything else apart from drugs. This makes everything about medicine to be in black and white”.

The planning and budgeting process was rated second in terms of transparency. Even though the process was rated to be inclusive, respondents reported that the working plans and final budgets are not made available to them, not even to those who individually sought them. This is clearly expressed by Decision-maker 8 who said: “I have personally walked around this hospital…I have asked the manager himself to give me the implementation plan for last financial year, until today we are finishing this financial year, and no one has been able to give me”

The nursing allocation process was rated as the most undemocratic process at ZCH. It was reported that most of the nursing allocation decisions are made by one actor without communication of either the decisions or rationales to other actors as expressed by Implementer 1 who argued that, “Sometimes the reshuffles happen without proper consultation and communication, and most of the times the reasons are personal with no proper procedures, and the allocation is done by one person”.

5.5.4 Cases of disagreements

The stakeholders involved in medicine selection reported that it was possible to disagree with the decision made. All the disagreements in the medicine selection process are deliberated upon and a consensus is reached as expressed by Decision-maker 3, who said, “Usually in medicine selection meetings, if a matter is up for debate, we make sure that people deliberate, and a consensus is always reached”. However, the respondents reported that it was difficult to disagree with decisions made in budgeting and nursing allocation. They attributed this to the lack of mechanisms for appealing their case as expressed by Implementer 5 in the following observation:

> I have never seen people openly disagreeing with the budgets allocation during the meetings, and it is not possible to refuse their decisions. We always complain behind their backs and that is our tradition because we do not have where we can report our disagreements.

However, some respondents felt it was possible to disagree with the allocation decisions at the hospital. For example, they reported that actors that are not happy with the budget allocation decisions often follow up informally with the hospital managers to argue their case and revise decisions. For the nursing allocation decisions, these are followed up by one-on-one negotiations between the nursing in charges and the disgruntled nurses, and revisions are made where possible as expressed by Decision-maker 2: "People who are not satisfied with what their department got go straight to responsible managers to complain and we have seen them getting their needs".

5.5.5 Implementation of decisions

The implementation of priority setting decisions varies across the priority setting activities that were examined. The planning and budgeting processes are reported to be mainly an activity on paper that is hardly implemented. This is clearly expressed in the following statement by Decision-maker 10:

> Every year we make plans, but we do not look to see last year's plans were implemented. Because there is no follow up, no one bothers to even implement. I think this is one of the reasons most of these activities are useless. They are just paperwork.

Several reasons have led to the lack of implementation of decisions in planning and budgeting including the lack of resources, feigned compliance due to perceived lack of local relevance by national guidelines, a government culture and lack of a strong accountability mechanism. However, the implementation of medicine selection and nursing allocation decisions is mainly compromised by resource scarcity.

5.5.6 Efficiency and equity

An examination of ZCH reveals that priority setting decisions across the three-tracer priority setting activities are developed based on, among other things, evidence of cost-effectiveness. The respondents revealed that there was always an attempt by the hospital to incorporate elements of efficiency since the priority setting processes criteria consider affordability of competing priorities. This is clearly expressed in the following statement by decision-maker 3:

> Cost is there as well because we have to weigh that yes we have a burden, the drug is available, but now let's look at our resources; how much has been allocated…can we go through the financial year with such kind of medication?.

While the Ministry of Health proposes universal health coverage policy aimed at enhancing equity, at ZCH unintended policy effects have resulted in the underfunding of the services, and thus, the introduction of inequities. However, as the informants reported, priority at this hospital is also given to departments handling emergencies such as the Theatre and Maternity. Implementer 6 expressed this as follows: "We handle emergencies at the Maternity ward and Intensive Care Unit (ICU)). That is why we have more nurses in these areas compared to all the other units". This demonstrates a concern for the worse off and is a form of incorporating equity in hospital priority setting.

5. 6. Outcomes of priority setting practices

Addressing the outcomes of priority setting processes is also important when examining priority setting processes. This study has identified several outcomes ranging from stakeholder satisfaction, stakeholder and public understanding and compliance, allocation of resources according to set priorities, moral distress, and perceptions of unfairness and corruption.

5.6.1 Stakeholder Satisfaction

The level of satisfaction with the priority setting process varies between stakeholders at ZCH. Different stakeholders reported not being satisfied with the budgeting and nursing allocation activities because the priority setting process is not inclusive. This leaves most stakeholders disgruntled as reported by hospital Implementer 7 in the following statement: "As junior nurses we are not included in the priority setting, I'm not satisfied with the process…I don't know how they set these priorities because we are not involved".

Stakeholders also reported being dissatisfied with the hospital priority setting processes because of lack of resources. For example, the number of nurses allocated to different service deliveries at ZCH does not meet the staffing norms on the recommended ratios because of a severe shortage of nurses and clinicians. While these guidelines were available at the national level, they were not put into practice because the MoH had not recruited new staff for quite a long time. This was seen to have compromised the quality of work at the hospital, leaving the hospital implementers dissatisfied with their work. This is clearly expressed by Implementer 5 in the following statement:

> The shortage of nurses compromises the quality of care given to patients. For example, in my ward sometimes we have over 40 patients and yet you have only two nurses on duty, sometimes only one. Yet in an ideal situation in medical wards, you are supposed to have six patients per nurse. And you can imagine 40 patients per nurse. Now, do you expect any quality there?

However, some stakeholders express a level of satisfaction with the planning, budgeting, and the medicines selection process. This general satisfaction comes in because the processes are now inclusive as expressed by decision-maker 8 as follows:

> I am 60% satisfied because this year there has been an attempt to get other people involved, for example, heads of departments and programme coordinators, unlike previous years…which means it was only the senior

> team deciding on what to do and what they should buy which is a very bad way of doing things…so it was more of top-down approach.

5.6.2 Stakeholder and public understanding and compliance

At ZCH, stakeholders who were directly involved in the prioritisation process understood the process. These often complied with the identified priorities. However, the guardians, who represented the members of the public, and some implementers, indicated a limited understanding of the prioritisation process, although they also tended to comply with the priorities. This is expressed by Implementer 2 in the following sentiments:

> In this process of setting priorities I'm only involved at a ward level; we do have morning reports where we present what we want in this department. The other part I don't know how they set the priorities and how they come up with what to implement because we are not involved.

5.6.3 Allocation of resources according to set priorities

Some of the respondents indicated that since the prioritisation and resource allocation process is participatory, and it details the priority activities and the available resources, stakeholders ensure that the resources are allocated according to the identified priorities. However, several respondents also discussed how limited funding for the health sector limited the allocation of resources for implementation in hospitals. Specifically, respondents highlighted the limited health sector budget and constrained human resources as reported by one of the hospital's Decision-maker 7:

> Many times, and that is the major challenge, we do have the guiding lines and how to implement those is a big challenge. If you look at the document from the Ministry of Health and what the Ministry wants to be in the future they are quite expensive and very good ideas, but the problem is lack of financial and human resources.

5.6.4 Moral distress

Moral distress according to the respondents refers to a situation when one knows the right thing to do but institutional constraints make it impossible to pursue the right course of action. Respondents at ZCH spoke of different aspects of priority setting situations that they found most difficult and often lead to their distress. Three interrelated themes arose: resource constrained environments, inequities in budgets, and misalignments of values. Decision-makers felt distressed when they had to make choices about what to do with limited funding, including how to organise required care in circumstances when they were aware of both human resource limitation and time constraints. As stated by Decision-maker 5:

> I think that is one of the things that as decision-makers we sometimes struggle, having enough time to actually do a full analysis of the decisions that we are making…Our budgets meetings schedules are limited. We always feel that we have not had enough time to actually walk through the budgets properly, sometimes we end up with a decision that could have been a little bit better, which is a hard thing to swallow.

Respondents also experienced distress in attempting to carry out management roles when they felt that the hospital's overall or main priorities differed from those they held. They felt that they would be unable to follow through if they tried to pursue what they felt to be the best, most ethical policy. They also felt that they had to frame their choices in a way that accorded with the Central Hospitals Implementation Plan (CHIP) directions.

A prominent example on misalignment of priorities was the compromise of the quality of care. Clinicians and nurses reported being frustrated because they were ill-equipped to provide care to patients due to lack of essential supplies and nursing staff in other wards as a result of priority setting outcomes. The process was reported to have compromised the quality of care provided to patients in non-priority wards as stated in this statement by Implementer 4:

> The shortage of nurses compromises the quality of care given to patients in the non-priority wards. For example, in my ward sometimes we have over 40 patients and yet you have only two nurses on duty, sometimes only one. Yet the Paediatrics and Maternity have more nurses because they are priority areas of the Ministry. And you can imagine 40 patients per nurse. Now do you expect any quality there? So we prioritise tasks and attend only to life-threatening cases and leave the other cases unattended to.

5.6.5 Unfairness and corruption

Perception of unfairness and corruption was reported among the respondents at ZCH. The beneficiaries reported that the whole process of priority setting has brought in the issue of unfair treatment among patients as other patients with special diseases are prioritised at the expense of others. This is clearly expressed by Beneficiary 1 who said, "I came here three days ago but my son who was burnt has not been treated. The doctors here prefer treating malaria patients; this is unfair because all of them are patients."

Additionally, the respondents were of the view that priority setting practices have led to aspects of corruption in the form of bribes among health workers. This was captured in the following quote by Beneficiary 2: "Doctors steal drugs at this hospital…they hide behind this priority setting. As a result, some patients are told to buy drugs for themselves while others are provided with." This corroborates what Decision-maker 7 said: "There are issues of corruption within the public hospitals right from the top, the Ministry of Health, down to the hospitals. This also compromises the priorities set."

5. 7 Chapter summary

This chapter has presented the findings based on the examination of priority setting practices at ZCH. The chapter has been presented in five subsections, namely the meaning of priority setting, focus areas of priority setting, the criteria guiding the current priority setting, the ethical aspects found in the practices, and the outcomes of priority setting.

CHAPTER SIX
DISCUSSION OF FINDINGS

6.1 Chapter overview

This chapter includes a discussion of major findings as related to the planning and budgeting, medicine selection, and nurse allocation practices that were examined and the criteria used to set priorities at ZCH. Also included is the discussion on the ethical evaluation of the practices with A4R framework and the outcomes of priority settings. The chapter concludes with a summary of the discussions.

6.2 Interpretation of the findings

This thesis has described the prioritisation process at ZCH and evaluated the actual process against the A4R framework. The evaluation information is useful for improving priority setting in healthcare institutions. Experiences from both developed and developing countries show that an ongoing iterative 'describe-evaluate-improve' approach would help build capacity and increase confidence of relevant stakeholders in priority setting overtime (Barasa et al., 2016; Martin & Singer, 2004).

The first observation in the ZCH findings concerns the appropriateness of the criteria used to set priorities. It has been pointed out in the literature that criteria used to set healthcare priorities should be clearly defined and understood by stakeholders and decision-makers (Gibson et al., 2004). However, the case is different at ZCH since there is no clearly defined priority setting criteria that is used to set priorities in all the three practices examined (planning and budgeting, medicine selection and nurse allocation).

The dominant formal criterion used to set priorities at ZCH is the need. Need was variously defined by the respondents but generally interpreted as disease burden among patients in the hospital's catchment area. This included the current demand for health services, which could be measured based on utilisation rates. This finding is in tandem

with findings in other settings where health need emerged as the most commonly used criterion for setting priorities in hospitals (Barasa et al., 2015).

However, different findings have been emanated on politically induced inequities in both high-income countries (HICs) and low and middle-income countries (LMICs). For instance, in Tanzania, Maluka et al., (2010) reported that there was a politically motivated shift in priority from malaria to HIV/AIDs irrespective of the fact that the former had higher morbidity and mortality rates.

The use of informal criteria to set priorities also stands out as an important area of concern among the informants. The use of informal criteria such as lobbying and bargaining to set priorities at ZCH is consistent with findings in several settings, both high income-countries (HICs) and low and middle-income countries (LMICs). For instance, in a case study of priority setting practice in an acute care hospital in Argentina, Gordon et al (2009) reported that decisions were made based on, among other things, personal relationships and mutual benefit. Also, a case study of a hospital in Uganda reported that departments whose leaders knew how to 'lobby' or 'make their case' are usually prioritised (Kapiriri & Martin, 2006).

At ZCH, the use of informal criteria is more prominent in budgeting and nurse allocation because of the leadership style which provide room for hospital stakeholders to make their case to the hospital managers one-on-one. However, informal criteria are minimal in medicine selection as the process provide a platform for members of the DTC to openly disagree and revise the decisions made during meetings.

It also emerged that multiple additional factors have led to the use of informal criteria. For example, lobbying and bargaining were reported to have been influenced by personal relationships and the absence of explicit guidelines to guide priority setting. The findings also reveal that the use of informal criteria was influenced by the scarcity of resources that the hospital was experiencing. For example, at the time of conducting the study, it was observed that the MoH had not recruited nurses and clinicians in all the public hospitals

in Malawi for quite a long time, which compromises the quality of care and formal nurse allocation at the hospital. The findings on the influence of informal criteria at ZCH are consistent with Gordon et al. (2009) who argue that absence of data led to the use of informal or arbitrary considerations in decision making and may lead to perceptions of unfairness and compromise the health system goals of equity and efficiency (Waithaka et al., 2018).

The second observation in the findings concerns the evaluation of the planning and budgeting, medicine selection and nurse allocation at ZCH against the conditions of A4R (relevance, publicity, appeals/revision and enforcement). According to the relevance condition of A4R, a fair prioritisation process requires that the rationales of priority setting decision should aim to provide a reasonable explanation of why each decision was taken (Daniels and Sabin, 2002). Specifically, a rationale is reasonable if it is based on evidence, reasons and principles accepted as relevant by the stakeholders. Closely linked to this condition is the inclusion of a broad range of stakeholders in the decision- making process (Gruskin & Daniels, 2008). Involving multiple range of stakeholders ensures that a wide range of relevant values and principles are taken into account.

As far as relevance condition is concerned, several issues can be discussed. First, ZCH management have attempted to decentralise priority setting activities as a lot of stakeholders are now involved in the processes, unlike in the previous years. However, due to power imbalance (core management team exert more control over the decision made than do the hospital implementers), this has not been very successful.

Furthermore, the findings demonstrate that priority setting processes at ZCH are dominated by members of the core management team, with minimal involvement of hospital implementers, let alone community representatives. In addition, owing to power imbalance, decision-makers at ZCH are seen to be reluctant to share decision-making responsibility with other relevant stakeholders.

Power imbalance is not a new occurrence within the health sector. This has been documented elsewhere in literature. For example, in a study on distribution of power in the health sector, Goddard, Hauck, and Smith (2006) found that senior hospital managers exercised more power over decisions compared to other hospital managers and frontline practitioners by virtue of their position as senior managers.

Consistent with findings in other settings, there seems to be tension between hospital non-clinical administrators on the one hand and clinical personnel (both decision-makers and implementers) on the other hand (Barasa et al., 2015). While several factors could explain this, worth mentioning is the role of professional identity and conflicting values. Nurses and Clinicians at ZCH do not seem to attach priority to administrative roles, but rather, identify themselves more with their clinical roles.

Even though some respondents complained that they were excluded from priority setting activities, they did not seem to be interested in these activities. It appeared that the clinical identities they have developed attached little importance to their involvement in priority setting activities. This resonates with findings in other settings on identity challenges of clinicians who take on managerial roles (McGivern, Currie, & Ferlie, 2015).

Another factor that the study found to have contributed to the issue of value conflict was medical orientation. The observation shows that medical orientation in Malawi, just like in other African countries, does not empower nurses and clinicians to carry out administrative roles alongside their clinical roles. This finding concurs with findings elsewhere, in Kenya for example. According to Barasa et al. (2015) medical education in Kenya, where the training of most of the clinician emphasises the clinical skills and hardly includes administrative skills.

Additionally, the ZCH study shows that the hospital lacked mechanisms of incorporating community values in all the processes. This finding is consistent with studies done in both HICs and LMICs (Maluka, Kamuzora, & Sebastian 2010). According to communitarian claims, it is not enough to just subject the community to the decisions made; they should

be involved to the extent of determining how resources are allocated (Mooney, 2005). Public participation is the only mechanism currently used to incorporate public views (Waithaka et al., 2018).

Lack of deliberations in planning, budgeting and nursing allocation reported among hospital stakeholders is a manifestation of power or rather a means through which senior managers use to prevent those below them from analysing and evaluating their decisions. Similar findings have been reported in a study conducted in Canada where the senior managers found a way to bypass staff-determined priorities by exempting executive-determined priorities from scrutiny (Dionne, Mitton & Smith, 2009).

Stakeholder engagement has been examined in several studies on hospital level priority setting. In line with this study, Barasa et al. (2015) found that the most commonly excluded stakeholders in most settings are frontline practitioners (nurses and clinicians) and the community**.** This finding corroborates those from a study by Nyandieka et al. (2015) whose objective was to assess priority setting process and its implication on availability, access and use of Emergency Obstetric Care (EMOC) services at the district level. The study found that relevant stakeholders, including community members, were not involved in the priority setting process, thereby denying them the opportunity to contribute to the process.

Considering empowerment as an element of relevance condition, the level of empowerment was found to be different among stakeholders at ZCH. Hospital implementers (nurses and clinicians) in all the three priority setting practices examined reported having a low-level empowerment to participate in priority setting activities compared to the managers. They attributed this to a lack of training. Findings at other levels in the health system reported that several factors come into play to achieve stakeholder empowerment. For example, in Tanzania, effective participation in priority setting decision was influenced by gender, wealth, ethnicity and education (Shayo et al., 2013).

With regards to publicity condition, transparency was the theme that was prominent among respondents at ZCH. Publicity as an important ethical aspect of priority setting process demands that decision-makers should communicate their priorities and the reasons behind their decisions so that hospital stakeholders and members of the public can understand the values involved in the choices made, and assess whether the processes decided upon are implemented (Waithaka et al., 2018).

The findings at ZCH show that the medicine selection process partly met the publicity condition as the process of medicine selection was regarded as the most transparent. This is because lists containing the medicines that are selected for use are made available at any given time in the hospital and were circulated to various departments. The only limitation to this process was that there are no communication to the public. This finding mirrors Barasa et al. (2015) who reported that hospital stakeholders had access to information on the medicine that had been selected for use in the hospital.

However, both the planning and budgeting, and the nurse allocation processes cannot be described as being transparent. This is because the processes have ineffective formal mechanisms of disseminating priority setting decisions. As regards to all the priority setting processes at ZCH, no mechanisms were in place to ensure that relevant stakeholders received information regarding the rationales and priorities identified. This could be attributed to the entrenched culture in Malawi of receiving and implementing whatever comes from the authorities. The findings on publicity condition is in tandem with several studies in both HICS and LMICs that have found that even when there is some communication, the sharing of rationales for decisions is not a tradition that leaders practice (Bukachi et al., 2014; Maluka et al., 2010; Zulu et al., 2014).

It is well documented that through appeals and revisions, decision-makers can improve the quality of decisions. This is because such mechanisms provide an opportunity to include emerging issues and to correct errors (Sibbald et al., 2009). Much as this is the case, ZCH had no formal appeal mechanism in all the three priority setting practices examined. It should be pointed out that formal appeal mechanisms are a problem not only

at ZCH since many health care systems across the world are fraught with deficiencies which hinder the condition of appeal and revision when stakeholders do not agree with the decision made (Gibson et al., 2006; Menon, Stafinski & Martin, 2007; Waithaka et al., 2018; Zulu et al., 2014).

The lack of formal appealing mechanisms at ZCH has resulted in informal appeals such as lobbying to take precedence and unfair distribution of resources. This finding is consistent with Barasa et al. (2015) who reported that although the informal appeals mechanisms may be useful in getting a few "strong lobbyists" get what they want, they are neither fair nor systematic and may be detrimental to the institution.

Finally, the last procedural condition of enforcement in priority setting requires that public or voluntary regulation of the decision process is put in place to ensure that the relevance, publicity, and appeal/revision conditions are met (Waithaka et al., 2018). However, there was no mention by participants at the study hospital of any system to ensure adherence to the conditions of fair priority setting, mechanisms to ensure adherence to set criteria and follow up of the implementation of decisions. Evaluation of the impact of the decisions was also lacking.

Whatever the case may be, decisions made during a priority setting process should result in implementation. Without implementation, stakeholders will view the priority setting process as a waste of time. Similar sentiments are expressed in a study on priority setting in a hospital drug formulary in Canada (Martin et al., 2003b). Later, another study also observed that conditions of fairness cannot be met without deliberate direct action by hospital leaders (Reeleder, Martin, Keresztes & Singer, 2005).

Overall, this study shows that the priority setting practices at ZCH contain some ethical aspects that are in tandem with the A4R framework. However, the processes do not completely adhere to the four procedural conditions of a fair process (relevance, publicity, appeals/revision, and enforcement). Similar findings have been reported when evaluating

the fairness of priority setting processes (Byskov et al., 2014; Essue & Kapiriri, 2018; Kapiriri et al., 2007; Kapiriri, Norheim, & Martin, 2009; and Maluka, 2011).

The third observation concerns the outcomes of priority setting practices at ZCH. Literature indicates that the satisfaction of stakeholder groups in a priority setting process is key to its success (Sibbald, 2009). The findings at ZCH reveal that the stakeholder satisfaction is not met in planning and budgeting, and nurse allocation. It seems that satisfaction of stakeholders at ZCH is linked to the level of their engagement. The findings of this study show that only stakeholders who are fully engaged reported being satisfied with the priority setting activities. However, those excluded from the processes reported being unsatisfied.

The findings on lack of stakeholder satisfaction at ZCH mirror those from other settings, for example, Canada. In Canada, an evaluation of priority setting in a hospital there reported that stakeholders were not satisfied with the process when there was lack of or poor communication about the process and when they were excluded from the process (Sibbald et al., 2010).

This study has also demonstrated the importance of stakeholder understanding in the process of priority setting. Stakeholder understanding is a mechanism which ensures that all relevant stakeholders have insight into the priority setting process (e.g. goals of the process, rules, and guidelines, procedures used, rationale for priority setting and rationale for priority setting decisions). It has been demonstrated that stakeholder understanding plays an important role in increasing their acceptance and confidence in the process (Sibbald et al., 2010).

The level of understanding of the priority setting process at ZCH varies across stakeholders and is dependent on the level of their engagement. For example, nurses, clinicians, and some departmental heads had low level of understanding of the planning and budgeting, medicine selection, and nurse allocation processes given that they were excluded from the processes.

Failure to understand a process has serious implications on the transparency of the processes. How well stakeholders understand the priority setting process is linked to the procedural conditions of relevance and publicity in the accountability for reasonableness framework. This is because people will only understand a process well if they are involved in it, and if its outcomes and rationales are adequately communicated to them (Waithaka et al., 2018).

Additionally, Barasa et al (2015) confirmed that priority setting processes are to result in changes in the allocation of resources. It has also been observed that when priority setting processes do not result in change, it makes the stakeholders view the process as a waste of time or mere window-dressing for predetermined outcomes (Sibbald, 2009). At ZCH, priority setting processes do not result in shifted resources. This is because historical allocation is one of the guiding criteria for priority setting processes at this hospital. This entails that departments or services that historically receive a larger share of resources continue to do so and vice versa. The priority setting process is, therefore, not responsive to the changing dynamics of resource needs there.

The importance of reallocation of resources in priority setting processes has been reported in other settings. For example, stakeholders at a hospital in Canada observed that a priority setting process should result in changes in organisational priorities reflected by a reallocation of resources (Gibson et al., 2004). In line with this study, Sibbald et al., (2010) reported that shifting of priorities is one of the results of a successful priority setting process.

The study also revealed moral distress as one of the outcomes of priority setting experienced at ZCH. The findings at ZCH show that both decision-makers and implementers were distressed in their own ways. But lack of resources was the dominant reason for the distress at it compromises their work. Based on the findings reported elsewhere, moral distress does exist among stakeholders in the context of priority setting and resource allocation (Mitton, Peacock, Storch, Smith & Cornelissen, 2010). Two key examples of moral distress that have been identified by Mitton and others are to do with

managers having to sell a direction or decision that they do not believe in, and managers breaking obligation to staff or colleagues.

The respondents also reported the presence of unfairness coupled with severe resource scarcity as contributing to their distress. This has resulted in reduced staff motivation and head of departments being less enthusiastic about participating in planning and budgeting meetings, so they often absconded. They mostly attributed this to the fact that they were unlikely to get any allocations even if they attended planning and budgeting meetings.

6.3 Chapter summary

The findings indicate that there are three main priority setting practices examined in the context of planning and budgeting, medicine selection, and nursing allocation. The study has identified successful parameters such as formal prioritisation processes, use of criteria in setting priority setting and the involvement of several stakeholders in the processes. The study has also discussed some less successful parameters, which should be the focus of concerted improvement strategies.

While there are robust plans, the main limitation seems to be around the actual allocation of resources to facilitate activities between identified hospital priorities and mechanisms to ensure that these activities are implemented. The critical role played by ZCH in implementing and enforcing ethics in the priority setting practices is highlighted. It has been established that the scarcity of resources at ZCH inevitably affects the implementation efforts.

CHAPTER SEVEN
CONCLUSION, IMPLICATIONS, LIMITATIONS AND AREAS OF FUTURE STUDY

7.1 Conclusion

The study was aimed at examining priority setting practices at ZCH to determine if they comply with the established ethical standards in Daniels and Sabin's A4R framework. Specific objectives included: (1) to identify participants who are involved in priority setting at ZCH, (2) to describe the focus areas in priority setting at ZCH, (3) to identify ethical aspects which are present in priority setting process at ZCH, (4) to describe factors that are associated with priority setting at ZCH and (5) to explain the outcomes of priority setting practices at ZCH. This study was qualitative in nature and employed in-depth interviews, focus group discussions and document reviews as data collection methods. To measure the legitimacy and fairness of priority setting practices, the study used accountability for reasonableness framework.

The findings illustrate that there are three main areas of focus in priority setting at ZCH. These are examined in the context of planning and budgeting, medicine selection and allocation of nurses. An ethical evaluation of this study based on the accountability for reasonableness framework shows that priority setting practices at ZCH do not fully meet the four conditions of the framework.

The study also shows that medicine selection is the most democratic process as it is inclusive and allows consultations and deliberations. Second on the list is the planning and budgeting process, followed by the nursing allocation, where the latter is rated as the most undemocratic process at the hospital. Furthermore, the study has revealed that both formal and informal criteria guide the selection of hospital priorities, and these criteria are not explicit. In terms of budgeting and nursing allocations, these are characterised by the dominance of informal criteria in decision-making.

According to the results of this study, three priority setting practices are associated with ethical issues at the study hospital, ZCH. First, relevant stakeholders are not involved when setting priorities. It is observed that the members of the public are not involved while some hospital stakeholders are not fully engaged in priority setting. There is also lack of understanding of priority setting process among the stakeholders especially those that are not involved in the process. The last set of ethical issues include lack of empowerment among stakeholders, poor communication strategies, unsatisfactory implementation of decisions, and the elements of efficiency and equity which are not explicit. Additionally, ZCH has been found wanting as far as a strong formal mechanism for appeal, revision, and accountability in all the processes is concerned.

The study has also revealed some important outcomes as regards priority setting practices at ZCH. First, stakeholders are more satisfied with the planning and medicine selection than with the budgeting and nursing allocation. Second, hospital stakeholders are distressed due to heavy workload and limited resources. There are also perceptions of corruption which are manifested in the unfair delivery of treatments experienced by the hospital beneficiaries.

7.2 Implications of the study

The findings of this study have several implications. First, the implications of moral distress that nurses and other health professionals experience at ZCH can be manifested in different dimensions. For instance, there is a psychological imbalance that nurses experience when facing impediments to performing interventions which they consider adequate. Among the stated manifestations, the most recurrent are feelings of powerlessness due to their perception of lack of inclusion in making decisions. This feeling of powerlessness can exacerbate with the development of a feeling of guilt because it appears to be associated with their professional ideals which limit their self-efficacy.

Another recurrent manifestation is frustration. The feeling of frustration can be associated with the moral distress experienced by the hospital implementers in different situations, as well as due to the singularities of each workplace. In cases of children and general

wards, it appears that moral distress is manifested because of overcrowding conditions. The hospital implementers realise that they are failing to provide quality care to the patients.

Furthermore, moral distress is associated with negative impact on the hospital implementer's job satisfaction. Job dissatisfaction can be associated with the abandonment of the profession and a feeling of not wanting to return to work after each shift. This is because nurses and clinicians question the purpose of the care they are providing to patients and the ethics of the hospital. These feelings are dangerous as they affect service delivery in the long run.

There is also a desire to change workplace, jobs or to completely abandon the profession. This can be related to the hospital implementers' incapacity to avoid and cope with moral distress. Such triggering situations may be followed by decisions made based on feelings of low self-esteem and powerlessness. The abandonment of the profession is a source of concern considering the high costs of training and hiring of professionals on the part of the MoH in Malawi.

With regards to perceptions of corruption, the tendency could lead to a poor health system in Malawi. This stands true considering the strong evidence in Malawi that suggests that corruption significantly reduces the degree to which additional funding for the health sector can translate into improved health outcomes. Additionally, even though corruption at the healthcare service delivery level (where patients directly interact with the health system and individual providers) is a neglected ethical issue, individual acts of corruption that have been reported by the respondents can cumulatively have a huge impact. Thus, although the acts of corruption are typically small in scale at ZCH, they can significantly undermine efforts to expand and improve access to vital health services.

Acts of corruption at the hospital level have wider systemic impacts. Firstly, poverty can be perpetuated in Malawi as families are forced to sell assets or go into debts to pay bribes for free services. Secondly, political stability and efforts to contain epidemics are

undermined because citizens encountering corruption at ZCH will lose trust in the hospital's willingness and ability to provide basic services.

Furthermore, the concept of deliberation in the three priority setting processes offers a variety of ways to determine and involve the "right" stakeholder, not only as those who are consulted, but also as those who play an active role in the process. Stakeholder values and criteria drive the entire priority setting process; any process that seeks to gauge and address a society's knowledge needs must then focus on who is involved and how they participate in the process. Failure to do so will leave this critical function to the technical experts, who often have significantly divergent values and criteria to those by other relevant stakeholders.

7.3 Study limitations

The study had some limitations, which warrant mentioning. One of the limitations, consistent with the use of the case study design, concerns statistical generalizability. Statistical generalizability is not the intention of the case study methodology, but rather, analytical generalizability. Being able to generalise study findings to the population from which a sample is drawn (in this case public hospitals in Malawi) is problematic when one is examining a phenomenon as highly complex and context-specific as priority setting. Nevertheless, analytical generalisation allows for conclusions that are transferable to other settings to be drawn about relationships.

Another limitation is drawn from the fact that the findings and conclusions of the study would have benefited from the views of priority setting stakeholders from the Ministry of Health. While hospital decision-makers, hospital implementers, and the hospital beneficiaries were interviewed, the views of the MoH representatives were not captured because of logistical, resource and time constraints. It can be argued, therefore, that one component of the issue is missing in this study. However, the study set out to examine whether priority setting practices at ZCH are ethically justified; an objective which the researcher believes was adequately addressed even in the absence of officials' interviews.

7.4 Areas for further research

The first potential research area is exploring the views and perceptions of health managers and policy-makers on the theoretical framework that has been applied in this study. Specifically, research could explore the acceptability of the four conditions of relevance, publicity, appeals/revisions, and enforcement. This will define its suitability and improve its utility as an evaluative tool for health care priority setting practices.

Future research can also focus on the importance of basing priority setting decisions on community values. Such research could explore methods for eliciting community values and comparing their suitability and applicability in public hospitals in Malawi.

Thirdly, research may also explore the effect of hospital autonomy on a hospital priority setting. This could be crucial in the midst of decentralisation since hospital governance in Malawi is in transition with the likelihood that hospitals will eventually be autonomous.

How publicity can be enhanced in Malawian public hospitals can also be a promising research area. This is because the transparency of the priority setting processes can be improved by publicising decisions and their rationales and making these decisions accessible to all stakeholders.

Research should also focus on effective ways of ensuring and promoting empowerment among stakeholders in priority setting processes. As noted in this thesis, and by other authors, some relevant stakeholders are not empowered to effectively participate in deliberative processes. It has also been shown in other settings that empowerment of stakeholders in deliberative processes is affected by social stratifiers such as social-economic status, gender, tribe and education levels (Shayo et al., 2013). These factors are however context specific and should be explored in different settings. More importantly, in light of such influences, there is a need to explore effective ways of promoting empowerment among stakeholders in different contexts

Lastly, research could also consider the effects of ethics committees in priority setting both at the national and hospital levels. This is important because ethics committees advise and raise awareness of ethical aspects in resource allocations; bridge clinical practice with higher-level decisions; and promotes fair resource allocation and stakeholder rights and interests.

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APPENDICES

Appendix I: In-depth and focus group guiding questions

INTERVIEW GUIDING QUESTIONS

Introduction

I am conducting research on how this hospital set priorities and make decisions about how to distribute (allocate) the resources available to them at this hospital.

DECISION MAKERS (Clinician and non -clinical administrators)

1. What is your understanding of priority setting of health care resources?

2. May you tell me about who is /are involved in priority setting?

Probe-

Do they have the required capacity?

3. Would you please tell me the priority setting process at this hospital?

Probe-

Is the current process fair and transparent?

Are there mechanisms to ensure the priority setting process is fair?

What if people do not agree with the decisions or process?

4. What are the health service priorities at this hospital?

Probe-

What criteria are these priorities set?

Is there a document where these priorities are outlined?

How satisfied are you with these guidelines?

How limited are these guidelines?

Have you ever found yourself in a situation where these guidelines are not used?

If so, what factors contribute to such cases?

5. What role do you have in priority setting and resource allocation at this hospital?

6. Is there any effort to obtain community views on how to set priorities and allocate resources?

Probe-

In what ways if it happens are community views obtained?

7. How can priority setting be improved at this hospital?

HOSPITAL IMPLEMENTORS (Clinicians and Nurses)

1. What is your understanding of priority setting?

Kodi mukamvetsedwe kanu kusankha thandizo lina la chipatala kukhala lofunikira kuposa lina zimatanthauza chiyani?

2. Would you please tell me the priority setting process at this hospital?

Mungandifotokozere m'mene ndondomeko yakasankhidwe kathandizo lachipatala kukhala lofunikira kuposa lina limayendera pa chipatala pano?

Probe/**kufunsa**

-Is the current process fair and transparent?

Kodi ndondomeko zimenezi zimapangidwa mosakondera ndi mosabisa?

-Are there mechanisms to ensure the priority setting process is fair?

- **Pali upangiri wina uliwonse owonetsetsa kuti kasankhidwe ka thandizo kamachitika mosakondera?**

3. May you tell me about who is/are involved in making such decisions?

Ndi anthu kapena magulu a anthu ati omwe amatenga nawo gawo popanga ziganizo zimenezi?

Probe/ **kufunsa**

-Do they have the required capacity?

Kodi magulu a anthu amenewa ali ndizowayeneleza kupanga ziganizo zimenezi?

4. What criteria are used to set these priorities?

Kodi zisankho zimenezi zimasankhidwa potsata ndondomeko zotani?

5. What do you think are the health service priority at this hospital?

Kodi mukuganiza kuti ndi zithanzizo zaumoyo ziti zimene zinaikidwa kukhala zofunikira pa chipatala pano?

6. How does the set priority affect your work?

Kodi zisankho zimenezi zimakhudza bwanji kagwiridwe kanu kantchito tsiku ndi tsiku?

7. How satisfied are you with the priority setting process overall?

Kodi mumakhutitsidwa ndi dongosolo la kapangidwe ka zisankho zimenezi?

FOCUS GROUP DISCUSSION GUIDE FOR HOSPITAL BENEFICIARIES (GUARDIANS)

1. What is your understanding of priority setting?

Kodi mukamvetsedwe kanu kusankha thandizo lina la umoyo/ lachipatala kukhala lofunikira kuposa lina zimatanthauza chain?

2. May you tell me about who is/are involved in making such decisions?

Ndi anthu kapena magulu a anthu ati omwe amatenga nawo gawo popanga ziganizo zimenezi?

3. What do you think is the purpose and goal of the priority setting process?

Kodi mukuganiza kuti cholinga chopangira ziganizo zimenezi ndi chiyani?

4. What do you think are the health service priorities of this hospital?

Kodi mukuganiza kuti ndi zithandizo zaumoyo ziti zimene zinaikidwa kukhala zofunikira pa chipatala pano?

5. How do the set priorities at this hospital affect you?

Kodi zisankho zimenezi zimakhudza bwanji thandizo lomwe mumalandira pa chipatala pano?

6. With regards to health care priority setting:

Potengera thandizo lomwe a chipatala anayika kukhala lofunikira kuposa lina:

Probe/ **kufunsa**

-What concerns you most?

Ndi chani chomwe chimakukhuzani pankhani imeneyi?

Appendix II: Informed consent for in-depth interviews

Chancellor College
Philosophy Department
Master of Arts in Applied Ethics

Title of Project: EXAMINING PRIORITY SETTING PRACTICES IN MALAWI: A CASE OF ZOMBA CENTRAL HOSPITAL

Informed Consent Form

Purpose of the Study: The purpose of this study is to examine resource allocation and priority setting practices at Zomba Central Hospital

What will be done? You will be required to answer the questions that you will be asked. This will take 30 minutes. The questionnaire will include questions concerning resource allocation and priority setting practices at this hospital.

Benefits of this Study: By answering these questions you will be contributing to knowledge about how this hospital allocate its resources and set their priorities.

Risks or discomforts: No risks or discomforts are anticipated from taking part in this study. But if you feel uncomfortable with a question, you can skip that question or withdraw from the study altogether. If you decide to quit at any time before you have finished the questionnaire, your answers will NOT be recorded.

Confidentiality: Your responses will be kept completely confidential. Each participant will be assigned a participation number, and only the participant number will appear with your responses. Only the researcher will see your individual responses. The responses will be securely kept within the Department of Philosophy's premises for some time before they are destroyed.

Decision to quit at any time: Your participation is voluntary; you are free to withdraw your participation from this study at any time. You also may choose to skip any questions that you do not wish to answer.

How the findings will be used: The results of the study will be used for scholarly purposes only. The results from the study will be presented in educational settings and at professional conferences, and the results might be published in a professional journal.
Contact information: If you have concerns or questions about this study, please contact the Head - Department of Philosophy, Dr Yamikani Ndasauka by email:

yndasauka@cc.ac.mw or phone: +265 99 74 67 877; or Postgraduate Coordinator, Dr. Simon M. Makwinja by email: smakwinja@cc.ac.mw or phone: +265 99 12 14 677.

I……. acknowledge that I have read this information and agree to participate in this research on ……..

Appendix III: Informed consent for focus group discussion translated in Chichewa

Chancellor College

Philosophy Department

Master of Arts in Applied Ethics

DZINA LA KAFUKUFUKU: Kuunikira m'mene utsogoleri wa pachipatala chachikulu cha Zomba umasankhira zithandizo zina zaumoyo kukhala zofunikira kuposa zinzake.

Informed Consent Form (Chilolezo chanu)

Cholinga cha Kafukufuku: *Cholinga chakafukufuku ameneyu ndikufuna kuunikira zam'mene zithandizo zaumoyo zimasankhidwira kukhala zopambana kuposa zimzake ndiutsogoleri wa pachipatala chachikulu cha Zomba.*

Zichitikire nzotani? *Mukuyembekezeledwa kuyankha mafunso omwe ndikhale ndikukufunsani. Ndipo izi zitenga pafupifupi mphindi makumi atatu. Ena mwamafunso akhuza zam'mene utsogoleri wa pachipatala chino umasankhira zithandizo zina zaumoyo kukhala zofunikira kuposa zinzake.*

Phindu lakafukufukuyu ndilotani?: *Poyankha mafunsowa muthandizira kuti zina mwa njira zimene unduna wa zaumoyo mogwirizana ndi chipatala chino umatasata posankha zithandizo zina zaumoyo kukhala zofunikira kuposa zinzake zisinthe komanso kuthandizira kupezeka kwa zithandizo zaumoyo zina.*

Zoopsa kapena zopinga: *Palibe choopsa kapena zopinga zina zilizonse zimene zingakuchitikireni chifukwa chotenga nawo mbali mukafukufukuyu. Koma ngati mukuona*

kuti palifunso lomwe simuli omasufuka kuyankha muli ndi ufulu kusaliyankha kapena kusiya kutenga nawo mbali ndipo mayankho anu sadzagwilitsidwa ntchito.

Chinsinsi: *Mayankho anu onse asungidwa mwachinsinsi ndipo palibe aliyense watengapo mbali mukafukufukuyu atchulidwe dzina lake mu lipoti. Aliyense apatsidwa nambala yachinsinsi ndipo idzimgotchulidwa ndi nambalayo. Ndiyekhayo mwini kafukufuku yemwe adziwe mayankho anu ndipo zonse zidzasungidwa mosamala bwino munthambi yamaphunziro komwe ochita kafukufukuyu amaphunzira (Department of Philosophy) zisanaonongwedwe.*

Ufulu osiya kutenganawo mbali: *Kutenga nawo mbali ndiufulu wanu ndipo muli ndiufulunso kusiya kutenga nawo mbali. Ndipo ngati pali funso lomwe mukufuna kusayankha teroni.*

Zotsatira zizagwilitsidwa ntchito bwanji?: *Zotsatira zakafukufuku ameneyu zizagwilitsidwa ntchito yamphunziro basi. Zotsatilazo zizafalitsidwa malo amaphunziro basi.*

Ngati pali chobvuta: Mutakhala ndinkhawa kapena mafunso okhunza kafukufuku ameneyu, funsani mkulu wamaphunziro poyimba phone kwa Dr. Yamikani Ndasauka kapena kutumiza email: yndasauka@cc.ac.mw or Phone: +265 997467877: komanso kwa Dr. Simon M. Makwinja pa email: smakwinja@cc.ac.mw kapena Phone: +265 991214677

Ine.....ndikuvomera kuti ndawerenga uthenga onse ofunikira ndipo ndine okonzeka kutenga nawo mbali pakafukufukuyu. Tsiku: .....

Appendix IV: Department of Philosophy approval letter of introduction

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

Our Ref: MA/PHIL/19/02/2019
Your Ref

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

19th February, 2019.

TO WHOM IT MAY CONCERN

INTRODUCTION LETTER: AGATHA MAGOMBO

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

As a requirement for graduating, she is supposed to conduct research leading to a dissertation. The title of the research she is conducting is: *Examining Priority Setting Practices in Malawi: A Case of Zomba Central Hospital.*

As part of his research, Agatha 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 be used for academic purposes and to inform policy only.

Assistance rendered to her will be highly appreciated.

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

Yours sincerely,

DR. Y. NDASAUKA
HEAD OF PHILOSOPHY DEPARTMENT

Cc: Dean of Humanities
Dean of Postgraduate Studies
Mr. Lawrence Mpekansambo (supervisor)

Appendix V: Zomba Central Hospital approval letter

Telephone No.: 01 526266/01525195
Telefax No.: (265) 1 524 538
Telex No.:
E-Mail: medzch@malawi.net

Please address all communications to:
The Hospital Director

Zomba Central Hospital
P.O BOX 21
ZOMBA
MALAWI

26th February, 2019

Agatha Magombo
C/O Chancellor College
P.O Box 280
Zomba.

Dear Agatha,

RE: PERMISSION TO CONDUCT A STUDY AT ZOMBA CENTRAL HOSPITAL

We would like to acknowledge receipt of your letter which you submitted to this institution whereby you have expressed interest to do your research study entitled "Examining Priority Setting Practices"

I would like to inform you that management has approved your request to proceed with the research study.

Therefore, we urge you to adhere to ethical considerations.

We look forward to supporting you.

DIRECTION
ZOMBA CENTRAL HOSPITAL
2019 -02- 28
P.O. BOX 21, ZOMBA

L.Thom-Chisale
CHIEF HOSPITAL ADMINISTRATOR
for: HOSPITAL DIRECTOR.