# Developing a framework for expenditure management in the Malawian public healthcare sector

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**PREFACE AND ACKNOWLEDGEMENTS**

The research presented in this thesis was conducted on expenditure management in the public healthcare service delivery sector in Malawi.

I praise the Almighty God for granting me the wisdom, strength and zeal to embark on and complete this journey. My heartfelt gratitude to my promoter, Professor Wedzerai Saratiel Musvoto, for his invaluable support, guidance, motivation and time; he had been with me on this journey since day one. Professor Musvoto, I cannot thank you enough for the support I received on this journey; even when I was tripping, you had been the inspiration I needed.

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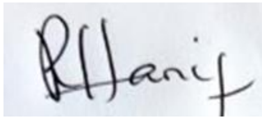
To everyone that I have not mention individually, know that in my heart of hearts, you are immensely appreciated.

## DECLARATION

This thesis, **Developing a framework for expenditure management in the Malawian public healthcare sector**, is submitted for the degree of Doctor of Philosophy in Economic and Management Sciences with Business Administration at the North-West University, School of Business and Governance. To the best of my knowledge, I Rabiya Hanif, declare that the entirety of this thesis is my own original work, and that I am the sole author, except where guidance was sought from my promoter, acknowledged and referenced material made by previous scholars and other practitioners. I further declare that this thesis or part thereof, has not been presented or submitted for any academic qualification elsewhere.



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Signature

Date: 10th December, 2021

**ABSTRACT**

The purpose of this study was to develop a framework for improving expenditure management for the public healthcare delivery sector in Malawi. A good public healthcare sector system must deliver high quality service. This can be linked to healthy and productive citizens who, consequently, are instrumental in contributing to the economic growth of the country. The need for improved expenditure management is, consequently, vital as governments struggle with the constrained resource environments in which they operate.

The need for the framework of the present study arose due to the fact that the public healthcare delivery sector in Malawi is marred by financial management deficiencies relating to budget formulation and implementation, funding, financial waste and leakages. This study was inspired by revelations that the Sub-Saharan Africa, including Malawi, reports the worst health outcomes as it is less efficient in translating health expenditure into health outcomes. The public sector in general, and the health sector in particular, has been experiencing deficiencies in managing finances. Over the years, the Malawi government and donor community have been making efforts to improve public financial and procurement management; however, cases of financial mismanagement and inefficiencies still arise.

The study adopted a mixed-methods exploratory sequential design. The study collected qualitative data that informed the quantitative data collection instrument. Qualitative data was collected through semi-structured interviews; whilst quantitative data was collected through self-administered questionnaires. Qualitative data was analysed thematically; whilst quantitative data underwent factor and univariate analysis.

The findings reveal that the healthcare delivery sector experience resource allocation, staffing, management, procurement and supply chain management, financial management, legislative and political challenges and shortfalls which affect public expenditure management. The specific issues include compliance and funding challenges; low staff morale and integrity; lack of political will, weak financial management systems, weak enforcement of compliance and disciplinary issues; dual management and central government control, centralised procurements; weak supervisory and monitoring functions; inequitable funds allocation, as well as planning and budget issues.

The study recommends enhanced domestic funding, improved supervisory and monitoring functions to enforce compliance as well as improved capacity of oversight functions. Furthermore, the study recommends working towards an improved formula for allocating government funding to hospitals; staff training and recruitments are necessary in order to boost staff capacity; consultations on budget and funds allocation must take place; improved quality and availability of financial information to monitor public spending is necessary; and the sector must foster constructive dialogue with the civil society and strengthen performance and financial management systems. The recommendations emerging from this study could assist in addressing the challenges in the public healthcare deliver services sector in Malawi. The adoption of the recommendations would result in improved management of public expenditure and, consequently, there would be improved service delivery in the health sector.

**Key words:** Public expenditure management, public finance management, financial management, public expenditure, health expenditure, healthcare services, health outcomes, Malawian context.

**Table of Contents**

PREFACE AND ACKNOWLEDGEMENTS ..... ii
DECLARATION ..... iii
ABSTRACT ..... iv
LIST OF TABLES ..... xv
LIST OF FIGURES ..... xviii
LIST OF ABBREVIATIONS ..... xix

**CHAPTER 1: GENERAL OVERVIEW OF THE STUDY ..... 1**
1.1 Introduction ..... 1
1.2 Contextualisation of the study ..... 2
1.3 The Malawian public healthcare delivery sector context ..... 5
1.3.1 The Malawian public healthcare delivery system structure ..... 5
1.3.2 Legislative framework governing public finance management ..... 7
1.3.3 Financial resource utilisation in the Malawi public healthcare delivery sector ..... 8
1.4 Research problem ..... 9
1.5 Research questions ..... 11
1.6 Specific research objectives ..... 12
1.7 Justification for the study ..... 12
1.8 Scope of the study ..... 12
1.9 Organisation of the study ..... 13
1.10 Chapter summary ..... 14

**CHAPTER 2: OVERVIEW OF PUBLIC EXPENDITURE MANAGEMENT AND ITS THEORETICAL FRAMEWORKS ..... 15**
2.1 Introduction ..... 15
2.2 Public financial management ..... 15
2.3 Public expenditure management and the public health sector ..... 20
2.4 Funding in the public healthcare delivery sector ..... 22
2.5 Financial resource utilisation in the public health sector ..... 25
2.6 Budgetary systems as a means of effective management of public expenditure ..... 27
2.7 Impediments to optimum public expenditure management ..... 31

2.8 The legal framework for public expenditure management 33
2.9 Management theories 35
2.9.1 Agency theory 36
2.9.2 Accountability theory 40
2.9.3 Stakeholder theory 42
2.9.4 The stewardship theory 44
2.9.5 X-inefficiency theory 46
2.9.6 Contingency theory 48
2.9.7 Lüder's contingency model 48
2.10 Chapter summary 50

**CHAPTER 3: PUBLIC EXPENDITURE MANAGEMENT: CONCEPTUAL FRAMEWORK AND EXPERIENCES AROUND THE WORLD** 51
3.1 Introduction 51
3.2 A conceptual framework for public expenditure management for the public healthcare service delivery sector in Malawi 52
3.3 Public financial management in the Malawian context 53
3.4 Budgeting in the health sector and its deficiencies 54
3.4.1 Budget planning, implementation and control 56
3.4.2 Financial resource allocation and inequities in public healthcare sector 58
3.5 Wastages and leakages 61
3.5.1 Management of procurements 62
3.5.2 Resource wastes and losses through thefts and pilferage 64
3.5.3 Financial leakages 65
3.6 Funding issues in the public healthcare delivery sector 66
3.6.1 Inadequate funding 68
3.6.2 Donor dependency 70
3.6.3 Delayed disbursements of funds 72
3.7 Public health expenditure and public health outcomes 73
3.8 Chapter summary 76

**CHAPTER 4: RESEARCH METHODOLOGY** 77

4.1 Introduction .......... 77
4.2 Research philosophy .......... 77
4.3 Research approach .......... 82
4.4 Research design .......... 84
4.4.1 The qualitative design .......... 85
4.4.2 The quantitative design .......... 86
4.4.3 The mixed methods design .......... 86
4.5 The study population .......... 96
4.6 Sampling and sampling techniques .......... 99
4.6.1 Sample for in-depth interview participants .......... 99
4.6.2 Sample for questionnaires respondents .......... 100
4.7 Data collection instruments .......... 101
4.7.1 Qualitative data collection .......... 101
4.7.2 Quantitative data collection - questionnaire .......... 103
4.8 Data analysis .......... 104
4.8.1 Qualitative data analysis .......... 105
4.8.2 Quantitative data analysis .......... 108
4.9 Validity and reliability .......... 109
4.9.1 Validity and reliability for the interview guide .......... 110
4.9.2 Validity and reliability for the questionnaire .......... 110
4.10 Ethical considerations .......... 111
4.10.1 Permission to conduct study .......... 112
4.10.2 Informed consent .......... 112
4.10.3 Confidentiality and anonymity .......... 113
4.10.4 No Harm to participants .......... 113
4.10.5 Equity and justice .......... 114
4.11 Chapter summary .......... 114

**CHAPTER 5: QUALITATIVE RESULTS ANALYSIS AND DISCUSSION** .......... 115
5.1 Introduction .......... 115
5.2 Thematic data analysis – The technique applied in qualitative data analysis .......... 115

5.3 Demographics for the research participants ........ 116
5.4 Discussion of the qualitative data ........ 117
5.5 The link between themes and research objectives ........ 118
5.6 Theme 1: Funding situation in the district hospitals ........ 122
5.6.1 Sources of funding ........ 123
5.6.2 Constraints/challenges of funding sources ........ 127
5.6.3 Implications for quantitative data collection tool ........ 134
5.7 Theme 2: Status of public expenditure management ........ 134
5.7.1 Budgeting and budget management ........ 135
5.7.2 Strengths ........ 144
5.7.3 Challenges in public expenditure management ........ 148
5.7.4 Implications for quantitative phase ........ 155
5.8 Theme 3: Vital functions in public expenditure management ........ 155
5.8.1 Legislation and public expenditure management ........ 155
5.8.2 Procurement and supply chain management ........ 156
5.8.3 Implications for the quantitative phase ........ 158
5.9 Theme 4: Management and personnel issues ........ 159
5.9.1 Management Attributes ........ 159
5.9.2 Personnel attributes ........ 160
5.10 Theme 5: Improvement strategies ........ 162
5.10.1 Improving funding in public district hospitals ........ 162
5.10.2 Public expenditure management improvement strategies ........ 164
5.10.3 Implications for the quantitative phase ........ 168
5.11 Chapter summary ........ 169

**CHAPTER 6: QUANTITATIVE DATA ANALYSIS AND DISCUSSION OF FINDINGS** ........ 170
6.1 Introduction ........ 170
6.2 Respondents' demographics – descriptive statistics ........ 171
6.2.1 Demographic profile of study respondents ........ 171
6.2.2 Districts where respondents are based ........ 172
6.2.3 Gender of study respondents ........ 173

6.2.4 Age group of the respondents ... 173
6.2.5 Designation of the respondents ... 174
6.2.5 Years the respondents have been in service ... 174
6.2.6 Highest qualification of the respondents ... 175
6.3 Principal component analysis ... 175
6.3.1 Factor analysis ... 176
6.3.2.1 Resource allocation challenges ... 182
6.3.2.2 Staff challenges ... 183
6.3.2.3 Financial management challenges ... 184
6.3.2.4 Political challenges ... 185
6.3.2.5 Legislative weaknesses ... 185
6.3.2.6 Procurement and supply chain management challenges ... 186
6.3.2.7 Management issues ... 187
6.3.2.8 Strategies for improved funding in the public district hospitals ... 188
6.3.2.9 Strategies for effective management of public expenditure ... 188
6.4 Descriptive statistics for research variables ... 189
6.4.1 The funding situation in the public health delivery sector in Malawi ... 189
6.4.1.1 Funding sources ... 189
6.4.1.1.1 Government funding ... 190
6.4.1.1.2 Donor funding/ funding from implementing partners ... 191
6.4.1.1.3 Council funding ... 191
6.4.1.1.4 Funding from patients' contributions ... 192
6.4.1.2 Challenges/limitations faced with the funding sources ... 193
6.4.1.2.1 Inadequate financial resources ... 193
6.4.1.2.2 Late government funding ... 194
6.4.1.2.3 Declining donor funding ... 194
6.4.1.2.3 Inadequate government funding ... 195
6.4.1.2.4 Donor funding is provided with specific instructions for its use ... 196
6.4.1.2.5 Weak income generation capacity of Councils ... 197
6.4.2 Resource allocation challenges ... 197
6.4.2.1 Inadequate financial resources ... 197
6.4.2.2. Late government funding ... 198

6.4.2.3 Misallocation of resources ..... 198
6.4.2.4 Budget planning and preparation suffer from burdensome requirements arising from underfunding ..... 199
6.4.3 Staff challenges ..... 200
6.4.3.1 Staff shortages compromise processing of transactions and reporting ..... 200
6.4.3.2 Staff shortages cause irregular deployment of personnel ..... 200
6.4.3.3 Staff incompetence ..... 201
6.4.3.4 Lack of performance appraisal ..... 202
6.4.3.5 Delays in disciplining staff ..... 202
6.4.3.6 Corrupt employees ..... 203
6.4.3.7 Lack of staff morale ..... 204
6.4.3.8 Lack of staff integrity ..... 204
6.4.3.9 Poor rapport with colleagues and superiors ..... 205
6.4.4 Financial management challenges ..... 205
6.4.4.1 Excessively complicated administrative procedures ..... 205
6.4.4.2 Poor control of expenditures ..... 206
6.4.4.3 Weak financial management system ..... 206
6.4.4.4 Lack of compliance with set procedures ..... 207
6.4.4.5 Weaknesses in financial reporting ..... 207
6.4.4.6 Inadequate flow of information ..... 208
6.4.4.7 Weak capacity in external and internal audit functions ..... 208
6.4.5 Political challenges ..... 209
6.4.5.1 Directives from central government to the hospitals ..... 209
6.4.5.2 Lack of political will ..... 210
6.4.5.3 Partial decentralisation of Councils ..... 210
6.4.5.4 Hospitals are managed by both the Council and Ministry resulting in dual management ..... 211
6.4.6 Legislative weaknesses ..... 211
6.4.6.1 Lack of compliance with legislative provisions ..... 211
6.4.6.2 Legislative provisions for penalties are not deterrent enough ..... 212
6.4.6.3 Legal provisions have inconsistencies ..... 213
6.4.6.4 Legal provisions have loopholes ..... 213

6.4.6.5 Legal framework is neither clear nor comprehensive ........ 214
6.4.6.6 There is weak monitoring of compliance of legal provisions ........ 214
6.4.6.7 There is weak enforcement of legal provisions ........ 215
6.4.7 Management challenges ........ 215
6.4.7.1 There is lack of fiscal discipline by management ........ 215
6.4.7.2 Management is not accountable to expenditure of public funds ........ 216
6.4.7.3 There is lack of monitoring of finances ........ 216
6.4.7.4 Management does not consult on resource allocations ........ 217
6.4.7.5 There is no autonomy over finances ........ 217
6.4.8 Procurement and supply chain management challenges ........ 218
6.4.8.1 Compromised procurement function ........ 218
6.4.8.2 Funding challenges affect compliance to procurement plans ........ 218
6.4.8.3 Centralisation of some procurements ........ 219
6.4.8.4 Poor procurement planning and budgeting ........ 219
6.4.8.5 Lack of effective supervision and monitoring ........ 220
6.4.8.6 Poor stock management ........ 220
6.4.8.7 Increasing prices constrain budget resources ........ 221
6.4.8.8 Strict procurement regulations ........ 221
6.4.9 Strategies for improved funding ........ 222
6.4.9.1 Introducing fee paying sections in the hospitals ........ 222
6.4.9.2 Lobbying for increased budgetary allocation ........ 222
6.4.9.3 Enhance revenue generating capacity of hospitals/Councils ........ 223
6.4.9.4 Charging additional taxes on alcohol and cigarettes and committing the funds generated to public health service delivery ........ 224
6.4.9.5 Introducing national health insurance schemes ........ 224
6.4.9.6 Entering into public private partnerships ........ 225
6.4.10 Public expenditure improvement strategies ........ 225
6.4.10.1 Improve the formula used in allocating government funding to hospitals ........ 225
6.4.10.2 Enhance capacity of oversight functions ........ 226
6.4.10.3 Provide training to staff ........ 226
6.4.10.4 Enhance cost cutting in non-priority areas ........ 227
6.4.10.5 Enhance use of ICT in production of reports ........ 227

6.4.10.6 Consult on budget and funds allocation ... 228
6.4.10.7 Increase funding for hospitals ... 228
6.4.10.8 Hospitals should be able to easily move funds from one budget item to the other due to the nature of their operations ... 229
6.4.10.9 Full devolvement from Central government to District Councils ... 229
6.4.10.10 Improve quality and availability of financial information to monitor public spending ... 230
6.4.10.11 Foster constructive dialogue with the civil society ... 230
6.4.10.12 Strengthen the performance management system ... 231
6.5 Chapter summary ... 232

**CHAPTER 7: A FRAMEWORK FOR PUBLIC EXPENDITURE MANAGEMENT FOR THE PUBLIC HEALTHCARE DELIVERY SECTOR IN MALAWI ... 233**
7.1 Introduction ... 233
7.2 A review of public expenditure management framework ... 233
7.3 The framework: A fusion of qualitative and quantitative results ... 235
7.3.1 The government ... 237
7.3.2 The Council and hospital management ... 238
7.3.3 Improved funding ... 239
7.3.4 Financial management ... 240
7.3.5 Personnel ... 241
7.3.6 Oversight functions ... 242
7.3.9 Enhanced public expenditure management in the public health service delivery sector ... 244
7.5 Chapter summary ... 244

**CHAPTER 8: KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS ... 246**
8.1 Introduction ... 246
8.2 Research problem – revisited ... 246
8.3 Research questions and objectives - revisited ... 247
8.4 Conclusions from the qualitative results ... 249
8.5 Conclusions from quantitative findings ... 251

8.6 Contributions of the study ........ 256
8.6.1 The Institutional level (practitioners) ........ 256
8.6.2 The public ........ 257
8.6.3 Policy level ........ 257
8.6.4 Research level ........ 258
8.6.5 Contribution to future research ........ 258
8.7.6 Contribution to new knowledge ........ 258
8.8 Limitations of the study ........ 259
8.9 Recommendations for future work ........ 259
8.10 Implications for future study ........ 261
8.11 Chapter summary ........ 261

REFERENCES ........ 262
ANNEXURE A: DATA COLLECTION TOOL - RESEARCH INTERVIEW GUIDE ........ 275
ANNEXURE B: DATA COLLECTION TOOL – QUESTIONNAIRE ........ 278
ANNEXURE C: ETHICAL CLEARANCE FROM NORTH-WEST UNIVERSITY ........ 288
ANNEXURE D: ETHICAL CLEARANCE FROM THE MALAWI NATIONAL COMMISSION ON RESEARCH IN THE SOCIAL SCIENCES AND HUMANITIES ........ 289
ANNEXURE E: INFORMED CONSENT FORM – QUALITATIVE PARTICIPANTS ........ 291
ANNEXURE F: INFORMED CONSENT FORM – QUANTITATIVE RESPONDENTS ........ 293
ANNEXURE G: PLAGIARISM TURNITIN REPORT ........ 295
ANNEXURE H: CONFIRMATION CERTIFICATE FROM THE EDITOR ........ 301

## LIST OF TABLES


Table 4. 1: Comparative studies and related research strategies ............................................96
Table 4. 2: Study population breakdown ..........................................................................101
Table 5. 1: Demographics for research participants .........................................................116
Table 5. 2: Themes and sub-themes..................................................................................118
Table 5. 3: Themes and research objectives.....................................................................119
Table 5. 4: Specific research objectives matrix..................................................................120
Table 5. 5: Themes and sub-themes from the thematic analysis.......................................120
Table 6. 1: Respondents demographic profile ...................................................................172
Table 6. 2: KMO values.....................................................................................................176
Table 6. 3: Commonalities ................................................................................................177
Table 6. 4: Cronbach Alpha reliability analysis ..................................................................179
Table 6. 5: Component matrix ...........................................................................................180
Table 6. 6: Descriptive Statistics for expenditure management for public health delivery sector in Malawi ...............................................................................................................182
Table 6. 7: Likert scale: Resource allocation challenges ...................................................182
Table 6. 8: Likert scale: Staff challenges ...........................................................................183
Table 6. 9: Likert scale: Financial management challenges...............................................184
Table 6. 10: Likert scale: Political challenges ....................................................................185
Table 6. 11: Likert scales: Legislative weaknesses ............................................................185
Table 6. 12: Likert scales: Procurement and supply chain management challenges ...............186
Table 6. 13: Likert scales: Management issues...................................................................187
Table 6. 14: Likert scales: Strategies for improved funding .................................................188
Table 6. 15: Likert scales: Strategies for effective management of public expenditure ............188
Table 6. 16: Inadequate financial resources.......................................................................198
Table 6. 17: Late government funding................................................................................198
Table 6. 18: Misallocation of resources ..............................................................................199
Table 6. 19: Budget planning and preparation.....................................................................200
Table 6. 20: Staff shortages compromise processing of transactions and reporting ...............200
Table 6. 21: Staff shortages cause irregular deployment of personnel ...................................201
Table 6. 22: Staff incompetence..........................................................................................202
Table 6. 23: Lack of performance appraisal ........................................................................202
Table 6. 24: Delays in disciplining staff ..............................................................................203
Table 6. 25: Corrupt employees .........................................................................................203
Table 6. 26: Lack of staff morale ........................................................................................204
Table 6. 27: Lack of staff integrity.......................................................................................205
Table 6. 28: Poor rapport with colleagues and superiors.......................................................205
Table 6. 29: Excessively complicated administrative procedures ...........................................206
Table 6. 30: Poor control of expenditures.............................................................................206
Table 6. 31: Weak financial management system .................................................................206
Table 6. 32: Lack of compliance with set procedures ............................................................207
Table 6. 33: Weaknesses in financial reporting .....................................................................208
Table 6. 34: Inadequate flow of information..........................................................................208

Table 6. 35: Weak capacity in external and internal audit functions........................................209
Table 6. 36: Directives from central government to the hospitals to undertake unplanned activities.........................................................................................................................209
Table 6. 37: Lack of political will...........................................................................................210
Table 6. 38: Partial decentralisation of Councils.....................................................................211
Table 6. 39: Dual hospital management..................................................................................211
Table 6. 40: Lack of compliance to legislative provisions .......................................................212
Table 6. 41: Legislative provisions for penalties are not deterrent...........................................212
Table 6. 42: Legal provisions have inconsistencies.................................................................213
Table 6. 43: Legal provisions have loopholes.........................................................................213
Table 6. 44: Legal framework is neither clear not comprehensive...........................................214
Table 6. 45: Weak monitoring of compliance of legal provisions ............................................214
Table 6. 46: Weak enforcement of legal provisions.................................................................215
Table 6. 47: Lack of fiscal discipline by management.............................................................216
Table 6. 48: Management not accountable ............................................................................216
Table 6. 49: Lack of monitoring of finances............................................................................217
Table 6. 50: Management does not consult............................................................................217
Table 6. 51: Lack of autonomy over finances..........................................................................218
Table 6. 52: Compromised procurement function....................................................................218
Table 6. 53: Funding challenges affect compliance to procurement plans...............................219
Table 6. 54: Centralisation of some procurements ..................................................................219
Table 6. 55: Poor procurement planning and budgeting...........................................................220
Table 6. 56: Lack effective supervision and monitoring ...........................................................220
Table 6. 57: Poor stock management.......................................................................................221
Table 6. 58: Increasing prices constrain budget resources......................................................221
Table 6. 59: Strict procurement regulations..............................................................................222
Table 6. 60: Introducing fee paying section in the hospitals .....................................................222
Table 6. 61: Lobbying for increased budgetary allocation.........................................................223
Table 6. 62: Enhance revenue generation capacity of Councils ...............................................223
Table 6. 63: Charging additional taxes .....................................................................................224
Table 6. 64: Introducing national insurance health schemes ....................................................225
Table 6. 65: Entering into public private partnerships...............................................................225
Table 6. 66: Improve formula used in allocating government funding to hospitals ...................226
Table 6. 67: Enhance capacity of oversight functions...............................................................226
Table 6. 68: Provide training to staff..........................................................................................227
Table 6. 69: Enhance cost cutting in non-priority areas.............................................................227
Table 6. 70: Enhance use of ICT in production of reports.........................................................228
Table 6. 71: Consult on budget and funds allocation.................................................................228
Table 6. 72: Increase funding for hospitals.................................................................................229
Table 6. 73: Hospitals should be able to move funds ................................................................229
Table 6. 74: Full devolvement of authority from central government to District Councils .........230
Table 6. 75: Improve quality and availability of financial information to monitor public spending ......................................................................................................................................230
Table 6. 76: Foster constructive dialogue with civil society........................................................231

Table 6. 77: Strengthen the performance management system ..............................................231
Table 8. 1: Research questions matched with research objectives..........................................248
Table 8. 2: Research questions answered and objectives addressed .....................................248

## LIST OF FIGURES

Figure 1. 1: Funds flow diagram for the Malawi healthcare delivery sector ................................. 6
Figure 2. 1: Basic public financial management system ............................................................16
Figure 2. 2: The financial public management system ...............................................................17
Figure 2. 3: Sustainable financing for health goals ....................................................................19
Figure 3. 1: A conceptual framework for public expenditure management on public health service delivery in Malawi ..........................................................................................................52
Figure 7. 1: Expenditure management cycle ............................................................................234
Figure 7. 2: A framework for expenditure management in public healthcare service delivery sector in Malawi .....................................................................................................................237

## LIST OF ABBREVIATIONS

| **Abbreviation** | **Meaning** |
|---|---|
| CMST | Central Medical Stores Trust |
| DHMT | District Health Management Team |
| DHSS | Director of Health and Social Services |
| DIP | District Implementation Plan |
| IFMIS | Integrated Financial Management Information System |
| IMF | International Monetary Fund |
| LMIC | Low and Medium-Income Countries |
| MoFED | Ministry of Finance, Economic Planning and Development |
| MoH | Ministry of Health |
| PCA | Principal Component Analysis |
| PEFA | Public Expenditure and Financial Management |
| PEM | Public Expenditure Management |
| PFM | Public Finance Management |
| QUAL-QUAN | Qualitative-quantitative |
| QUAN-QUAL | Quantitative-qualitative |
| UHC | Universal Health Coverage |
| UNICEF | United Nations Children's' Emergency Fund |
| UNGA | United Nations General Assembly |
| WHO | World Health Organisation |

# CHAPTER 1: GENERAL OVERVIEW OF THE STUDY

## 1.1 Introduction

This is a study of expenditure management in public healthcare service delivery sector in Malawi. This study purports to design a framework to improve management of expenditure in public healthcare delivery sector in Malawi. The need for the framework arises because, despite efforts by governments to regulate and introduce reforms in the management of public finance and public procurement, cases of financial mismanagement and inefficiencies still arise. Elsewhere, the lamentations are the same. For instance, Basheka and Phago (2014:154) point towards financial inefficiencies in public expenditure management in South Africa, despite the fact that public finance management is highly legislated. This state of affairs implies that legislation alone is not enough to ensure that public finances are efficiently and effectively managed. As such, there is need to look into the public financial resource management environment and come up with ways for improvements.

Notwithstanding initiatives made in the area of public financial management, researchers bemoan the lack of effective and efficient use of public finances in the public sector in general and the health sector in particular. For example, Ashiabi *et al.* (2016:1396) found that there is need for Sub-Saharan African governments to increase expenditure in the public healthcare sector for improved outcomes; however, the authors hold that increased funding alone will not achieve improved quality in healthcare service delivery; but rather the sector should look into 'misallocation and poor management', of financial resources. Accordingly, governments in this part of Africa need to find ways of enhancing resource utilisation since if the current status is not rectified, not much effect will be experienced in the sector, regardless of how much funding is pumped in. In addition, Cashin *et al.* (2017:13) stress that availability of funding is one thing, but how the finances are handled to ensure that desired goals are achieved is crucial for institutions, and accordingly, emphasise on the need for equitable and efficient use of financial resources. It then follows that, for the achievement of public goals, focus should be on how the available funds are handled. This study, therefore, zeros-in on public expenditure management in the public healthcare delivery sector in order to map expenditure management improvements.

The need for improved expenditure management is vital as governments struggle with the constrained resource environments in which they operate. According to Cashin *et al.* (2017:3), the management of expenditure is extremely important in situations with limited monetary

resources, to ensure that there is value for money and that high quality services are offered to the public. These facts indicate that what governments should focus on, is the management of financial resources as that ensures that financial resources serve their intended purpose. Public expenditure management aims at maintaining monetary discipline, allocating and using resources in line with government priorities and promoting the efficient delivery of public services (Allen & Tommasi, 2001:19,20). Thus, governments should strive to manage their expenditure in order to achieve public goals. It is envisaged that the framework emanating from this study will lead to better management of public expenditure and provide answers that can assist with strategies to improve public expenditure management in the public healthcare service delivery sector which, consequently, leads to improved quality of services.

## 1.2 Contextualisation of the study

This study generally explores public financial management with a focus on expenditure management in the public healthcare service delivery sector in Malawi. According to Kioko *et al.* (2011:i113), scholars in the area of public administration and management acknowledge that financial resources support public organisations, but note that there is less research appreciation on how studying public financial management can inform theory, research, and practice in general public management. Consequently, this study contributes towards effective management of public resources in the public sector, thereby, making an impact on public sector goal achievement. Chu *et al.* (2019:33) state that as countries are bent to increase access to healthcare, there is need for robust, well-governed and financed health systems. Thus, availability of finances is essential for provision of public services. Furthermore, it is the goal of every government to be able to provide essential services like health and education for its people; but the challenge that governments face is to secure effective and efficient management of the finances. Yefriza (2015:147) points out that governments have a prominent role in providing funding to public hospitals. This bears out the point that, access to healthcare is a right of the citizens and it is the responsibility of the government to provide for the same. Provan and Milward (1995:27) hold that access to finances has an impact on the effectiveness of public service delivery and achievement of crucial public service delivery outcomes, but Kioko *et al.* (2011:i113) point out that there is little attention in research in the area.

Clearly, the vital role that finances play in service delivery cannot be disputed, and downplaying the essence of management of the financial resources is detrimental for service delivery. Piatti-Funfkirchen and Schneider (2018:336) bemoan the way the public sector handles its financial resources, which affect implementation of policies; and hence, reflect as to whether indeed

governments manage to attain efficiency, equity, quality, and accountability goals in the current resource management state. On the correct supposition that public financial resource management is generally poor, there may be little wonder as to the often astonishingly poor delivery in the public sector. Goryakin *et al.* (2017:8) identify credibility, transparency, reliability and efficiency of the budget process; as well as institutionalised internal controls and proper use of allocated funds as quality measures of public financial management. Accordingly, the management of public finances should be comprehensive, because there is a number of public sector objectives that have to be satisfied. Despite these attributes of ideal financial management, Basheka and Phago (2014:163) note that in Uganda, for example, the budget, which is an important tool in financial management, was untrustworthy which increased the risk that financial goals would not be achieved. Thus, noncompliance to set procedures in financial management is recipe for failure in public sector management. Leruth and Paul (2007:104) conclude that a good expenditure management system is crucial for financial efficiency in the public sector. This entails that if the public sector is to achieve its goals, then it should focus on managing its financial resources. Fritz *et al.* (2014:8) explain that a good public management system purports to improve financial discipline, enhance efficiency on resource allocations with emphasis on priority identifications and achieve operational efficiency that eliminate financial leakages. Thus, ideal public financial management results in comprehensive achievement of goals. Expenditure management relates to the efficient and effective use of resources which is the focus of this study.

Hospitals in the public health sector of developing countries consume large amounts of resources due to the continent's disease burden and reliance on public services by the poor public who cannot afford to pay for private care. For instance, for the year 2018/2019, Malawi contributed on average 9.75 percent of its national budget, but still posted poor health outcomes (UNICEF, 2019:1,4). Inasmuch as it is appreciated that financial resources were committed for healthcare delivery, the non-achievement of health outcomes may be due to inadequate funding coupled with poor management of finances. Anselmi *et al.* (2018:27) proclaim that if health institution administrators were efficient, resource availability would be enhanced. This entails that improved efficiency of financial resource utilisation would free resources for service delivery. There are claims that, apart from health delivery systems being big consumers of public resources, many developing countries are inefficient (Grigoli & Kapsoli, 2018:385; Musgrove, 1996:6; Zere *et al.*, 2001:337). Clearly, it is the management of the resources that is crucial as there is always a limit as to how much finances a government can pump in for service delivery; as such, countries should improve on effectiveness and efficiency in resource use.

Furthermore, Grigoli and Kapsoli (2018:397) point out that there is spending inefficiencies in emerging and developing countries and as a result they report low outputs and outcomes on health. This leads to the conclusion that if the available resources were to be used efficiently even if they were limited, countries would see some improvements in their health outcomes. Van Wyk (2004:411) stresses that financial management systems in the public sector aim at supporting the management of economic and efficient utilisation of resources, which he argues, ensures delivery of outputs. These facts indicate that for the public sector; economic, efficient and effective use of resources is crucial for the attainment of public goals. With the above in mind, Obiwuru *et al.* (2011:101) note that the degree to which organisational staff handle resources rely among others as well as managers' leadership styles; the authors conclude that efficiency in mobilising, allocating and utilising financial resources is to a large degree a function of leadership. Thus, enhancements aimed at improving management of finances should include the management level, and not only focus on the operational level. Ruiz *et al.* (2019:96) note that although attaining effective and sustainable spending on health by governments is a daunting task, improved governance and harmony between ministries of finance and health is necessary as both ministries strive to achieve budgetary control and having a healthier nation respectively. Thus, calls for coordination between these two crucial players is vital. The observations presented herein, point to the need to ensure efficiency in the use of the available funds; otherwise, the current status in public financial management in the health sector will continue to have a negative impact on service delivery and the achievement of goals.

The Malawi Public Finance Management Act of 2003 fosters and enhances effective and responsible economic financial management and adherence to fiscal discipline. A supporting legislation is the Public Procurement and Disposal Act No. 27 of 2017 as the allocated resources cater for procurement of goods and services, hence, the efficiency with which the goods are procured, and their subsequent logistics management is crucial. Implicitly, the various pieces of legislation regulate the entire cycle of funds management, from revenue generation to use of the funds. In short, what happens in the process of handling public resources is important for ensuring that such resources have been used for the purposes they were meant.

Despite instituting measures aimed at ensuring effective and efficient use of financial resources, mismanagement of the same in the public sector has been noted due to varying reasons. For example, Rangongo *et al.* (2016:1) discovered that there is rampart public financial mismanagement in public education institutions in South Africa, citing lack of "knowledge of

legislation and skills, poor monitoring and control of funds, unavailability of financial policies in schools, not acting against culprits, and lack of honesty, openness and trustworthiness".

Given that there is poor management of public finances, it is imperative for governments to do more in ensuring improved management of public resources. Specifically, for the public health sector, Cashin *et al.* (2017:14) argue that there is need for a sound understanding between the health and finance functions in order to appreciate each other's positions. This is said in light of the revelation that a lack of relatable measures and expectations of spontaneous results on health spending suggest ineffectiveness and inefficiency in the public health sector. Furthermore, Cashin *et al.* (2017:14) point out that variations in public spending reveals difficulties in forecasting health expenditure. It is worth exploring, therefore, that with the reforms being introduced to improve public financial management, why is it that public finance management inefficiencies still occur? This study analysed the expenditure management situation in the public healthcare delivery sector of Malawi and explored suggestions towards efficient utilisation of finances with a view to improve on delivery of public health services.

## 1.3 The Malawian public healthcare delivery sector context

### 1.3.1 The Malawian public healthcare delivery system structure

The Constitution of the Republic of Malawi guarantees Malawians "access to adequate and equality to health care". This is enshrined in the constitution of the Republic of Malawi, where it is stated that it is the government's obligation "to provide adequate health care, commensurate with the health needs of Malawian society and international standards of healthcare". In Malawi, the Ministry of Health (MoH) is responsible for all health-related matters including delivery of health services and training of health personnel. The Ministry of Health is linked with the Ministry of Finance, Economic Planning and Development (MoFED) as it receives funding and directions on all matters related to financial management.

The delivery of public healthcare services takes place in levels: community, primary, secondary and tertiary. These are connected to each other through a referral system (cf. Ministry of Health (2017a:2); whilst Makwero (2018:2) recognises three tiers: primary, secondary and tertiary. This author incorporates the community level into the primary level.

The focus of the present study is public expenditure management at the district hospital level, which incorporates all the levels excluding the tertiary level. The tertiary level caters for the central

hospitals and they command different management structures from the secondary level. The primary and secondary levels are in the management of district councils headed by District Commissioners (Ministry of Health, 2017a:2). In this set-up, the Director of Health and Social Services (DHSS) is in charge of healthcare at district level and reports to the District Commissioner. Borghi *et al.* (2018:61) illustrate the flow of funds for the decentralised public healthcare service delivery sector in Malawi, which depicts multiple funding sources for the health sectors (figure 1.1).

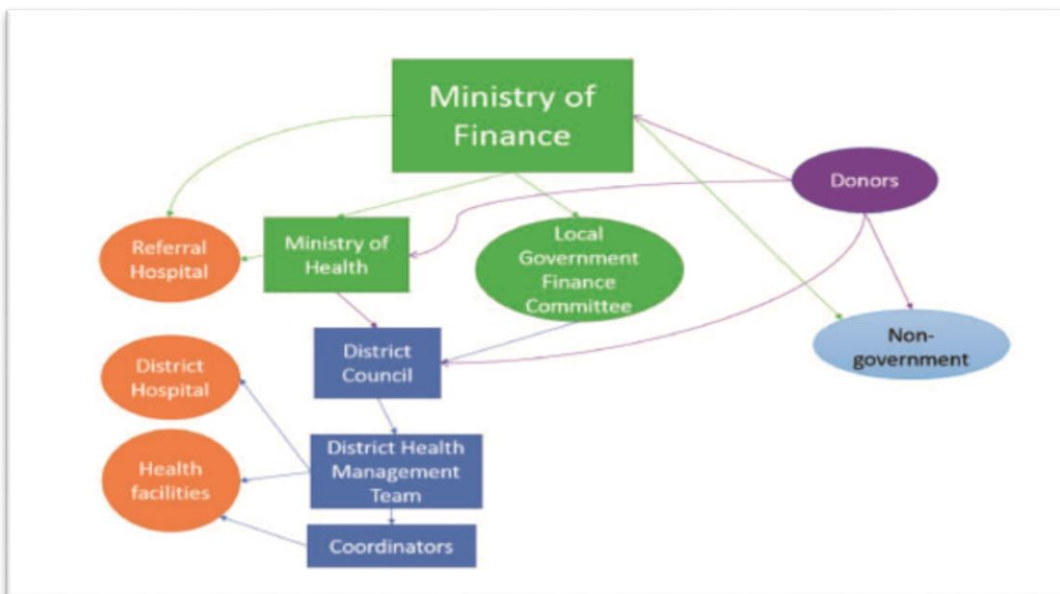



**Figure 1. 1: Funds flow diagram for the Malawi healthcare delivery sector**

**Source:** Borghi *et al.* (2018:61)

The funds flow diagram in Figure 1.1 indicates that in the decentralised health service delivery structure, finances stem from donors and the government to the district councils. The District Health Management Team is responsible for hospital management including financial resources at the district level. According to Borghi *et al.* (2018:60), Malawi decentralised financing and management of public healthcare at district level and that the District Health Management Teams (DHMT) manage healthcare in each district and annual plans and budgets are produced in liaison with the communities. Clearly, decentralising healthcare service provision was meant to move away from the challenges experienced when there was central control and enjoy the benefits of a decentralised setup. With the disintegrated system, the districts have a greater degree of control over planning and budgeting, however, Cashin *et al.* (2017:26) claim that with the decentralised

setup it is hard for the central government to confirm that funds are utilised for their purported objectives. Notwithstanding the claims made by Cashin *et al.* (2017:26), the disintegration of health systems has been applauded for improved planning in the health sector; addressing budgeting issues through community involvement; accountability and technical efficiency in the management of resources (Tsofa *et al.*, 2017:151). With the aforesaid in mind, one sees that decentralised management structures have contributed to improved management efficiencies.

According to Akortsu and Abor (2011:128), the economic development of a country is dependent on the health status of its people. In that vein, the Malawian Government holds that a healthy population is a key player for socio-economic development, and thus, improved health outcomes are not only essential but also a prerequisite for increased national productivity, accelerated economic growth and poverty reduction (Malawi Government, 2017:18). Thus, it is anticipated that social and economic development of any country can be achieved if the public is healthy. Accordingly, the Malawian Government aims at increasing quality and equitable access to healthcare services (Ministry of Health, 2017a:27). It follows that, to achieve a healthy nation, there is need to enhance accessibility to healthcare.

The Ministry of Health has pointed out that public healthcare service delivery does not always meet the expectations of the public (Ministry of Health, 2017a:27). This infers that health outcomes are yet to be achieved. The Malawian Government observes that despite improvements in accessing healthcare, the public healthcare service delivery sector is challenged with limited access to health care services; low quality of health services that are on offer to clients, which directly leads to compromised effective care; and inefficiencies in the healthcare delivery system (Ministry of Health, 2017a:27). In short, the managerial and operational environment in public health delivery service provision in Malawi is handicapped. The government alludes these challenges to among other factors; inadequate financial resources, misallocation and inefficiencies in the utilisation of financial resources in the sector (Ministry of Health, 2017b:14). Thus, deficiencies in resource utilisation has led to poor quality health service delivery in Malawi. The interest of this study was to explore deficiencies in the area of expenditure management.

### 1.3.2 Legislative framework governing public finance management

The public finance management is governed by the Public Finance Management Act of 2003. The Public Finance Management Act aims at instilling discipline in financial management in the

way public revenue is generated, accounted for and utilised. Generally speaking, the Public Finance Management Act 2003 of Malawi is "an Act to foster and enhance effective and responsible economic financial management by the government." The Public Finance Management Act purports to enforce accountability of managers in resource utilisation in service delivery. Thus, there is legislative machinery in place to direct the management of public finances, the effective implementation of the Act is crucial for public goal achievement.

Likewise, Tsheletsane and Fourie (2014:43) bemoan the many cases of poor financial management despite the availability of legal instruments to govern effective financial management. This entails that there is more to enhance management of finances than merely having legislation in place. In support of these sentiments, Ibrahim *et al.* (2017:370) found that having a legal and regulatory framework is not a guarantee that there will be compliance to the legal provisions. As part of public financial management reforms, Malawi automated the financial management system and introduced public procurement legislations to guide on procurement of goods and services in the public sector. Thus, the significance of the procurement function in the public sector necessitated the enactment of its own legislation, the Public Procurement and Disposal Act (2017). Boe and Kvalvik (2015:871) rightly claim that regulating public procurement allows a country to make efficient use of resources. Clearly, public procurement management supports public financial management as they share the same values of effectiveness, economy, efficiency and value for money when undertaking transactions. To a large extent, Malawi's health sector uses public funds for provision of public services; that is probably why the manner in which public financial management is done attracts public attention.

### 1.3.3 Financial resource utilisation in the Malawi public healthcare delivery sector

S2 of the Public Financial Management Act (2003) stipulates that internal controls are measures that ensure among other functions that there is: "effective and efficient management of financial resources; no wastage or extravagance with respect to public resources and public resources are employed in an effective and efficient manner". However, fiduciary and financial management risks in the public health sector are high on the risk management matrix (Ministry of Health, 2017a:56). This entails that resources allocated to support delivery of public health do not all get where they were intended to, thereby, compromising service delivery. For instance, Abiiro *et al.* (2014:5) found out that drug shortages are caused by mismanagement of drugs by health personnel and inadequate supplies by the central drug distributing unit. This could infer that internal controls over drugs were weak. Kakumba (2008:184) posits that effective controls in

public sector management results in prudent resource utilisation, improved responsiveness; transparency and accountability. The notion of control, he holds, decreases wastage of both human and material resources. Thus, designing and implementing financial controls effectively would allow the public sector to manage public resources and respond to public goals satisfactorily. Boateng (2014:547) argues that it is not the increased funding that is wholly responsible for improved results, but rather better management of available funds to ensure that funds are allocated to priority areas and have been used for their specific purpose. It follows that, even if the resources were inadequate, institutions can still go a long way towards goal achievement if there was proper management of resources.

Ashiabi *et al.* (2016:1396) explain that Sub-Saharan African governments strive to improve on their health funding in line with the Abuja declaration; however, the authors hold that simply increasing funding is not enough to achieve health goals. Rather, countries should deal with the misallocation and poor management of resources. In other words, often finances are not the problem, but the manner in which the available resources are managed is crucial. Cashin *et al.* (2017:41) point out that there is need for coordination between the public finance management and health systems for improved use of public funds and sustain advancement for sustainable Universal Health Coverage (UHC). For the reasons that both financial management and health systems are concerned with attainment of goals, a synchronisation of decisions and activities in this regard would be beneficial.

It can be argued that though Malawi's public finance management system is regulated; the country experiences shortfalls in the way its finances are managed. In as much as it is crucial to have adequate financial resources in order to deliver public services, it is even more salient that the available resources are properly managed so that they serve the public in the best way possible.

### 1.4 Research problem

The public health delivery sector in Malawi is marred by financial management deficiencies relating to funding; wastage and leakages; and budget formulation and implementation. Sub-Saharan African countries experience highest levels of inefficiencies compared to other regions of the world (Grigoli & Kapsoli, 2018:397; Makuta & O'Hare, 2015:933). In Malawi, the public health sector is said to be less efficient in resource use when delivering public health services (International Monetary Fund, 2018; World Bank, 2017:2).

Government spending in the health sector is inadequate to satisfy health needs (Mbuya-Brown & Sapuwa, 2015:1; UNICEF, 2019:16). Despite that budgetary allocations have been steady in nominal terms over the years, the real per capita has been declining (Piatti-Fünfkirchen *et al.*, 2020:iii). To a large extent, the sector is donor-funded as about 70% of public healthcare funding is from external providers (Borghi *et al.*, 2018:66). This degree of reliance on donors subjects the public healthcare services delivery sector to external shocks in cases of donor flight, World Bank (2013:19) as was the case in the financial mismanagement case dubbed 'the cash-gate scandal' (Kayuni, 2016:169). This entails that if there were a problem with the donors, service delivery would be greatly incapacitated. Moreover, although there is external funding to depend on, a great portion of the funding is already committed to selected diseases which means other areas of the sector are grossly underfunded (Carlson *et al.*, 2015:5; World Bank, 2017:14). Clearly, committing resources to a selected category of activities which excludes others, results in incomprehensive service delivery. Constrained funding in the public health sector leads to chronic shortages of hospital drugs, equipment and staff resulting in provision of poor quality services (Mussa & Masanjala, 2015:13,15). In addition, there are challenges of low staff morale which breeds absenteeism, corrupt practices and low performance (International Monetary Fund, 2018:7). Subsequently, it is the poor who are significantly affected as they are the ones who mostly seek public health services (Mbuya-Brown & Sapuwa, 2015:4; Mchenga *et al.*, 2017:30; Mussa & Masanjala, 2015:6; O'Hare & Curtis, 2014:133) thereby, compounding the disease burden in Malawi (World Bank, 2013:107).

With reference to the decentralised setup for the health sector, O'Neil *et al.* (2014:29) note that at the district level, planning and funding is uncoordinated, whilst financial planning and supervision is weak. The weaknesses experienced by the sector have an impact on service delivery as well as achievement of goals. The Ministry of Health (2017a:57) places disintegrated planning; budgeting and monitoring and evaluation systems at a very high risk. This entails that with the poor collaboration in planning, budgeting and supervisory functions; the impact on the public health sector would be very high. Furthermore, it is observed that the public health sector in Malawi face delayed financial disbursements; financial leakages and unsatisfactory reporting on finances and accountability (UNICEF, 2019:14). The issues raised herein point to public financial management compliance issues in the sector in relation to budgeting and expenditure management is challenged with.

The public health sector in Malawi is challenged with resource leakages and wastages. For instance, it is acknowledged that there is mismanagement and pilferage of resources in the health sector contributing to poor service delivery (Abiiro *et al.*, 2014:5; Ministry of Health, 2017a:56); shortfalls in public financial management and embezzlement of public finances (Mussa & Masanjala, 2015:16); and leakages and the high risk that allocated funds may not be used for their intended purposes (UNICEF, 2019:8). This means that allocated funds may not be utilised for their intended purposes. Hence, there is a need to improve on efficiency in terms of health expenditure. This can be achieved through strengthened financial reporting and accountability (UNICEF, 2019:1). Thus, improved spending efficiency results in achieving a set level of output with fewer resources or higher output with same resources that is, there is value for money, reduction of wastage of resources and fiscal discipline (International Monetary Fund, 2018:4). Accordingly, enhanced spending efficiency improves resource availability for set activities.

This study has been inspired by the finance management deficiencies and challenges that the public health sector in Malawi face, which include inadequate funding and financial management inefficiencies that arise in form of waste and fruitless expenditure; financial leakages, mis-procurement and theft. If the healthcare system were more efficient in resource management, more resources would be released into the system (Mbuya-Brown & Sapuwa, 2015:1; Twea, 2016:2). In view of the arguments made in this section, the present study evaluated the public resources management environment in the public health sector in Malawi and subsequently, developed a framework that could be used to enhance expenditure management.

### 1.5 Research questions

The study sought to answer the following research questions:

**RQ1.** What is the funding situation in the public healthcare delivery sector in Malawi?

**RQ2.** What factors deter role players in public healthcare delivery sector in Malawi to achieve optimum expenditure management?

**RQ3.** To what extent can budgetary systems in public healthcare delivery sector be utilised in the effective management of expenditure?

**RQ4.** How can efficiency in utilisation of financial resources in public healthcare delivery sector in Malawi be enhanced?

## 1.6 Specific research objectives

The main aim of the study was to develop a framework aimed at improving expenditure management in the public healthcare service delivery sector in Malawi. In order to achieve the study aim, the following specific objectives were pursued:

**Objective 1.** Determine the funding situation in the public healthcare delivery sector in Malawi.

**Objective 2.** Ascertain factors that influence optimisation of expenditure management in the public healthcare delivery sector in Malawi.

**Objective 3.** Establish the extent to which budgetary systems are utilised in the effective management of expenditure in the public healthcare delivery sector in Malawi.

**Objective 4.** Explore ways of enhancing efficiency in utilisation of financial resources in the public healthcare delivery sector in Malawi.

## 1.7 Justification for the study

The study area was inspired by various reasons. According to Makuta and O'Hare (2015:933), Sub-Saharan Africa reports the worst outcomes on health and is less efficient in translating expenditures on health into health outcomes. Thus, the poor health outcomes in this part of the African region are associated with the continent's prevalent inefficacies. As the world has embraced a move towards achieving Universal Health Coverage (UHC), there is need to explore increasing health funding and improving the management of such funds. With reference to Malawi's public health sector, it was found that although there have been measures in Malawi to institute controls in form of regulations and other legislations, the implementation gaps are still wide (World Bank, 2017:5). This entails that there is need to improve the financial management environment with a view to address public service delivery goals. specifically, inefficiencies are noted in the utilisation of financial resources in the public health sector in particular (World Bank, 2017:2). This leads to the conclusion that the poor health outcomes in the healthcare sector in Malawi result from, among other factors, financial management lapses. Inasmuch as there have been efforts to provide solutions to public financial management by various studies, none has been identified on the improved public expenditure management in the region and Malawi specifically.

## 1.8 Scope of the study

This research focuses primarily on aspects that affect public expenditure management, that are consequently impacting service delivery in the public healthcare sector in Malawi. Among other considerations, the study presents an analysis of the funding environment in the public healthcare sector and the challenges faced in funding. The study also explores challenges that the public

expenditure management environment faces and sought to identify strategies aimed at addressing the challenges.

## 1.9 Organisation of the study

### 1.9.1 Chapter 1: Introduction

Chapter 1 provides the introduction and background of the research. The chapter articulates the study's research problem and formulates the main research question; the specific research questions and consequently, presents the specific objectives of the study. The chapter also provides the justification and scope for the study.

### 1.9.2 Chapter 2: Overview of public expenditure management and its theoretical frameworks

Chapter 2 discusses the terms public financial management and public expenditure management and links them with the objectives of the study. In addition, the chapter provides a framework of the relevant management theories and provides a link between the theories and public expenditure management in the healthcare sector, and shows how the theories support each other in enhancing the management function.

### 1.9.3 Chapter 3: Public expenditure management: Conceptual framework and experiences around the world

Chapter 3 commences with a conceptual framework of the study which brings the current public expenditure management conditions in the public health delivery sector and relates them to the study objectives. The chapter further discusses different public expenditure management experiences around the world, thereby, providing empirical evidence of public expenditure management issues in the public healthcare delivery sector that were raised in chapter 2.

### 1.9.4 Chapter 4: Research methodology

Chapter 4 explicates the research methodology of the study. It discusses the study's research philosophy, approach and its strategy. The chapter also outlines the population, sampling methods and study sample, data collection and analysis, validity and reliability issues and ethical considerations for the study.

### 1.9.5 Chapter 5: Qualitative results, analysis and discussion

Chapter 5 provides qualitative data analysis, presents and discusses the qualitative results of the study. The results of this chapter informed the quantitative data collection instrument in Chapter 6.

### 1.9.6 Chapter 6: Quantitative data analysis and discussion of findings

Chapter 6 provides the quantitative data analysis. It further presents and discusses the quantitative data results. The quantitative analysis includes univariate and principal component analysis (factor analysis).

### 1.9.7 Chapter 7: A framework for public expenditure management for the public healthcare delivery sector in Malawi

Chapter 7 develops and presents the public expenditure management framework for the public healthcare service delivery sector in Malawi. The framework incorporates all the suggestions emanating from the study.

### 1.9.8 Chapter 8: Key findings, conclusions and recommendations

Chapter 8 presents the key findings, research conclusions, recommendations and contributions of the study to the body of knowledge.

## 1.10 Chapter summary

Public sector management is challenged with financial challenges. The problem of constrained resources is more so an issue in the public health service delivery. The importance of a ticking and vibrant healthcare delivery sector is that a healthy nation is believed to bring economic development through increased productivity. With the realisation that financial resources will always be limited, the call has been that governments need to be efficient and effective in the use of the resources that are available. In the public sector, the budget has been seen as a tool that helps in managing financial resources as such, its management is of importance. It is, therefore, important that strategies aimed at improving management of public expenditure should be identified and implemented. In so doing, the financial resources allocated to the public healthcare delivery sector will contribute to the much sought-for health outcomes. Despite the legislative environment guiding utilisation of resources, reports indicate that the available finances are not used as efficiently and effectively as they would. As such, a framework is required to provide improved public expenditure management. It is envisaged that the framework will inform practice and policy on the best way that expenditure can be managed efficiently.

# CHAPTER 2: OVERVIEW OF PUBLIC EXPENDITURE MANAGEMENT AND ITS THEORETICAL FRAMEWORKS

## 2.1 Introduction

Chapter 2 purports to provide an overview of public expenditure management by reviewing literature on public financial management and linking it with public expenditure management, which is the focus of this study. The aim of this review is to assess the role of public financial management and public expenditure management on public healthcare service delivery, and consequently, explore the financial management deficiencies in the public healthcare sector. To understand the principle underlying public expenditure management and its role on public health service delivery, various management theories are discussed. This chapter further identifies and explains the theoretical relationship between public expenditure management and its effect on public service delivery in general and on public healthcare service delivery in particular. Lastly, the chapter examines Lüder's (1992) contingency model on financial management and links it with expenditure management in public healthcare service delivery.

## 2.2 Public financial management

Public financial management is regarded as the management of public finances and includes revenues as well as expenditures and the consequent impact of the finances on the public and/or the economy as a whole (Andrews *et al.*, 2014:2). As a management function, therefore, public financial management, entails undertaking the planning, organising, coordinating and controlling functions of financial resources. Additionally, Andrews *et al.* (2014:2) view public financial management as a system in which the parts of the system sequentially inform and support the other. With reference to figure 2.1, Andrews *et al.* (2014:2) state that public financial management system is in four stages: budget formulation, budget approval, budget execution and budget evaluation. What is clear is that budgeting and budget management is central to public financial management. Actually, budget management is less common in the discussion of public finances, and expenditure and financial management is more common instead (Huzaila-Majid & Singaravelloo, 2017:255). Thus, in public sector management, budget management and financial management address the same issues. The public financial management system as illustrated by Andrews *et al.* (2014:2) is centred on the budgetary process making it a crucial aspect in public financial management in general and expenditure management in particular. Thus, effective public financial management entails effective budget management.

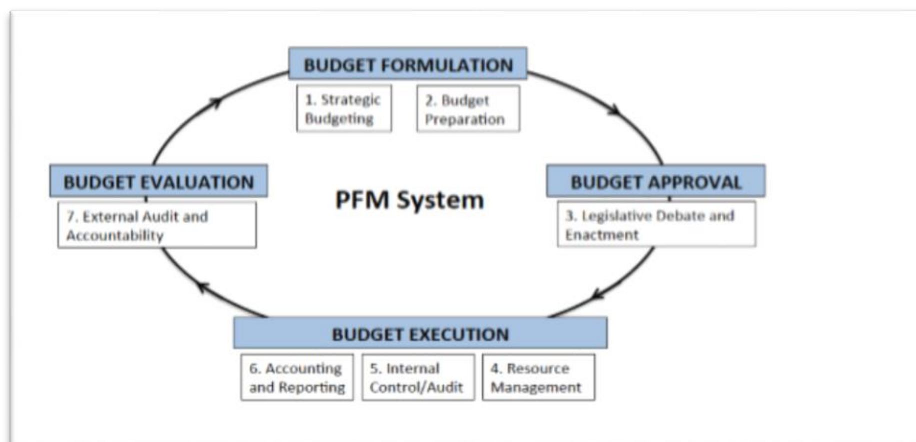



**Figure 2. 1: Basic public financial management system**

**Source:** Andrews *et al.* (2014:2)

Andrews *et al.* (2014:1) proclaim that structures of public financial management are a component of state policy procedures that strategically guide apportionments of public resources. The authors further note that, regardless of the differences in public financial management settings amongst countries, the broad public financial management procedures are similar. It follows that the notion of public financial management is familiar to most countries since their objectives are founded on similar basis, namely the effective and efficient provision of public services. For the most part, as summarised by Cashin *et al.* (2017:2) and represented in figure 2.2., a public financial management system involves budget formulating, executing and monitoring. These can be explained as looking into priority setting and funds allocation, budget usage and how payments are made, and exertion of control and accountability for resources. Thus, public financial management hinges on resource planning, utilisation and monitoring.

Piatti-Funfkirchen and Schneider (2018:336) view public financial management in the health sector as a chain of processes that are followed to effectively manage public health funds. Thus, public financial management is a mix of rules and procedures for the management of public funds. As Warsame and Ireri (2017:1) explain, a public financial management structure facilitates efficiency in the utilisation of financial resources and increases transparency and accountability in operations. This leads to the conclusion that the purpose of public financial management is the attainment of efficiency in the use of funds. The focus of the present study is, thus, on the utilisation of financial resources; in other words, expenditure management in the healthcare service delivery function of the public sector in Malawi.

The budget cycle is central to public financial management to ensure proper planning, execution and accountability of expenditure (Cashin *et al.*, 2017:9). It follows that the budget is a working tool in as far as public funds management is concerned. As illustrated in figure 2.2, Cashin *et al.* (2017:9) summarise the budget cycle into three steps thus, "budget formulation, budget execution and budget monitoring", wherein funding negotiations, allocations and disbursements made to government ministries are guided as well as ensuring that compliance with set regulations for management of finances is being adhered to. This entails that public financial management is well regulated with the purpose of safeguarding public resources, and hence, being able to provide public resources.

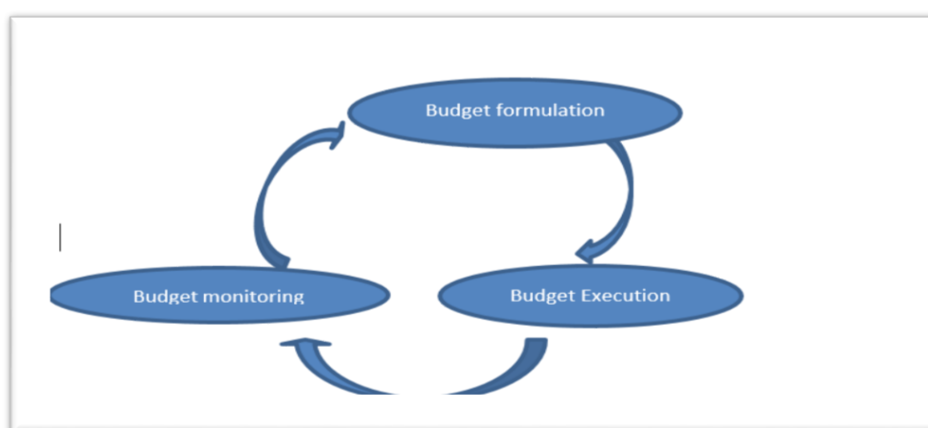



**Figure 2. 2: The financial public management system**

**Source:** Adapted from Cashin *et al.* (2017:9)

Andrews *et al.* (2014:7) explain that public financial management functions allow for prudency in making financial decisions; permit production of dependable budgets; ensure that financial resource flows are dependable and efficient; and guarantee that managers are accountable for the financial resources entrusted to them. The authors, however, realise that these public financial management functions have not always been effective in a number of countries, implying that there is still need for tailor made reforms aimed at perfecting quality and outcomes of public financial management in the public sector. This infers that public financial management practices must be improved in countries if governments were to enjoy better financial management. Furthermore, Andrews *et al.* (2014:10) note that the international community has an interest in the performance of public financial management in countries. To this end, it came up with various tools such as the Public Expenditure and Financial Management (PEFA) assessment tool. However, the authors note that these assessment tools are concerned with compliance with good

practice and not necessarily with what these practices are meant to achieve. This implies that for countries to achieve public financial management goals, they need to adjust their practices in line with the country's situation. It should be noted that no uniform approach to public financial management would achieve the desired results. Piatti-Funfkirchen and Schneider (2018:337) claim that a well-implemented public financial management system enhances operational efficiency and allows for the provision of quality services as well as accountability on behalf of service providers. In such a case, public financial management becomes an enabler in the provision and delivery of health services. Thus, public financial management enables the achievement of objectives if implemented properly. On the other hand, Piatti-Funfkirchen and Schneider (2018:337) view public financial management as a hindrance when there are poor controls in the budget and accounting systems that may allow leakages of resources and bottlenecks that negatively affect health service delivery. Accordingly, public financial management can actually be detrimental to goal attainment if poorly implemented. Improvements to an existing public financial management system are generally important, but more so to the public healthcare delivery sector, because it is inherently challenged with issues requiring flexibility in its quest to achieve efficiency, equity and quality service delivery (Cashin *et al.*, 2017:3). Thus, public financial management is vital in the achievement of public healthcare delivery sector goals and objectives if effectively aligned to the specific requirements of the sector.

Piatti-Funfkirchen and Schneider (2018:336) state that delivery of healthcare services relies on a number of issues ranging from financing (public or private or both); availability of infrastructure and human resources, management practices; and the culture of the organisation among other factors. Hence, financial inputs into the public healthcare service delivery sector are important for the attainment of goals, but effective resources management is crucial. It is the input side, specifically the finances of the healthcare service delivery sector, that is the focus of the present study. This is predicated on the correct supposition that inputs such as drugs, infrastructure, and utilities, among others, are necessary for service delivery and for them to be acquired, finances have to be available. Focusing on management of finances, Piatti-Funfkirchen and Schneider (2018:336) explain that public financial management influences service delivery in the health sector whilst contributing to the objectives of health systems like efficiency, equity, quality and accountability. Thus, the emphasis is on the effective management of financial resources for health service delivery. The presence of an effective public financial management system is every government's desire, because it is associated with stable economic environment, cost reduction, and best use of public financial resources (Bawole & Adjei-Bamfo, 2019:301). This notion

suggests that there is a relationship between a well operating public financial management environment and improvements in resource use. Cashin *et al.* (2017:3) note that Universal Health Coverage is at the heart of many governments. Furthermore, they argue that public finances are critical to the sustainability of service delivery; in that regard, a vibrant public financial management system is a necessity as it ensures more predictability of budget allocations, 'on-time execution' of budgets and improved accountability and transparency in the utilisation of finances. Therefore, public financial management is an enabler to public service delivery, because it is central to financial resource management. Cashin *et al.* (2017:7) stress that with public funds, it is not only the availability of funding that matter for the public health sector; but also ensuring that the funds are utilised effectively and efficiently so that the required health services benefit the deserving public. Thus, the emphasis on public financial management is not only based on the availability of finances to cater for operations, but to ensure that available funds are put to the best use and that the funds are well accounted for. This is better summarised in figure 2.3, where the availability of adequate finances, efficiency in resource utilisation and management of finances and its accountability are seen as ingredients for achieving health goals. Thus, if an aspect is missing from this component, service delivery leading to universal health goals is likely not to be achieved. Having realised the need for financial resources to be available, an equally crucial issue is to make sure that the resources are well managed.

**Figure 2. 3: Sustainable financing for health goals**

**Source:** Cashin *et al.* (2017:7)

Guess and Ma (2015:129) further hold that failures in public financial management may result in cash flow issues, huge debts and non-provision or compromised service delivery. This leads to the point that a vibrant public financial management system enhances financial operations and consequently, improve service delivery. Relating to Malawi, Cashin *et al.* (2017:18) reveal that

although there have been positive results enjoyed by the public healthcare sector in Malawi as a result of the introduction of various reforms aimed at improving quality and efficient service delivery, the major problem is achieving equity, effectiveness and efficiency in spending in the sector. Thus, countries should strive to ensure that spending has to be equitable, effective and efficient if they have to achieve enhanced service delivery. Kioko *et al.* (2011:i121) point out that public administration and management scholars are aware that finances have a crucial role in delivering services to the public and hence, the global financial challenges necessitate adjustments in the way the public sector plans and delivers public services as well as how it manages its finances. This supports the view that countries should ensure availability of finances for public service delivery, but more crucially see to it that the funds are properly managed. For instance, Chu *et al.* (2019:44) note that Western Pacific countries are challenged with complex resource use decisions in order to provide access to quality and affordable healthcare services. The authors further state that such decisions are extremely difficult to make, given the constrained resource environment in which they operate.

Clearly, financial resource management is intricate, because it is affected by a number of players who operate in complex environments. This study narrows its focus to public expenditure management which effectively determines management of funds and excludes funds generation in the public sector.

### 2.3 Public expenditure management and the public health sector

Ocheni and Agba (2018:156) explain that in general, public expenditure relates to how the operational and capital needs of a country are attended to. Thus, expenditure management addresses what the available funds are used for in an organisation to attain its objectives. Furthermore, Jaelani (2018:189) claims that public expenditure is an important tool for enhancement of a nation's welfare. It is necessary, therefore, to ensure that such expenditure is managed properly; hence, public expenditure management. Public expenditure management constitutes a series of financial management activities and involves resource allocation over budgetary processes; prudent and transparent budget implementation management; 'accounting, reporting and auditing' (Ocheni & Agba, 2018:156). This leads to the conclusion that budget management underlie public expenditure management and as such, budget management is important in the management of expenditure. Cashin *et al.* (2017:7) brings another dimension applicable to public expenditure management which entails that to manage public expenditure effectively, a series of activities have to be implemented in order not to create weak points in the system. For instance, if financial transactions are not properly accounted for, there will be

challenges in reporting and audits will pick those issues resulting in reduced funding or even more stringent control measures being imposed. This will result in identifying the activities necessary to manage the budget and ensuring that these are being adequately attended to, because if certain areas are left out, expenditure management will be lacking.

Public financial management plays a crucial role in achieving effective expenditures and quality of spending on public healthcare service delivery, and it is argued that there is need to think through public expenditure management in order to narrow the distance between existing rules, conditions and procedures in expending for health (World Health Organisation, 2016:9). As such, it is stressed that effective service delivery is not just about the availability of funds, but perhaps most significantly pertains to how the allocated funds are managed.

Lauzán (2017:585) claims that the public healthcare sector has challenges in optimising the use of resources due its inherent nature, as well as being a part of the complex public sector. This author, however, opts for the adoption of healthcare service delivery technologies that promote enhanced functionality; excellence and system sustainability. This demonstrates a recognition of the uniqueness of healthcare sector delivery expenditure management challenges. In Bangladesh, for example, Islam *et al.* (2018:67) caution that changes made to the public expenditure management with the intent of achieving better health financing and outcomes will necessitate financial control, transparency and accountability.

Thus, the budget is a critical tool in public expenditure management as it traces the financial resources from need assessment to usage and the associated accountability and control procedures. Adding on to health and spending, Rahman *et al.* (2018:113) advise that if high value healthcare is desired, it is imperative to appreciate the relationship between health spending and quality in order to identify areas where it would be beneficial to increase expenditure for better health quality as well as to identify areas where it would be possible to save finances without negatively affecting service quality. It follows, therefore, that there is need for a cost-benefit analysis so that resources are allocated accordingly. Glassman (2014:69) suggests that achieving maximum health return from money requires financial resource use maximisation, not only budget cuts or cost reductions. Clearly, what the health sector requires, is seeing to it that it is making the best of the available resources. The emphasis here is that availability of funds is important, but the management of funds for effective and efficient utilisation for service delivery is as crucial if target outcomes are to be achieved.

The debate on public expenditure management indicates shortfalls in management of budgets and, consequently, disruptions to service delivery. Boachie *et al.* (2018:60) note that their study to re-evaluate "Public Health Expenditure' and its consequences on health delivery in Ghana" was necessary as the study determined the contribution of government in advancing the health statuses of its people. Thus, public health expenditure is responsible for overall healthcare service delivery to the public unlike private health expenditure since not every individual would afford the expenses required for public healthcare. Islam *et al.* (2018:67) add that Bangladesh requires strong political intent and better governance system if it were to improve on its public financial management practice noting that a long term initiative was required if the change process was to be effective. This shows that the extent of political will and good governance affects the quality of financial management in a country. Also, Vian and Bicknell (2014:674) elucidate that poor governance in a country renders the achievement of goals impossible even if the country has abundant resources. This argument suggests that the availability of resources alone cannot deliver the desired goals, but rather, resource management is crucial. The discussions lead towards the importance of managing available public resources if goals are to be achieved.

In summary, if governments would like to have functional public expenditure management to achieve public sector goals, they have to explore varying ways to make public expenditure management effective. It is deduced, therefore, that there is no prescription for public expenditure management enhancement but that governments must look at their situations and design a befitting structure to manage public expenditure. This is even more pertinent as the present study explores public health service delivery, which may require its own unique considerations in as far expenditure management is concerned.

### 2.4 Funding in the public healthcare delivery sector

Public institutions face funding constraints which hamper service delivery. This shortage of funding extends to public health delivery institutions. With reference to the developed world, Ubel and Jagsi (2014:1280) reveal that the costs of providing healthcare are budget draining and result in financial hardships to the governments, the public themselves and employers. It follows that limited availability of resources in the healthcare service delivery sector, necessitates effective management of these resources to make the best of what is available.

Ashiabi *et al.* (2016:1386) note that Sub-Saharan Africa does not devote adequate resources to health, as such, the authors claim that if inefficiencies in resource use were addressed and allocations to the health sector were increased, the continent would have been able to provide increased number of facilities for health, trained more medical personnel, have adequate drugs

and offer improved remuneration to health workers, thereby, improving health outcomes. This discussion implies that limited health sector funding impacts the health sector delivery negatively, because it denies the sector access to goods and services that would support service delivery. The availability of adequate funding is, thus, crucial for the provision of public services (Basheka & Phago, 2014:154). Although financial resources are essential for service delivery, one should keep in mind that we are in a world where there is a limitation to resources.

Kiross *et al.* (2020:5) observe that Sub-Saharan African countries have improved health expenditure for the last 15 years despite their funding being the lowest on the globe. This means that health expenditure in the Sub-Saharan Africa remain on the lower side. Grigoli and Kapsoli (2018:384) add that public health spending is limited particularly in Low and Medium Income Countries (LMICs), but it is stressed that only increasing expenditure and not addressing the efficacy with which the resources are used, may not yield much in terms of attaining improved health outcomes. This bears out the point about making financial resources available and seeing to it that they are used in the most efficient way. To confirm the low funding levels, Ashiabi *et al.* (2016:1386) compare health expenditure in OECD, North America and Sub-Saharan Africa. They found that it was 13 and 17 percent of GDP respectively for OECD and North America while for Sub Saharan Africa it was 6 percent only. This confirms the extent of underfunding that the public healthcare sector in Sub-Saharan African countries is experiencing. Boachie *et al.* (2018:62) observe that for Ghana, allocations to health budgets are low and declining, and cite that in 2014, the allocation to the health sector was only 6.82 percent of the national budget, in contrast to the 15 percent of the Abuja Declaration target. The Abuja benchmark was meant as a guide for health funding commitments for African countries, a desire to have increased funding to health; but it seems African countries fail to achieve that. Despite these funding concerns, Chu *et al.* (2019:39) note that emerging countries have shown a trend of increasing health expenditures, thereby, subsidising health services to the poor. The authors add that health ministries are tasked with the responsibility for effective resource use and strategies to improve efficiency of resources. In other words, public expenditures seem to be the major source of funding to the heath sector which, if not properly managed, may lead in failing to achieve health outcomes. Ocheni and Agba (2018:159) state that the public has high anticipations of service delivery from government, thereby, triggering high demands for increased funding. However, the authors caution that such calls for increased funding may not yield much if there is no prudency in resource use; as well as accountability and transparency. These sentiments suggest that governments in the African continent and beyond are yet to satisfy funding requirements of their public health sectors.

Barenberg *et al.* (2016:1766) claim that public expenditure is crucial for health service provision to the general public, specifically the poor members of the public. As such, adequate and efficiently used resources in public health, would allow for availability of inputs, hence, facilitating service delivery. It is recommended that governments in Sub-Saharan African countries should strive to increase their spending on health as it has been concluded that expenditure on healthcare is important in contributing to improved health outcomes (Kiross *et al.*, 2020:5). Thus, public healthcare service delivery and, consequently, health outcomes depend on the extent of public healthcare expenditure. Servan-Mori *et al.* (2016:1) confirm these observations, stating that health outcomes can be improved by a subsequent increase in resources in addition to the identification of the elements of health systems performance such as efficient, effective and transparency in the use of the said resources. Thus, it is not just about increases in funding that would improve health outcomes, but also the efficiency, effectiveness and transparency with which the resources are used.

There are a number of illustrations on the level of public healthcare delivery sector funding and how they affect healthcare service delivery. Cashin *et al.* (2017:17) propound that despite the enhanced health coverage and a strong primary health care system in Brazil, the continued underfunding in the sector compromised quality service provision and resulted in the public digging deeper from their pockets. Das (2017:475) notes that limited funding in the health sector means that public health service provision may suffer, which results in increased access costs to users. Thus, when health funding is limited, healthcare access is compromised. This implies that finances are required so that the sector can acquire goods and services that facilitate service delivery, but if these finances are not available or inadequate, they can act as a threat to quality services being rendered.

As noted, there are various ways of increasing funding for healthcare delivery. However, which strategy to use and how to adopt are country specific issues, and each country should select options that best suit their economies. Inasmuch as the health sector needs to access adequate funding for improved service delivery, Chu *et al.* (2019:43) point that countries may not completely fill the 'financing gap' but rather enhance efficiency relating to monitoring, procurement, duplications and/or overlaps. Thus, being efficient in resource use, frees finances to be used on other things or indeed improve service delivery by improving on the availability of the resources required for service delivery.

## 2.5 Financial resource utilisation in the public health sector

The ensuing discussion on resource availability and management reveals that the need for improved financial resource utilisation in a limited resource environment is imperative. The public and policymakers are key stakeholders in a country's healthcare system, and as such, it is salient that the efficiency of a country's healthcare system is assessed to determine points of resource leakage and to identify areas for improvement (Radojicic *et al.*, 2019:1). For the reasons that the public, through taxes, finances the provision of public services including health and that policy makers are entrusted by the public as its representatives, their interest in the management public financial resources is unquestionable. Anselmi *et al.* (2018:27) found that if there is efficiency in financial resources management by health administrators, the availability of resources may go up by 34% without having to increase revenue levels. It follows that, matters of financial resource efficiency in a hospital setup are the responsibility of hospital managers; and how they manage the resources impacts on resource utilisation levels. Anselmi *et al.* (2018:27) intimate that simply increasing financial resources without addressing the administrative inefficiencies in financial resources may not improve resource efficiency. This entails that financial management efficiency concerns all players in the sector.

Countries face diverse challenges in ensuring effective and efficient utilisation of resources. Operating in an environment of constrained resources, the UK is still struggling to engage organisations on the best way to adopt strategies on resource utilisation for the betterment of service providers and the public (Sanderson *et al.*, 2020:112888). In addition, Cashin *et al.* (2017:7) propose that those in charge of resource allocation and management should report on the effectiveness and efficiency with which resources are used. There is a need for increased transparency and accountability regarding resource utilisation. Thus, transparency and accountability are required in all stages of the budget cycle; for example, inclusive budget setting, and provision of reports that spell how allocated funds are spent. This is in light of Carlitz (2013:s53) contention that enhanced transparency in managing budgets increases government spending efficiency. Therefore, it can be concluded that spending efficiency results from a transparent budget management system. For instance, to enhance transparency and accountability, public agencies in the Philippines are required to post on their websites issues relating to funds among others, budgets and procurements plans (Capuno *et al.*, 2018:135). However, the authors note that the local government units do not even submit hard copies and reports are produced manually adding to the challenge of evaluating the 'equity, efficiency and sustainability' of funding and budgeting for the health sector. These facts indicate that governments may have the measures in place to achieve set financial management goals, but

those entrusted with implementation of such activities do not abide to the set procedures. Despite noting challenges regarding total transparency and accountability, Carlitz (2013:s54) still holds that making financial information available to the public allowed them to check the performance of the public sector. There is, therefore, a need to institute accountability and transparency measures in the system of managing resources. Managers need to assume a leading role in ensuring that there is order in the way finances for the institutions they are managing.

Schiavo-Campo (2018:92) holds that the focus on finances should be on how they are used in order to ensure that they are deployed in the best way in order to benefit the public. This suggests that the emphasis for governments should be on how best to utilise financial resources, regardless of the abundance of resources, since if their utilisation is not checked, intended outcomes may not be achieved. Than *et al.* (2017:670) elaborate that a country with constrained resources should strive to allocate its financial resources more efficiently. Hence, the first step would be proper resource allocation to ensure that resources have been committed to crucial areas. Moreover, Moreno-Enguix and Bayona (2017:107) note that public financial resource management has been a concern for public organisations and the public themselves. This could be due to the complexity of public sector management and the increased demand on transparency and accountability by well-informed societies. In the same vein, Naranjee *et al.* (2019b:100154) note that South Africa faces health funding issues and advise public healthcare sector players to be mindful of the financial situation by ensuring that they still provide quality healthcare whilst managing expenditure. This demonstrates that literature places emphasis on the proper management of the available resources so that the health delivery sector can get value for money by maximising its resource usage.

There is a number of strategies that literature provides to ensure the optimum use of financial resources. Cashin *et al.* (2017:8) argue that governments should dedicate adequate finances which should be equitably and efficiently used and properly accounted for. In terms of the equitable and efficient use of resources, the authors suggest that resources should target those in need. It follows that the allocation of financial resources should be on a need and benefit basis. Cashin *et al.* (2017:8) add that optimum resource use calls for accountability, which entails improved financial management practices, and on-time reporting. These authors concur with Basheka and Phago (2014:168) on internal controls and audits as strategies that would improve expenditure management.

Cashin *et al.* (2017:33,35) identify a number of strategies that could lead to improved utilisation of financial resources. These include improved communication and coordination between finance and health functions (also identified by Capuno *et al.* (2018:94); undertaking improvements in processes and systems use to attain budget flexibility; and ensuring improved information aimed at enhanced transparency and accountability; and finally, increased public trust and improved allocation and efficiencies in financial resource management. Thus, to manage expenditure effectively, management needs to implement strategies which demand change of behaviour and attitude towards work practices.

Regarding the suggested coordination between health and finance personnel, Ruiz *et al.* (2019:120) note that there is a disconnect between the two functions, and state that this stems from the fact that ministries of health place less value on economic issues when assessing budget proposals. Thus, one source of complexity in management of expenditure in public healthcare delivery sector arise from the fact that this is a combination of too different disciplines each with its own unique goals and objectives, hence, there is a need to merge their interests. With regard to enhancing expenditure management, Chu *et al.* (2019:39) allude to the need for strengthened 'financing institutions' which would result in coordinated financial planning having achieved allocative and technical efficiencies. The authors also cite reporting and monitoring enhancements throughout the public financial management system. Identified financial resource utilisation improvement strategies include improved communication, enhancement of internal controls, increased coordination between health and finance personnel and transparency and accountability in financial resource usage. This entails that there is a need for a change in the way that business as usual was conducted if governments were to attain improved expenditure management.

**2.6 Budgetary systems as a means of effective management of public expenditure**

Gambo *et al.* (2019:1) consider the budget as a managerial tool that should permit the achievement of goals. Thus, when used effectively, a budget can be an enabler of goal achievement for managers, since the budget is basically a translation of an organisation's plans for goal achievement into monetary values. Furthermore, efficient budget management entails making expenditures in line with budgetary provisions, and there should be consideration of funds' availability in order not to be wasteful or have deficits in spending (Jaelani, 2018:213). The budget is, thus, used as a plan to guide the spending of financial resources by considering how much resources are available.

Accordingly, budgeting is a key aspect in the public sector; as it is the centre of public welfare provision (Ajibolade & Oboh, 2017:218; Anessi-Pessina *et al.*, 2016:491). Hence, for the public sector, budgeting is a crucial process that translates institutional goals into monetary implications. Given that decisions on public expenditure are multifaceted and that governments face enormous pressure to deliver improved service delivery, those making decisions should be properly guided in their "planning, decision-making and control" (Alkaraan, 2018:588). A well-prepared budget document does just that.

This implies that, what is provided in the budget and how the budget is formulated, executed and managed, would have an impact on public service delivery. Ruiz *et al.* (2019:119) add that to attain efficiency in budget spending, there is need to put in place good practices throughout the budget cycle in order to oversee effective allocations at all stages of the budget cycle; in order to ensure agreement between expenditures and the needs of the health sector. Thus, budget management must involve the management of the individual stages in the budget, because missing any stage in the budget cycle may hinder expenditure management.

Ajibolade and Oboh (2017:224) hold that the preparatory and implementation stages of the budget as well as "the regulatory and control measures'' contribute to the success of the budget. These sentiments are echoed by Capuno *et al.* (2018:94) who argue that a strong process of budgeting is a recipe for the public healthcare sector spending. It follows that a sound budgeting process would result in a good spending guide. If this is coupled with effective budget cycle management, the public sector would achieve its goals. This is notwithstanding the fact that the budget is also seen as a tool in misappropriating and mismanaging of government funding (Ajibolade & Oboh, 2017:224). Thus, often, the budget has been used to divert resources from the intended purpose, thereby, hindering goal achievement. Overall, the budget is used to allocate financial resources and ensure that the available finances are properly managed, allowing for the achievement of objectives.

In relation to healthcare service delivery, the budget is intended to achieve the following objectives in providing services: efficiency, equity, quality and accountability (Piatti-Funfkirchen & Schneider, 2018:340). Therefore, the budget is meant to achieve the stated financial management objectives in service delivery. To this end, Abdellatif *et al.* (2019:91) note that one should ensure that there is an effective budget administration process, because this has an important role in determining outcomes. Thus, the emphasis in financial management is on how the budget is managed. Indeed, Anessi-Pessina *et al.* (2016:493) note that budgeting is a tool that is used for

"bargaining and allocating power and resources, for planning and controlling, and for ensuring transparency and stakeholder involvement". Indeed, if the budget system has to assist in managing expenditure, then Cashin *et al.* (2017:10) state that budgets should be monitored and this entails making sure there is compliance with laws and guidelines in spending, ensure the presence of good systems of financial management and institute internal control systems and audits with a view to achieving budgetary objectives. Furthermore, Cashin *et al.* (2017:10) emphasise that there is need to see to it that each step of the budget is complied with in order to achieve efficiency and effectiveness in resource use. Thus, a comprehensive approach to budget management is vital, and one must observe all the stages of the budget cycle.

According to (Ruiz *et al.*, 2019:108), a system of reporting and monitoring is essential in ensuring the effective execution of the health sector budget as well as preventing over or underspending. The authors caution that countries delay providing reports due to the hierarchy in the reporting chain. The aforementioned implies that, if there were proper budget management, the organisation will benefit, because the budget has multiple functions that enhance management of finances.

To ensure the effective use of budgets as a tool in financial management, Gambo *et al.* (2019:11) suggest that there should be sufficient provisions in budgets; needs should be prioritised when allocating funding, capable personnel for healthcare budget coordination and implementation should be available and donor requirements should be fulfilled to attract them. It follows that an effective budget management requires the identification of their crucial aspects and complying with them.

However, for the budget to serve its purpose, there is also a need for budget executing firms to monitor compliance on the same. Flink (2017:1) illustrates the importance of the budget by noting that financial inputs into a public organisation are known to be unpredictable, whilst at the same time managers are still expected to maintain targeted outcomes. Cashin *et al.* (2017:15) add that the health sector faces unique challenges that require flexibility in the management of flows of funds if equity, efficiency and quality are to be achieved in the sector. This uniqueness stems from the fact that the health sector has inherent uncertainties that restrict accuracy in budget forecasting. This presents a strong case for the budget, to be among other qualities, a flexible document.

Piatti-Funfkirchen and Schneider (2018:338) note that the stages in the budget process are connected to service delivery. They identify the 'budget formulation stage' where priorities in

health expenditure are established and incorporated; the 'budget execution' phase which guides utilisation of funds in health service delivery; and the 'budget evaluation' point which informs how the implementation faired and lessons are drawn for the future. These notions suggest that it is imperative for budget holders to ensure that each stage of the budget process is adhered to if set goals for the organisation are to be achieved. Thus, for effective service delivery, public expenditure management should conform to the budget objectives of efficiency, equity, quality and accountability. Furthermore, Carlitz (2013:s50) points out that there is increasing pressure from 'the top' and the civil society towards improved transparency and accountability and notes that enhanced accountability provides assurance that finances are not wasted. Accordingly, accountability and transparency initiatives should guide the budget processes throughout.

Apart from the general recommendations made regarding the budget's role in public expenditure management, Cashin *et al.* (2017:2) suggest that health budgets need to provide unique measures to cater for the specific needs of the health sector. These measures include combining of all funds for health, allowing for 'intergovernmental transfers' to address inequities in health and to improve equity and allowing for flexibility to health providers for resource management. This implies that these special considerations are important, because the health sector is a unique one with its own complexities. If funds were to be optimally managed, the uniqueness of the health sector in relation to budgeting has to be incorporated.

Vakhaevich and Vakhaevna (2016:354) recommend that in order to enhance spending using the budget, governments must enhance financial control systems; develop a financial management structure in regions and districts; increase the quality of public financial management in the public sector; implement the principle of accountability and transparency in the budget process; analyse the effectiveness of public spending; enhance the efficiency of procurement systems and improve on inter-budgetary transfers of funds. These points bear on the fact that an effective budget management calls for a well implemented system of financial management. Ruiz *et al.* (2019:99) maintain that countries should make sure that budgetary systems are flexible. Thus, the flexibility of the budget system in the public health sector is important. Gambo *et al.* (2019:11) considered a number of budget, political, structural and cultural factors that affect the implementation of budgets and the, effective and efficient utilisation of resources needed to ensure the delivery of primary healthcare in Nigeria. The authors incorporated the following budget factors for good expenditure management in their study: sufficient budget provisions and donor support, prioritisation of needs, properly coordinated; and well implemented and monitoring of budgets. Furthermore, the authors cited 'good governance', to infer a stable political environment coupled

with great policies and a government that is committed to providing for the healthcare as factors that could affect the implementation of budgets. It is emphasised that neglecting any stage in the budget process may result in increased public expenditure management deficiencies, implying that all budgetary stages are crucial.

### 2.7 Impediments to optimum public expenditure management

Optimum public expenditure management is the financial goal of any country. Measures are put in place to achieve this, but it has been observed that public expenditure is often not ideally managed. A study done on Zambia and Tanzania, Piatti-Funfkirchen and Schneider (2018:336) found a number of factors that impede management of finances and, thus, hinder effective public health service delivery. For example, the government is inflexible when it comes to additional financial resources; there is misalignment between budgeting and planning; funding sources are fragmented; the public sector internal controls are rigid; budget allocations are not adequate; and there is a system of budget evaluation that is bent on compliance at the expense of equity, quality, and efficiency in service delivery. Accordingly, with these factors that hinder public expenditure management, quality service delivery cannot be attained satisfactorily. Therefore, for the budget to meet its purpose there is need to address factors that are deemed to prevent achievement of optimum expenditure management.

Micah *et al.* (2019:1) points to the notion that a country's attributes such as bad governance (also cited by Biadgilign *et al.* (2019:41) or corruption levels are significant in appreciating variations in public health expenditure issues in Sub-Saharan African countries. This entails that governance or corrupt practices in a country have an effect on how expenditure is managed, and consequently, on the extent that a country's objectives are achieved. In Nigeria, also, Ajibolade and Oboh (2017:227) note that the country experiences challenges in its budget system. These challenges include: cash basis of accounting, budgetary slacks, line-item or incremental budgeting approach, the country's political system and management issues including poor planning, poor preparation and implementation of projects, poor cash flow management, and lack of adequate budget performance monitoring. To this end, it is recommended that Nigeria should aim towards a 'progressive and resilient budgetary system' with the aim of promoting accountability of public funds, adopting the accrual accounting system and implement 'the international public sector accounting' (Ajibolade & Oboh, 2017:234).

Thus, there is a need for countries experiencing various budget management challenges to device measures aimed at financial resource use optimisation. In addition, Huzaila-Majid and Singaravelloo (2017:260) note that the following issues deter effective expenditure management

in Malaysia: poor coordination and monitoring, inadequate personnel, factors external to the departments and ministries, inconsistencies in policies and negligence. Such challenges are seen to cause hiccups in the efforts of effective and efficient management of resources. Thus, governments are faced with both internal and external factors when managing financial resources. Cashin *et al.* (2017:14) mention that underspending is another challenge in public expenditure management in the public health sector. The authors note that this is usually due to challenges in budgeting and funds disbursement, inflexibility to reallocate resources and at times, because of low capacity to absorb resources or merely inefficiencies. This implies that underfunded institutions may seem as if they have used fewer resources than budgeted because of budget management challenges at the implementation phase.

Hlafa *et al.* (2019:5) explain the conditions in the public health sector of selected developed and developing countries. In Italy, the public health delivery sector produces unsatisfactory health outcomes due to poor governance, lack of organisation and unchecked spending which stem from discrepancies between local and central government decisions. The presence of complex governing structures, as in decentralised structures, may lead to conflicts in decision making which impacts on expenditure management. Furthermore, Hlafa *et al.* (2019:1) highlight the health statuses of different countries and point out that despite their massive investment in the public healthcare sector, the USA, reports very poor healthcare delivery results due to lack of qualifying medical personnel; on the other hand, health delivery sectors in developing countries like Zimbabwe lack adequate finances, medical personnel and a wanting environment. Brazil, in turn, is handicapped by an archaic healthcare system and South Africa is challenged with poor governance, weak leadership and inadequate accountability. These facts indicate that the public health delivery sectors of both developed and developing countries are facing various challenges which impact on management of expenditure and consequently, health outcomes. This means that solutions designed to address such challenges should be specific to the situations and not general.

Hlafa *et al.* (2019:1) observe that the main problems in most developing countries are weak management and constrained funding. The cited examples imply that the public health delivery sector world over face a myriad of problems, for instance inadequate funding and mismanagement of the funding acquired, affecting service delivery and, consequently, outcomes. The reasoning here is that, the availability of finances and how they are handled by those entrusted with such a responsibility will have an effect on health outcomes; as without financial resources there will be no medication, medical personnel even basic utilities to support provision

of healthcare. Yefriza (2015:148) adds that inaptitude of institutional arrangements to accommodate public expenditure management has resulted into inefficiencies. The author adds that these weaknesses include lack of political will, absence of clear policy, "transparency, comprehensiveness, integration, and accountability" issues and budget approval delays. This gives rise to the notion that an institutional setup plays a significant role in the effectiveness of public expenditure management.

Structural factors affecting budget implementation comprise misalignment among people who monitor budgets; a bad system of reporting; inadequate personnel; absence of information on performance; insufficient planning and untimely budget revisions. Thus, expenditure management approaches need to be holistic in order to capture all aspects that has potential to affect how financial resources are managed. Madue and Mahwai (2008:359) discovered that public expenditure management is hampered due to a lack of proper execution of performance management systems; non-availability of information; inadequate participation of managers in budgeting and managers having inadequate qualifications to ably manage finances. Accordingly, internal management deficiencies that present challenges to public expenditure management need to be identified and resolved in order to achieve optimisation of financial resources use.

Ruiz *et al.* (2019:107) explain that the operational challenges faced in management like "excessive bureaucratic procedures", limited "definitions of spending categories", and restrictive conditions for transfers of finances within the sector result in under use of allocated funds. The authors further note that countries in the OECD experience budget overruns in the health sector, and this results in budget deficiencies or extra budgetary requests for additional resources. Thus, operational challenges impact on public expenditure management, and as such, operational environment and tools need to be improved to create a conducive environment for managing expenditure.

The factors that derail optimum public expenditure management have been discussed in this section. These are operational, management and organisational structure. It has also been pointed out that, notwithstanding similarities in certain cases, each country has unique public expenditure management issues, and therefore, addressing public expenditure management should require attending to country-specific challenges.

### 2.8 The legal framework for public expenditure management

In most countries, public financial management is regulated by the government, and the goal is to provide direction on management of public finances. Herbert (2007:255) propounds that the

enactment of public financial management provides powers to undertake public financial decisions. This follows from the fact that public offices are delegated positions, and as such, public officers require authority to act on behalf of their principals. In South Africa, at the national level, the Public Finance Management Act, 1999 (PFMA 1999) is at the basis of financial management policies and regulations in the public service. This Act aims at enhancing public expenditure; and at the municipal level, the Municipal Financial Management Act, 2003 (MFMA) supports the PFMA 1999 in the delivery of public services (Madue & Mahwai, 2008:359). However, despite such elaborate public finance legal and regulatory provisions guiding financial management in South Africa, public expenditure management still face challenges. Thus, the presence of legal instruments to regulate financial operations does not guarantee their effectiveness and efficiency. Herbert (2007:253) advises that the public sector should ensure that a country's financial frame is comprehensive enough in the components of accounting for allocated finances, budgeting and monitoring of public expenditure. Thus, public financial management legislation provides guidance on handling of public finances, and it serves as the legal basis for generating and expending public funds. Therefore, governments should ensure that it its officers have been oriented sufficiently to handle such functions.

Legislations for public financial management in various countries aim to safeguard and provide regulation for financial resource management. For example, PFMA of Zambia (2018) purports to strengthen accountability in the use of public resources; has public finances oversight, management and control roles in order to ensure that public finances are efficiently and effectively utilised. This entails that the effective and efficient use of finances can be achieved, if there is supervision and control over public finance resources. The PFMA (2016) in Zimbabwe aims to guide control and management of public funds, make provision for budgets and production of financial statements and the PFMA (1999) of South Africa is for the regulation of management of public finances to allow their efficient and effective management. Clearly, the public financial management legislation focuses on management of financial resources, but it seems that despite the presence of a legal setup in public finance resource management, countries still face public financial management deficiencies. These are likely to result in leakages and the misuse of public funds.

Different countries face different challenges relating to legislation and its impact of financial management. For instance, Greece suffers from weak legal enforcement and monitoring, unclear and ambiguous provisions of public financial management which leads to non-compliance (Kontogeorga, 2017:153). This means that in as much as legislation is crucial, how it is crafted

and oriented to the managers and employees has an effect on the level of compliance. In the Islands of Trinidad and Tobago, Herbert (2007:256) report on poor budget monitoring and non-compliance to the public financial management legal provisions and regulations. This implies that there is more that needs to be done in the public financial management environment apart from the presence of regulations.

In Tanzania, Basheka and Phago (2014:162) acknowledge the country's good budgetary performance and monetary discipline in line with economic growth but note that the Public Finance Management Act face hiccups relating to participation of parliament in budgeting, ambitious goals that could not be financially supported, unpredictable availability of funds, ineffective and inadequate internal controls. These facts indicate that a presence of well-crafted legal instrument to direct public resource require an enabling environment to allow the instrument's effective implementation.

### 2.9 Management theories

Theoretical frameworks are a means of conceptualising complex relationships in research. To appreciate the role that public financial management in general and public expenditure management in particular has on public health delivery sector, different management theories are discussed in this section. This chapter identifies and explains the theoretical relationship between public expenditure management and public health delivery.

Anessi-Pessina *et al.* (2016:503) point out that when identifying research issues, one needs to reflect on theory and research methods to ensure that the area is relevant for the society as well as practitioners which necessitates engaging relevant information resources. Public expenditure management is viewed from different theories. As Abor (2015:112) points out, the healthcare delivery sector is complex and the emerging complexities, can best be addressed by applying multiple theories and appreciate what other researchers had established in the area of public health service delivery and related studies *vis-a-vis* related theories. This demonstrates that intricate studies require multi-approaches in terms of theory application and research approach in order to articulate the topics comprehensively. Anessi-Pessina *et al.* (2016:498) observe that both economic and objectivist organisational theories for positivistic and interpretive studies are applied to public budgets. That is to say, the multi-theory application is more appropriate to specifically budget related studies. This section focuses on clarifying the theories that underpin public expenditure management and connects them to public health service delivery. The following management theories are discussed: agency, stewardship, accountability, stakeholder, contingency, x-inefficiency and Lüder's (1992) contingency model.

### 2.9.1 Agency theory

The agency theory is also referred as  the principal–agent model by Snippert *et al.* (2015:571). Keay (2017:1292) explains that the agency theory is applied in relation to governance issues in the corporate world; and it discusses and theorises the duty and behaviour of agents. Thus, the substance of the agency theory entails the relationship between the principal and the agent; where the principal delegates responsibility to the other, the agent, who is expected to act in the best interest of the principal. The agency theoretical framework is well established and researched, and it is used to explain public expenditure management systems and reforms. It is characterised by a string of agency relationships, and consequently, can address agency problems that arise (Arce, 2017:442; Leruth & Paul, 2007:104).

The agency theory is appropriate for this study, because public sector management setups involve principal-agent relationships due to the inherent nature of requiring principals and agents. Arce (2017:442) explains that the fields of accounting, economics and finance apply the agency theory to evaluate behaviours of managers and their compensations. This entails that financial management, which is narrowed to expenditure management in this study, needs to appreciate and apply the theory in order to understand actions and behaviours of those entrusted with resources.

Basheka and Phago (2014:155) record that governments are agents of citizens, meaning that the citizens are the principals; however, the government is represented by individuals who are supposed to effectively manage, among others, public finances. Consequently, there is an overlap of positions where a principal is also an agent in a different setup. Nevertheless, the implication is that agents undertake delegated responsibility and, therefore, need to be accountable to the principals who engaged them. In addition, Basheka and Phago (2014:158) contend that public sector agents report to a multitude of principals. It follows that agents need to identify the relevant principals to which the agents are responsible to and note their requirements.

O’Neil *et al.* (2014:58) analyse the theory by applying it in a decentralised setup where the authors highlight challenges in oversight and discipline from the principal-agent perspective. They depict the central government as the principals with authority over the local government officials, their agents, and they bemoan that this relationship does not produce anticipated outcomes. This was alluded to in terms of information asymmetry and insufficient systems for monitoring and discipline. These facts indicate that, in the course of discharging responsibilities, the performance of the agent may not satisfy the principal, and may therefore mar the principal-agent relationship. According to Snippert *et al.* (2015:571), the agency theory examines the relationship between

individuals, or organisations where there is a contractual agreement between the principal (the contractee) who requires work to be done by the agent (the contractor), expecting that the agent performs in accordance with the desires of the principal. The authors further point out lack of a goal congruence and information asymmetry are factors that distract agents from fulfilling their responsibilities.

Basheka and Phago (2014:155) lament that in African countries, there is chronic mismanagement of finances leading to huge leakages of public resources. The authors, therefore, assert that it is crucial for the public financial management system to be well-functioning to ensure the productive, transparent and efficient use of funds. This demonstrates that agents may be acting in their own interests by diverting finances meant for implementation of activities of the principal; and hence, a vibrant public financial management system that is well implemented may assist in safeguarding the use of funds. Keay (2017:1295) observes that agents exercise discretion, because it is not possible for the principal to oversee each and every activity and transaction within the institution and this could contribute to agency problem. This suggests very strongly that the agency problem exists because of the discretionary powers that the agents have, and can be abused to serve people's own interests and not those of the principals.

As Basheka and Phago (2014:156) put it, public expenditure management in a principal-agent setup entails managing expenditures (this is done by officials or agents) who have been entrusted to discharge responsibilities on behalf of the citizenry (principals). Hence, the extent of the effectiveness to which expenditure is managed depends on how the agent discharges their delegated responsibility.

Tsheletsane and Fourie (2014:43) state that the Public Finance Management Act that governs financial management in the public sector, is embedded in the principles of agency theory, as it creates a setup by means of which managers can manage and deliver public services whilst holding them responsible for the resources entrusted to them. The agency theory is therefore about the delegation of responsibilities to individuals on trust by another party to undertake the delegated responsibility. In short, the major theme inferred from the agency theory is the achievement of targets by agents, using the best management capabilities they can, on behalf of the principals.

The agency problem that is underpinned in this study are the goal incongruences and information disparities between donors, the government and the public on side and those entrusted with management of institutions on the other hand that leads to sub-optimisation of resources in the

public healthcare service delivery sector in Malawi. Thus, for an effective contractual relationship between the principal and the agent, there should be goal congruence between the parties and information sharing, so that there is transparency. The agency theory is under criticism for its promotion of goal incongruence of agents over their principals (Obermann *et al.*, 2020:989). However, Dumay *et al.* (2019:23) maintain that the agency theory is better placed to explain the reason behind the dishonest behaviour by managers and why nothing much is done to prevent such behaviours. Thus, the fact is that there is a principal with goals to be achieved but delegates that responsibility in the hands of another party, the agent and the latter have additional motives different from the institutional arrangement. Thus, they may be pursuing their own goals at the expense of the institution.

Agency problems emerge when there are information discrepancy and goal incongruences between the principal and the agent (Arce, 2017:442; Kauppi & van Raaij, 2014:953; Snippert *et al.*, 2015:571). It follows that, in the course of discharging the delegated responsibility, the agent amasses information that they can use to their advantage. On the level of principal-agent goal incongruences, it can be inferred that there is a mismatch between the intent of the principals for the organisation and what the agents want to achieve from the organisation.

According to Basheka and Phago (2014:155), most African democracies suffer disruptions to public service delivery agenda due to the 'opportunistic behaviour' of officers entrusted with responsibility to manage public finances which is detrimental to the masses who depend on those services. Thus, agency problems may result in non-achievement of organisational goals. Bawole and Adjei-Bamfo (2019:303) agree with Basheka and Phago on the agency problem. They fault the agent who tends to pursue his personal interests in the course of discharging his assigned tasks. The agency problem is therefore, a result of the agent who in the discharge of entrusted responsibilities, pursues personal and not organisational goals. Arce (2017:443) concurs with Basheka and Phago and Bawole and Adjei-Bamfo as he claims that the principal-agency approach holds that those entrusted with resources and responsibility to deliver do so only for the rewards associated with the positions, and that is why principals must look into the opportunistic behaviour of agents. Otherwise, organisations experience inefficiencies including resource use. This is the reason why principals need to institute measures to ensure compliance to procedures aimed at ensuring maximum use of resources in order to achieve organisational goals.

Linking accountability and agency theory, Iyoha and Oyerinde (2010:262) infer that accountability should exist where there is principal-agent relationships and stress on the importance and

relevance of accountability as there is need for agents (who in this study are managers of public health institutions), to show to their principals that with the powers vested in them, they efficiently and effectively utilised the resources given to them and achieved set goals. This notion supports the point that accountability on the side of the agent is an ingredient for managing principal-agent relationships. This is because by being accountable, the agent is transparent about what he or she has done with the resources entrusted to them.

In Ghana, Adjei-Bamfo and Maloreh-Nyamekye (2019:4) evaluated the principal–agent relationship, and argue for a double-agency relationship that exist in public procurement where the agent, (politician) is in social contract with the principal (citizen). However, politicians delegate their responsibility to public service officeholders (agents); these are the citizens who, consequently, enter into contracts for the supply of goods and services for the citizens. Accordingly, principal-agent relationship is concerned with the dual role of an individual who serves both as an agent and principal, depending on the cap they are wearing at the material point in time.

For ease of application, Bakalikwira *et al.* (2017:3) point out that the theory reduces an organisational structure to only two participants, thus, the managers running the hospitals and stakeholders. In this case, stakeholders can mean the government, the public and donors. Thus, this simplistic view of players in an organisation enable stakeholder analysis in the hospital to be easier. Basheka and Phago (2014:155) point out that challenges that stand in the way of achieving effective stewardship of finances should be identified so that solutions to the same should be developed. The authors further illustrate that in some cases, governments have vulnerable public financial management environment which are a cause of low stewardship of finances due to the low governance and, consequently, non-enforcement of laid down procedures. This implies that it is not sufficient to legislate public financial management in order to reduce agency problems, but rather that further measures are needed to allow improved governance and compliance enforcements.

Basheka and Phago (2014:156) opine that those entrusted with the management of public funds and the leadership are equally to blame for mismanagement, and for neglecting their oversight responsibility. Consequently, the trustees, the citizenry and Civil Society Organisations have contributed to financial management maladministration by being indifferent to financial malpractices. This is most likely where the stakeholder comes in. In other words, the various stakeholders have different roles towards organisations where they have an interest. For

example, if governments, the public and donors were to demand accountability for resources entrusted to management, the agency problem could be addressed at least in part. Basheka and Phago (2014:156) hold that the representatives elected by the principals should endeavour to safeguard the interests of the masses by being accountable in the discharge of their duties.

In summary, the principal-agent relationships and its challenges are inevitable in public sector management due to the inherent nature of the sector. Such being the case, there should be ways to minimise challenges arising from such relations. One may be compelled to argue that accountability of those in entrusted positions is a crucial aspect in managing agency challenges, because this shows transparency and direction in taking care of delegated responsibilities.

### 2.9.2 Accountability theory

Bakalikwira *et al.* (2017:2) define accountability as a process that involves providing feedback on the use of funds that were allocated for a given use. In turn, Ajibolade and Oboh (2017:221) consider accountability as an obligation of those entrusted with resources and responsibilities. Thus, accountability is the provision of feedback on a delegated responsibility in order to confirm whether the delegated duty was or was not discharged as intended and that the resources entrusted to the agents were applied for its purpose.

As a theory, Myende *et al.* (2018:3) regard the accountability theory as a tool deployed to appreciate the actions of the agents and their various stakeholders in the financial management exercises. Thus, being accountable entails reporting on the activities that have been undertaken using the resources made available. Furthermore, Rangongo *et al.* (2016:2) consider accountability as the means through which procedures and policies of an organisation are legal and represent stakeholders' interests; that activities are carried out in accordance to procedures and pinpoint that whenever finances are entrusted from one person to another, the entrusted person has to account for the same. Accordingly, accountability is crucial for those that are in delegated positions in order to report back to those that they were working for. This means that, despite the varying definitions on the concept of accountability, a common view held by scholars is that it emphasises the need to provide feedback by those in charge of managing resources to those who gave them management powers.

Basheka and Phago (2014:165) emphasise the need for commitment and will on part of leaders entrusted with government agendas. However, these authors bemoan the lack of political will and commitment among African leaders, and call upon governments to create and provide a conducive legal and regulatory atmosphere aimed at transparency and accountability. These

sentiments show that accountability for resources is what governments look for from managers in order to satisfy themselves the extent to which planned activities and goals have been pursued. It could be deduced that accountability in any other profession is desired at all levels, and that every individual should be accountable to the one they report to or that engaged them. These facts indicate that accountability is more important in the public sector where all officers are in delegated positions. For example, Myende *et al.* (2018:3) explain that South Africa's instructions on accountability for public schools require maintenance of finance record as well as audited accounts and reports to users of financial statements on income generation and funds utilisation. By extension, the very same instructions apply to all institutions accessing and using public funds. Thus, the public health sector as part of the entire public sector needs to be accountable by reporting on their affairs including financial matters.

Keay (2017:1292) notes that a great deal of studies have focused on general accountability and importance of trustees. This author adds value by linking stewardship and accountability theories in order to establish that accountability is vital. It is argued that if the governing institution has absolute trust in its officers who, in turn, must maintain stewardship principles, there would be less requirement for monitoring, but accounting for actions and decisions remain important. The implication is that an officer with stewardship principles must still be accountable to those in charge. These sentiments support the view that the agency theory and agency problems could be addressed by managers and agents who are accountable to their principals.

Iyoha and Oyerinde (2010:261) point to the lack of accountability in public entities in Nigeria, despite enabling legal provisions. The authors argue that accountability can be achieved through a strong proactive and professional accounting structure and not the reactive approach of laws. Thus, the emphasis is on the need for and recommendation to public officers to be accountable. Furthermore, Tsheletsane and Fourie (2014:44) relate accountability to the functions of the regulatory framework for financial management, the Public Financial Management Act, which was promulgated to regulate and enhance financial management and accountability. These legal instruments serve to enhance financial management in the public sector, and specifically provide for measures to ensure accountability, for example providing for frequent and scheduled reporting.

Interestingly, Tsheletsane and Fourie (2014:44) reveal that despite the legislation of the public financial management, financial management in South Africa is still poor and lacks accountability. It follows that without managers who are accountable, the efficiency and effectiveness of

management of financial resources is not certain. Tsheletsane and Fourie (2014:46) therefore, suggest that if accountable and responsible management were to be achieved, the public sector should ensure that citizens participate in decision-making; the rule of law should be enforced, and that the leadership should be visionary. These points lead one to believe that enforcements to comply with set procedures and a participatory public would enhance accountability in the public sector. However, for that to happen, the quality of the leadership is important. Carlitz (2013:s53) links the principal-agent relationship with accountability and transparency issues, and notes that information asymmetry leads to incorporating bad office bearers. The author claims that transparency and accountability in budget management empowers the populace in making informed election choices and consequently, thereby, making a positive impact on the economy.

Thus, accountability entails effective financial management, where management prepares reports on resources entrusted to them; and internally, employees are made aware of the institution's standing financially which is reflected in the employers' ability to provide them with adequate resources to enable them to work and patients have access to quality medical care. This points to the fact that in the public health delivery sector, management should be accountable to the government and donors for funds entrusted to them; the public also requires accountability from managers of the public hospitals, because they use public funds to run the hospitals and deliver services. This is necessary because whatever actions the managers take have a direct effect on the public, because they are the ones who use hospital services.

### 2.9.3 Stakeholder theory

Stakeholders include all players (both from within and outside an organisation) who have an interest in the decision-making process of an entity (Richter & Dow, 2017:428). Thus, this category of individuals and organisations are critical as their role within the organisation cannot be underestimated.

In a public health delivery sector, stakeholders include the patients, the government, donors, the public, civil society organisations and service providers. Stakeholder theory proclaims that an entity's existence is dependent on the stakeholders' backing and, therefore, managers are advised to seek consent when undertaking activities that have an effect on the stakeholders (Omran & El-Galfy, 2014:265). Thus, the wellbeing of an institution and its success requires cooperation between its managers and stakeholders; otherwise, the institution may face challenges if the stakeholders become frustrated. The stakeholder theory is concerned with how stakeholders are handled by managers and, therefore, explains the behaviours of managers not just information provision (Dumay *et al.*, 2019:25). These authors contrast stakeholder and

agency theory, in the sense that in agency theory, managers are said to be interested in things that benefit them as individuals, whilst the stakeholder theory looks at how management handles stakeholders and make the necessary disclosures. Therefore, the stakeholder theory gives positive consideration to players in an organisation, including managers who are thought to act in the best interest of an organisation. To this end, governments use public funds to finance healthcare delivery and are of course interested in how those funds are utilised and whether indeed through the funds it has a healthy population. Similarly, the donor community is interested in the manner in which donations to the health delivery sector are utilised by managers who are entrusted to meet these expectations.

Organisational stakeholders and their interests could be many and diverse. The stakeholder theory enables managers to appreciate the needs of the diverse stakeholders with a view of reconciling them with the objectives of the organisation in order to maximise the value of the stakeholders (Abor, 2015:111; Bakalikwira *et al.*, 2017:267). Thus, managers must analyse their institution, identify its stakeholders and the interests they have in the organisation and strive to satisfy the needs. For instance, managers in the public health sector in Malawi ought to know, appreciate and value parties with vested interest in their sector like the government, the civil society organisations, the public, donors and the international community; what role each of these interest groups play; their expectation as well as the consequences if the desires of any of the stakeholders are not satisfied.

In addition, (Franco *et al.*, 2019:53; Richter & Dow, 2017:428) state that institutions are challenged with the issue of stakeholder management in terms of addressing individual stakeholder claims or indeed competing claims of the stakeholders. Therefore, managers need to undertake a stakeholder analysis in order to able to manage the stakeholders. Furthermore, the stakeholder theory affirms that stakeholders have a role to play in an entity to ensure its existence for instance, where critical organisational resources are controlled by the stakeholders; the organisation has to comply with their requirements (Omran & El-Galfy, 2014:266). It means, therefore, that managers should not ignore or side-line their stakeholders, but should rather would work and collaborate with them.

Richter and Dow (2017:429) applied ‘Habermas’ normative framework’ and demonstrate that stakeholder theory could stimulate managerial conduct and assist in conflict resolutions, sorting out inconsistences and ease corporate tensions. This is because stakeholders are like a pool of controllers in different aspects of organisational management where they act as checks and

balances. In this research, stakeholder theory is used to appreciate the interconnectedness between resource availability and use as provided in the health budgets, as well as financial management deficiencies in the use of public resources where managers ignore or incorporate stakeholders in the public health delivery.

### 2.9.4 The stewardship theory

According to Keay (2017:1292) the stewardship theory encompasses trust, professionalism, allegiance and willingness among managers; it also entails their regard for others who are dependent on them and the decisions they make. Thus, stewards are loyal to their organisations. The basis of the stewardship theory is that employees who uphold stewardship principles would not pursue personal interests as experienced in agency theory but have the interest of the organisation first (Bakalikwira *et al.*, 2017:4; Keay, 2017:1297). This implies that stewards have the interest of the organisations they serve at heart, and they are trustworthy and responsible.

Iyoha and Oyerinde (2010:261) consider accountability as a financial management and stewardship issue in the effective and efficient use of resources in public operations. Thus, management accountability is crucial in managing finances and exercising stewardship. Luecal (2009:34) expounds on financial stewardship institutional accountability of the board of directors and management, noting them as the responsible individuals for managing organisational activities in a way that ensures effective and efficient utilisation of resources. Thus, financial stewardship responsibility has always existed at the board and management level, where the Board must see to it that the managers are acting for the good of the organisation in confirming that resources are put to the best use possible. Of late, there has been increased attention on stewardship due to increased demand for accountability, economic pressures, complexities in decision making and proliferation of laws and regulations (Luecal, 2009:34). Clearly, the economic enlightenment by the public has placed pressure on managers to act in the best interest of their organisations. Simply put, the changing global and organisational platform has resulted in varying perspectives in the expectations of different players.

There is debate on the differences between the agency and stewardship theories. Keay (2017:1292) states that the stewardship theory contrasts claims asserted by the agency problem that managers act in self-interest. Puyvelde *et al.* (2012:437) contrast the agency and stewardship theories and show that the agent is more of an individualist who seeks opportunities; is centred on mistrust; involve more disciplinary issues and requires constant monitoring. On the other hand, the stewardship theory is founded on cooperation, goal congruence and trust. Also, the agency theory is founded more on control and conflicts whilst the stewardship theory is more focused on

cooperation and collaboration among workers and decision-makers. Consequently, there are claims that the stewardship theory provides a substitution for theorising the principal-agent relationship; then it rejects the emphasis of agency problems and rather hold that agents must act in the best interests of an organisation (Arce, 2017:442; Keay, 2017:1293). This implies that the agency and stewardship theories have divergent views of managers, where they are seen as plunderers and safe-guarders respectively. Arce (2017:443) explains, furthermore, that an employee who has sound stewardship principles would be embittered by lack of trust of the principals in them. Thus, whether a manager is a steward or an agent is a question of the reflections that come through observations on how these individuals perform their responsibilities. The reason why there are financial management deficiencies in the public sector and specifically public healthcare delivery sector in Malawi is most likely because managers in these institutions are more focused on principles of agency theory than on stewardship.

Snippert *et al.* (2015:574) explain that an individual is a steward if his or her actions are not just for him or her, but for the organisation as a whole. Thus, such an individual puts the organisation's interest first and in so doing, establishes and develops trust. Thus, stewardship entails selflessness on the part of managers. Dumay *et al.* (2019:12) contend that stewardship of an institution's resources is important if trust were to be maintained between the trustee and trustor. This implies that stewardship is founded on trust between the employee and the employer.

The stewardship theory can, therefore, be seen to complement the agency theory (Puyvelde *et al.*, 2012:437; Snippert *et al.*, 2015:574). Accordingly, it is possible for agents to share the same goals with the principal and be in line with the stewardship view. This study looks at expenditure management in the public sector by those entrusted to manage the financial resources to achieve improved health outcomes. Thus, if employees behave as stewards, they would safeguard and prudently manage the resources for better public health delivery; there will be reduced policing as in agency theory and more collaborations and trust between managers and their supervisors.

Applying stewardship theory in the management of donors, Harrison (2018:545) discovered that donors value stewardship and that it is important for management to maintain stewardship strategies. These stewardship strategies include respect for donors' accountability; reciprocity (which is simply being grateful to supportive stakeholders) and showing responsibility i.e. abiding by set agreements, for example using funds for the tasks they were allocated for. Additionally, Waters (2013:328) adds relationship nurturing as a further strategy to Harrison's list.

Thus, stewardship is an attribute of management that attracts and retains donors. Luecal (2009:35) guides that financial stewardship can be achieved by having a process that is followed consistently to guide decision making and execute how money is spent as well following a formalised risk management process that safeguards loss of finances. This guidance allows one to infer that properly implemented public financial management would improve stewardship of managers. Relating to the public health service delivery in Malawi, it has been argued in this study that the sector relies on government and donors for funding. Both stakeholders would value stewardship from the managers or the practitioners, and managers should ensure that they are good stewards if funds are to keep coming through.

Ubel and Jagsi (2014:1280) extend financial stewardship to health personnel and claim that stewardship can uphold the wellbeing and healthy status of the populace by increasing access to healthcare as well as diverting on saved resources to other equally deserving activities that contribute to wellbeing. Therefore, the authors believe that if physicians shun away from being financial stewards in making decisions, the public may experience worse outcomes. It should be emphasised, therefore, that funds need to be utilised responsibly from identification of priority areas to spend on; allocation of resources to deserving institutions to the actual spending ensuring that money is being spent on what they were supposed to. What the public healthcare delivery sector in Malawi requires, are stewards at all levels of management.

**2.9.5 X-inefficiency theory**

The X-efficiency theory holds that individuals are sub-optimisers who normally operate that way unless there are efforts to enforce optimisation (Christian & Crisp, 2012:728). This explanation seems to relate X-inefficiency as an extension of the agency problem illustrated by the agency theory where managers double their roles, thus, being principals at one level and an agent at another. It follows that managers may be susceptible to adopting inefficient behaviour. Christian and Crisp (2012:728) apply the X-inefficiency proposed by Leibenstein (1979) to explain the concept of efficiency. In their work, Christian and Crisp (2012:728) elaborate that expenses shoot up unless there is deliberate effort by employees or those in charge to manage and put them in control and as managers in the public sector are agents of the state, the expenditure management function may be compromised as per the inference in agency theory. Thus, with a view to achieve optimisation in the use of financial resources, there may be a need for enforcements to ensure compliance to laid down procedures on resource management.

The thinking by Leibestein (1979) that managers do not minimise expenses, contrasts with the view held by the neoclassical theory that maintains that organisations operate at the lowest cost

as the market is competitive and that there is no need for management function to keep costs down (Christian & Crisp, 2012:731). On the correct supposition that the neoclassical theory is referring to private institutions, it follows that since it is perceived that there is no competitiveness in the public sector, public sector management should always strive to manage and control resource use. Leibestein's theory, however, is in agreement with the complexity theory which states that human attitude has a critical role to play in making an impact on a system (Christian & Crisp, 2012:731). Thus, the behaviour of managers and their subordinates affects the efficacy and effectiveness of resource use in this case.

Borenstein and Farrell (2000:224) discuss X-inefficiency in line with reduction of costs by institutions whereby excess cost consuming activities in a firm are identified and cut; however, the authors point out that not all removed costs reflect inefficiencies. This implies that organisations that want to be efficient need to undertake cost-benefit analysis in order to eliminate wastes and non-value adding activities. Explaining and applying the X-inefficiency concept to public health service delivery, Christian and Crisp (2012:731) view this as the consequences of managers that try to satisfice within set instructions, whilst realising that other factors cause managers to operate or handle resources inefficiently. These factors include peer pressure that managers operate in an inefficient environment of management, weak management and poor leadership. One can, therefore, infer that the work culture and environment influences the extent of efficiency that is experienced in institutions.

Interestingly, Borenstein and Farrell (2000:224) note that organisations that face funding constraints are more likely to cut costs in order to minimise X-inefficiencies. Thus, cost reduction is one of the strategies to minimise X-inefficiencies. Applying the X-inefficiency concept in South Africa, Christian and Crisp (2012:734,735) acknowledge that the public sector, of which the public health system is a constituent, is complex, and note that interactions of participants who are supposed to abide by the set rules and regulations in the system contribute to inefficiency.

Accordingly, the public health service delivery sector faces inefficiencies as has been argued in this study. It is frustrating to see that resources are too limited to adequately cater for the health sector, but even worse, the sector is facing inefficiencies which further cripple operations. These inefficiencies in the public health delivery sector in Malawi noted for this study are linked to deficiencies in public expenditure management that the sector faces. The argument is that, perhaps if the few resources that are available could be used more efficiently, these could help to improve healthcare service delivery.

### 2.9.6 Contingency theory

According to (Ohemeng, 2009:460; Omotosho & Anyigba, 2019:259), the core of the contingency theory is how an organisation responds to a challenge given its specific situation. It shows that how things are done in an organisation is dependent on the specific situation of the organisation. It follows that there is no uniform approach to issues. Marmat and Jain (2019:137) applied the contingency framework to study effective quality approaches in hospitals, and established that this could be best appreciated by evaluating factors that determine quality and, hence, contribute towards work done for manageable quality healthcare in India. If the prevailing conditions were to be different, strategies developed and applied elsewhere may not provide the necessary relief. Thus, it could be settled that the contingency theory explains that if change has to take place in an organisation, game changers have to be mindful of factors that relate with their organisation and not just adopt the so-called best practices. This study looks at the public health sector; its complexities may well differ from another sector, for example, education. As such, public healthcare sector approaches are being sought in this study in order to address the specific sector challenges. The framework that is the final product of this study specifically addresses the public healthcare sector in Malawi, and specifically the district hospitals, by incorporating strategies gathered from this study.

### 2.9.7 Lüder's contingency model

Lüder's (1992) contingency model adds to theory application on public expenditure management in public healthcare delivery service in this study. Lüder proposes a model that describes an approach to reforms introduced to provide detailed and dependable public finance information and a foundation for enhanced control of finances in the public sector (Lüder, 1992:108). This allows one to infer that, for accountability to be achieved, information provided by managers needs to be informative and reliable. Lüder's model can be linked to aspects of accountability, stakeholder, agency, stewardship and contingency theory in that it looks at the best way in which information about the use of public financial resources can be made available to users to permit them have an insight into operations of the organisation. Alkaraan (2018:591) explains that Lüder's model prescribes that the success of a reformed system relies on how the existing conditions have been dealt with. Thus, managers should refrain from a uniform approach to their organisational problems but rather tailor the approaches to the unique challenges faced. Lüder's model contains four units, or stimuli, namely the structural variables or information producers, the structural variables for users of information and the unit on implementation barriers. The present study scrutinises Lüder's units to explore the journey towards enhancing public sector financial management.

For change to be effected, Lüder propounds that there should be an incitement in the sector, or organisation financial stress, or indeed financial scandals, all of which result in non or inadequate provision of public services, for example healthcare. And as Lüder alludes to, this may spark a reaction from the public or other representative bodies demanding more accountability on resource use. Lüder then examines the assertiveness of stakeholders (users and producers of financial information) on the duties they have towards the status on management of finances and efficiencies.

Regarding users, Lüder stipulates that these depend on the socioeconomic status of the players; the higher the status, the higher the edge to demand for more information. This may explain why, for example, the public as a direct beneficiary of public health services often seems mute despite appalling conditions in public hospitals. Instead, the media and civil society seem to be the ones shaking up the public sector.

Another aspect that Lüder includes in his model is the "political culture" of a country, where an open and inclusive government allows demands for information from the public, unlike a closed one. Regarding the producers of information, Lüder explains that the calibre of staff in terms of their drilling and conscription has a role in permitting transformation in the way information is made available. Lüder also notes that barriers to execute change may prevent reforms from taking place. These barriers include the extent of decentralisation in decision making in the public sector which may result in diverse procedures being produced; the flexibility of the legal system, and finance staff qualifications. Therefore, the way in which institutions manage their finances depends on a number of factors as noted by Lüder.

This implies that there cannot be a uniform prescription on enhanced management of expenditures or revenues. For example, Yefriza (2015:148) deduced from her study that the approach towards public expenditure management depends on the context of the country if reforms are to be useful. The present study looks at expenditure management in the public sector specifically in the health sector. The sector has a number of stakeholders who have diverse demands. These stakeholders include the public who fund the hospital in form of taxes and for that reason they have a right to demand a report on how their funds have been used. The government is another equally crucial stakeholder who serves as agents to the public, but are also principals to the managers who manage healthcare service provision. Government needs to be informed of how the funds they entrusted to managers are being used; and lastly but not least, there are donors who provide funding to co-fund hospital operations and who need feedback on

resource usage. Thus, if the information coming through is unsatisfactory to these stakeholders, the outcomes in the health sector are low or unsatisfactory and may well may trigger reforms within the sector.

### 2.10 Chapter summary

This chapter has reviewed literature on public financial management and linked it to public expenditure management in the public healthcare delivery sector. Furthermore, seven theories were examined in order to bring into perspective the principles that guide management of public financial resources, particularly and provide a link between public expenditure management and public health delivery. The theories may seem contradictory to one another, but each one of them brings different aspects of management to the discourse, thereby complementing each other. It can be argued that the common theme among these theories is that they concur that financial resources allocated to institutions have to be managed, accounted for, and used for the purpose they were made available for. Implicitly, the theories hold that management of institutions must be done by persons not necessarily owning the resources. This arrangement brings in diverse scenarios that an organisation has to consider regarding the best angle to ensure that resources are used to achieve the reason for the existence of the organisation. In, Chapter 3, the development of a conceptual framework for financial management deficiencies that public expenditure management faces which has an impact on public health service delivery, is presented.

# CHAPTER 3: PUBLIC EXPENDITURE MANAGEMENT: CONCEPTUAL FRAMEWORK AND EXPERIENCES AROUND THE WORLD

## 3.1 Introduction

The previous chapter provided an overview of public financial management and public expenditure management and the relevant theories. Chapter 3 discusses the conceptual framework that portrays factors related to public expenditure management deficiencies, specifically pertaining to the public health delivery sector in Malawi. In order to assess how public expenditure management in the public health delivery sector can be improved, it is necessary to explore the areas that are established as the financial management deficiencies in the sector. The conceptual framework emerging from the study sets a foundation that was used to formulate and specify an appropriate framework for improving public expenditure management in the public healthcare service delivery sector in Malawi. The conceptual framework also identifies the concepts that explain the failures in public expenditure management in the public healthcare delivery sector. Finally, the framework constructs a link between the theories identified and discussed in chapter 2, areas of financial management deficiency, research objectives and public health outcomes, in so doing addressing answers to research questions set out in chapter 1. Basically, the framework illustrates that the current public health service delivery sector in Malawi faces deficiencies in the areas of funding, budgeting and resource utilisation which affects public health service delivery and therefore, health outcomes. The research objectives formulated in this study address these deficiencies and consequently, public expenditure management may well be improved. Improvements in public expenditure management contributes to enhanced quality of healthcare service delivery and, therefore, health outcomes.

This chapter presents the conceptual framework for enhanced public expenditure management in Malawi and the financial management deficiencies in the health sector around the world. The layout of the chapter is as follows: section 3.2 of the chapter commences with a description of the variables of the conceptual framework, section 3.3 discusses budgeting in the public health sector, section 3.4 explains resource wastages and leakages in the public health sector, 3.5 deliberates the funding situation in the public health sector and section 3.6 argues about public health expenditure and health outcomes and section 3.7 provides the summary chapter.

### 3.2 A conceptual framework for public expenditure management for the public healthcare service delivery sector in Malawi

Chapter 1 established that there are financial management deficiencies in the public healthcare service delivery sector in Malawi in the areas of budgeting, financial resource utilisation resulting in wastages and leakages of financial resources and funding. Figure 3.1 shows a framework that depicts the variables that impact public expenditure management and public health service delivery.

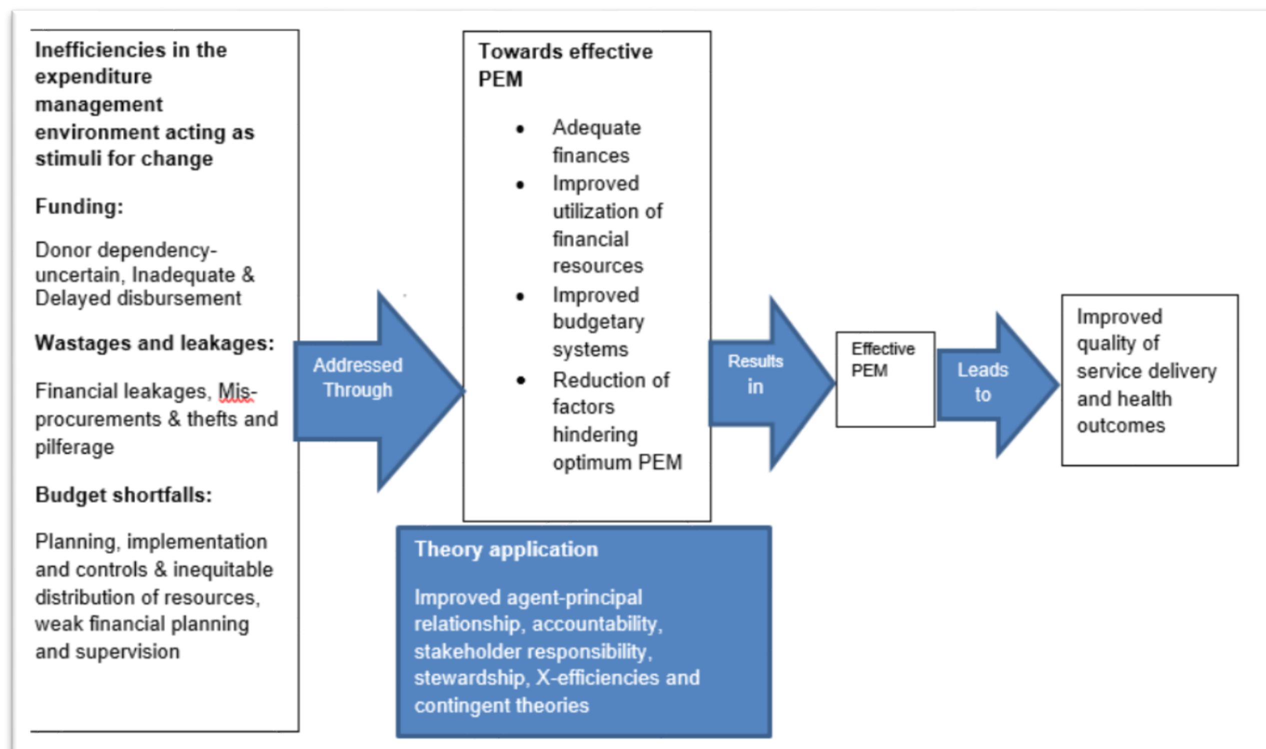



**Figure 3. 1: A conceptual framework for public expenditure management on public health service delivery in Malawi**

**Source:** Own source

The conceptual framework above shows that financial management deficiencies exist in the areas of budget preparation and execution, financial wastages and leakages and funding challenges that affect public expenditure management and consequently, compromise on service delivery. Furthermore, it is hoped that if the research objectives are addressed, the sector would experience effective public expenditure management. Public expenditure management herein refers to the processes and procedures through which a public entity ensures that the financial resources are appropriately allocated and effectively and efficiently utilised. Specifically, for

Malawi's public health sector, as can be referred to figure 3.1 in the conceptual framework, the following financial management deficiencies are experienced: donor dependency; inadequate funding; delayed disbursements; financial leakages; mis-procurements; theft and pilferage; uncoordinated budgets; inequitable distribution of resources; and a weak financial planning and supervision function. Regardless, even in a state of abundance of resources, appropriate management of financial resources is necessary if goals are to be attained.

### 3.3 Public financial management in the Malawian context

Malawi decentralised provision of selected services including health at district level, as such districts councils have mandates to deliver services, however, their ability to influence outcomes is limited, since most spending decisions are made at central government level. For instance, decisions on staff hiring, salaries and wages payments, development expenditures, drugs and medical supplies are made centrally. This entails that hospital and Council management have limited oversight, thereby, undermining stewardship functions (Piatti-Fünfkirchen *et al.*, 2020:iii). Furthermore, Piatti-Fünfkirchen *et al.* (2020:v) explain that the fragility of the health systems is undermined by the poor communication on budgets coupled with late releases of inadequate finances.

The desires of the Malawi Government to achieve the Universal Health Coverage as has been spelled out in the Ministry of Health strategic plan, (Ministry of Health, 2017a:XII) is hampered by the limited resources environment the country is in and the limited funding sources for the health sector (Chansa *et al.*, 2018). As such, efficiency in the utilisation of government spending is crucial especially with the debate that quality of public finance management has an effect on health outcomes (Piatti-Funfkirchen & Schneider, 2018:337). Studies have revealed that there are weaknesses in the management of public finances in the public healthcare delivery sector in Malawi. For instance, Carlson *et al.* (2015:6) point out that management of public expenditure is challenged by manipulation of systems and procedures to by-pass controls in expenditure, inadequate procedures for monitoring of consumption and prices against set standards, supplies leakages, mis-procurements, collusions of staff and suppliers when acquiring maintenance contracts resulting in higher costs and inadequate budgets. Such inefficiency in resource management are attributed to: weak supervision, lack of performance management and accountability systems, staffing structures that permit overriding of checks and balances leading to misuse and abuse of resources with sanctions that are not deterrent enough to prevent abuse (Carlson *et al.*, 2015:7). With such a financial operating environment, it is inevitable to have incapacitated service delivery in the public healthcare sector.

### 3.4 Budgeting in the health sector and its deficiencies

Piatti-Funfkirchen and Schneider (2018:336) observe that public financial management is concerned with the management of financial resources in the public sector using the budget. Thus, budget management is critical to public resource management.

Anessi-Pessina *et al.* (2016:502,503) expand on these observations as they consider the budget as a tool for negotiating and allocating resources; planning and effecting control over resources; and stakeholder involvement and attaining transparency. Hence, the multiple functions of the budget strengthen its significance in public service delivery sector. Oyewo and Adyeye (2018:48) add that a good budget system permits the prudent use of financial resources in the public sector. It follows that if the budgetary system is mismanaged, usage of public financial resources maybe compromised. Specifically referring to the health sector, Capuno *et al.* (2018:93) hold that a robust budgetary process is a condition for effective spending. Thus, the rigour required in the budget process cannot be ignored if the document has to serve its purpose.

Anessi-Pessina *et al.* (2016:502) set the ground in this regard by asking what has to be done in research studies in public budgeting in order to contribute more in addressing the challenges that the public sector is facing. The authors suggest that there is need to isolate the specific area that requires investigations whilst addressing the relevance of such a study to the people and the practitioners. This indicates that there are gaps in research relating to public sector budgeting which have to be filled. For instance, Anessi-Pessina *et al.* (2016:506) note that budgeting research can contribute towards external accountability, stakeholder inclusion and identifies it as a good research area. This implies that the budget is a crucial tool for management and achievement of goals in the public sector as such there is need for more scholarly work on budgeting to inform practice and policy. The need for proper budgeting in the public healthcare sector management, a sub sector of public management, is well debated.

The World Health Organisation (2016:34) identifies challenges associated with budgeting for healthcare in Africa as including non-prioritising of the health sector in sharing public revenues; unstable funding in the health sector; production of historical based budgets; unequitable budgetary allocations; underspending budgetary allocations which portrays weaknesses between public finance and health management. In addition, Le Gargasson *et al.* (2014:1040) identify excessive usage of off-budget procedures, limited human resource and capacity, lack of motivation, interference on funds flows from ministries and dependence on donors' disbursement schedule as causes of inefficiencies in budget management. Therefore, it is imperative for

respective governments to identify the budgetary challenges in the public health delivery services and address them otherwise public health service delivery will remain poor.

With regard to underspending, it is explained that obtaining the right to use full budgetary allocations requires cooperation between financing authorities and health managers (World Health Organisation, 2016:34). Thus, the underspending experienced by public health sectors could be explained by a misalignment between the health and finance functions.

Regmi *et al.* (2010:372) explain that in Nepal, financial resources were moved from central to local government in a bid to improve resource allocative efficiency in the healthcare sector but this was not attained. The authors cite that one of the challenges was that the budget preparation stage was faulty, because instead of assessing resource needs as a guide to budgetary provisions, officials simply increased the previous budget's figures. This practice supports the view that for effective budget management, all stages of the budget process should be done thoroughly, because each budgetary stage feeds into the next. Moreover, the budget setting stage is crucial as this determines how much funds are allocated for improved service delivery. With this in mind, Tsofa *et al.* (2016:261) call for more research into the circumstantial issues affecting overall planning and budgeting processes in the public sectors, specifically the health sector. Thus, research is required to improve public sector budgeting process and management. It could, therefore, be deduced that if effectively prepared and executed, a budget would be a great tool used in management of resources starting from need and priority setting to its implementation; otherwise, the myriad challenges attributed to budgets implementation and management will continue to impair public health sector service delivery.

### 3.4.1 Budget planning, implementation and control

Piatti-Funfkirchen and Schneider (2018:336) claim that the manner in which governments use budgets to manage public financial resources impacts on health policies and, consequently, the authors question whether public objectives on efficiency, equity, quality, and accountability are attained. This debate leads to the thinking that public goals can be better achieved if there were good budget management. Anessi-Pessina *et al.* (2016:497) identify allocative functions of the budget where limits are set to guide spending levels for each spending unit. Thus, the allocations made in the budget have to be analysed periodically against actual spending in order to determine compliance to budgetary provision. Piatti-Funfkirchen and Schneider (2018:338) link the budget cycle to public health service delivery pointing out that during budget formulation stage spending priorities are established and incorporated in the budget to cater for health delivery activities. Thus, the monetary provisions set in the budgets have to be complied with in terms of spending activities and amounts, if budget holders are to be seen to be managing expenditure and since the allocations are for set areas, budgets should help the public health sector to deliver its outcomes.

Andrews *et al.* (2014:2) explain that a budget proposal undergoes an approval process by the legislature wherein authorisations are obtained to permit generation of funds to support the expenditure as provided in the budget. This is in the view of the fact that before the implementation of any plan, including a budget which is a financial plan of goal achievement for an organisation, authorities need to sanction its implementation. Andrews *et al.* (2014:3) expand on the budget execution and resource management stages of the budget process, noting that the execution stage requires that the necessary processes are followed to generate funding for the spending organisations, and that finances are made available to pay for expenses for the procurement of goods and services. Thus, as budget allocation permits budget holders to spend as per the provisions, the execution stage looks into the disbursements and utilisation of funds. The budget evaluation stage in which ‘external audit and accountability’ processes take place, is the last leg in the public financial management processes. Here one evaluates the compliance of financial transactions to set rules and procedures. Thus, budget evaluations are done to confirm if the allocations in the budget have been utilised as provided. Therefore, it has to be noted that each of the budget processes have a unique function that it serves and if an organisation lacks in some aspects, there may be shortfalls as to what the budget could achieve.

Achievement of health goals does not only rely on increased health funding, but also on ensuring that budget allocations in the sector are suitably marked, and that the implementation of budget

allocations and the resources allocated to the sector are used efficiently (World Health Organisation, 2016:8). Thus, it is not enough to have sufficient allocations in budgets; one must also ensure that resources are used efficiently and for what they were meant to be.

Such issues arise, because resources for public health delivery are often not distributed in the most favourable way possible and, hence, marked priority areas and populations are not adequately served. Furthermore, deficiencies in financial management have resulted due to the incomprehensive and unsystematic execution of public health budgets (World Health Organisation, 2016:8). This bears out the point that equitability of resource allocation within and amongst service delivery institutions is crucial if national health outcomes are to be achieved.

Regarding the misalignment of budgets and planning, one should note that the activities of producing health policies, planning and budget production are not linked and coordinated and as a result, priorities in the health sector and funds provided by the Ministry of Finance do not always agree (World Health Organisation, 2016:21). Clearly, then there has to be alignment of budget activities by the health and finance officials so that funding and institutional activities are synchronised. In addition, Capuno *et al.* (2018:93) note that the Philippines, for example, introduced a compendium of public financial management reforms that oversees formulation and planning of budgets. They, however, record that healthcare service delivery budgets are decentralised to local governments where they experience a weak connection between the budget for health, plans and goals. This entails that it may not be sufficient to have measures aimed at budget implementation, but one must also consider having suitable organisational structures. Witter *et al.* (2014:451) explain that budgets provide guidance on expenditures, but if during the year the sector face changes or there are funding issues, then there will be discrepancies. Thus, a budget is a financial plan with underlying assumptions, and therefore, as appreciated, not all assumptions hold true during the budget implementation phase. The art of budget management is therefore a delicate one.

Ajibolade and Oboh (2017:233) explored public expenditure versus economic growth, and found that Nigeria's economy was declining despite availability of government expenditure to improve economic development. The authors cite public financial mismanagement and poor budget implementation practices as the causes. This explains the notion that there is more to the achievement of goals than mere increases into finance availability; thus, finances need to be managed effectively. Ajibolade and Oboh (2017:234) conclude that the Nigerian government, for example, has not experienced sound achievements through the budget system due to

noncompliance with specifications in the budget and flouting of procurement procedures. The authors, therefore, recommend improvements in public sector accounting for more transparent and accountable public expenditure. Thus, it is hoped that being accountable and transparent will expedite developments in the economy and result in effective resource utilisation. This argument leads to the fact that compliance with set procedures, transparency and accountability results in effective funds management. Iyoha and Oyerinde (2010:370) state that in Nigeria, budget planning and implementation, a critical tool in public entities, seems to be little apart from a ritual and not a vital guide leading to effective and efficient financial resource use. Clearly, this is the reason there are lamentations about governments not achieving stated goals, because institutions lack goal congruence. Despite all the sentiments on the importance of the budget in public management, Piatti-Funfkirchen and Schneider (2018:336) note that there has not been an examination on the link between formulating and approving; executing; and evaluating the budget versus health service delivery and recommends that an argument be raised on the same. This entails that there are gaps that researchers need to fill in, in the area of budgeting. It is worrisome that managers at different levels of interacting with the budget are failing to benefit from its merits.

Financial controls lead to effective management of finances. Financial controls purport to facilitate the execution and effectiveness of finances (Lvova & Burnysheva, 2018:488). Thus, controls are measures meant to safeguard finances in order to ensure that they are being spent where they were supposed to. Masciandaro and Quintyn (2016:982) consider the financial supervision function as a principal-agent issue. By implication, the manager is the agent entrusted with organisational resources, and is watched over by his supervisors who in this case is the principal. This is the case because it is in the principal's interest to see to it that resources have been utilised in the best way on set activities. Gauthier and Wane (2008:70) explain that the public health sector in Chad, for example, faces inadequate supervision and regulation of resources to the extent that some resources were not serving the purposes they were meant to. It is, thus, implied that for a budget to assist in achieving organisational goals, controls must be in place to oversee how the budgetary provisions and actual disbursements relate; otherwise there is a possibility that budget targets in terms of allocated amounts and activities may not be achieved and the resources could be diverted.

### 3.4.2 Financial resource allocation and inequities in public healthcare sector

Public health systems face challenges in ensuring that financial resources are well distributed amongst populations. For instance, there are inequities in accessing healthcare due to the wide gap between health needs and what is provided (Alami, 2017:146). This entails that the mismatch

between the resources provided and the health needs may not result in the achievement of health outcomes. Achieving health goals should include among other factors the fact that budget allocations should be made according to set targets and needs (World Health Organisation, 2016:8). Given that there are inequalities in resource distribution in the public healthcare delivery sector; health outcomes vary among populations. Sikander and Shah (2010:884) refer to inequalities in service delivery in healthcare, and note that resources should be distributed in a way that ensures that public funds reach the deserving poorest in the districts. Thus, it is imperative to have efficiency in resource allocation. There is advocacy for equitable resource distribution, more especially to the vulnerable populations because these groups may not afford to finance their own healthcare. According to Morton (2014:165), inequalities in public healthcare service delivery are a common experience, and although there seem to be much effort devoted to the matter, it remains a concern as to how it can be overcome. Morton adds that an ongoing challenge in resolving this problem is the lack of information about population health status distribution. Hence, it is necessary to determine an appropriate formula to guide resource allocation that takes into consideration poor populations.

Cashin *et al.* (2017:17) note that allocations are made basing on number of hospital beds and staff which results in funding the wealthy urban areas more. Thus, the traditional funding allocation basis of using capacity and not need, have proved to be inappropriate in addressing inequitable resource allocation. This is the case, as it has been observed, that there is no optimal distribution of finances for health service delivery, consequently, deserving populations fail to access medical care (World Health Organisation, 2016:25). It follows that the resultant health outcomes in areas where people are experiencing unequitable distribution are poor. Also, despite additions to public health expenditure, there has not been improvements in financial health protection for the most vulnerable. This is because public resources do not get to their targets and are not used for what they were meant for, and consequently, disastrous health spending is common among the poor (Mchenga *et al.*, 2017:29; Novak & Bridwell, 2019:434; World Health Organisation, 2016:25). This implies that due to inequitable funding, the poor either forgo accessing healthcare for lack of resources or access healthcare at the expense of other personal needs. For example, in Chad, the healthcare budget is heavily subsidised with public funds, but due to inequitable distribution of financial resources, subsidised health services are mostly accessed by the rich. An estimated 63% of healthcare budgets are allocated to national hospitals in the city where most of the rich are, and only 26% is allocated to the rural hospitals to cater for the poor. This discrepancy in resource distribution may result in compromised access to healthcare more especially by the poor

community. Accordingly, Boachie *et al.* (2018:59) argue that allocation of finances should be appropriately done, otherwise institutions will experience ineffective spending.

In South Africa, Hlafa *et al.* (2019:2) noted that there were discrepancies in health outcomes amongst provinces and call upon the government to reorganise healthcare system in order to eliminate the differences. Thus, governments should see to it that allocations are done on an equitable basis commensurate to need, otherwise countries will continue to report poor health outcomes. Clemente *et al.* (2019:507) discovered that the decentralisation of the health system led to disparities in healthcare delivery and alluded the situation as relating to healthcare expenditure determinants in that area whose basis include fiscal advantages and size of some regions in the country, population density and politics. In the same vein, Borghi *et al.* (2018:59) advise governments to trace financial resource allocations at all levels up to the subnational level in order to achieve maximum equitability in allocations and confirm that the allocated resources address health needs. This implies that some sectors of the population receive less allocations than they need and would not fully access medical care, thus impacting on national or regional health outcome indicators. This may be a setback for economies, since to appreciate benefits of a healthy nation, means all-inclusive healthcare that does not leave anyone behind.

South Africa is failing to provide high quality health care despite the huge amount of financial resources that go into the sector citing inequities in resource distribution among other reasons (Christian & Crisp, 2012:725; South African Lancet National Commission, 2018:1). This shows that the inequitable distribution of resources results in low quality healthcare provision. As such, governments need to review the way resources are distributed in order to address the situation. Maharaj *et al.* (2018:190) established that in South Africa, resource allocation and expenditure inequities in the public health system exist in the districts and provinces. However, the authors point out that developing and developed countries should be apportioning financial resources on a needs based allocation of resources. Thus, a needs-based approach to resource distribution can ensure that sub-nations that require more funding as per their needs requirements are properly taken care of, thus improving health outcomes. This is contrary to what South Africa is practicing at the moment as Maharaj *et al.* (2018:190) note that financial resources in healthcare are apportioned using historical inflation-adjusted figures. These figures incorporate inequities in resource allocation across South Africa, where it is recommended that an evidence-based and equitable resource allocation basis for resource allocation should be pursued. It follows that historical bases for allocation is not the best way to realistically allocate resources as needs change and more are added whilst others become obsolete; thus, if there were errors in

determining the budget at the beginning these will be incorporated in the future budgets. Islam *et al.* (2018:66) made similar observations as Maharaj *et al.* (2018:190), and reveal that the public healthcare system in Bangladesh uses prior funding trends and number of beds. The authors, therefore, suggest that the country should consider allocating public resources for healthcare basing on a selected criteria established by demand for resources like size of the population; burden of diseases, bed turnover rate in a facility otherwise without a needs based criteria, there would be allocation inefficiencies. It may well be that those handling allocations of public resources could also look into other costs in rural healthcare provision as Maharaj *et al.* (2018:191) observe that it is costly to deliver health services in the rural areas due to among others, scattered populations and transportation costs. Implicitly, the best resource allocation basis for public health care service delivery is one based on need. Thus, the higher the demand for healthcare services, the higher should be allocation for resources; otherwise, our health delivery sectors will continue to suffer from health coverage and access gaps.

### 3.5 Wastages and leakages

Efficiency in the use of resources in the public sector relies on, among other factors, an institution's desire to implement strategies enabling efficiency in resource utilisation (Boe & Kvalvik, 2015:873). This entails that institutions need to devise ways on how they can utilise resources in the best possible way. Świrska (2014:109) cites that Poland experiences inefficiencies in resources utilisation such as the mismanagement of resources and wasteful resource use; such issues require increased transparency. This implies that increased transparency can enhance resource inefficiency. Christian and Crisp (2012:726) note that an X-inefficient public health sector provides wide spectrum for improved outcomes if the inefficiencies are reduced; the authors recommend further research on the nature, extent and contributors to inefficiencies; citing that such research would be instrumental in guiding the designing of policy which would encourage managers in being more efficient. Thus, institutions need to be efficient in order to free resources for the good of their institutions. This study contributes to reduce that research gap.

Examples of inefficiency in public resources utilisation in the public sector are numerous. For instance, Christian and Crisp (2012:725) note that South Africa experiences poor service delivery and consequently, poor outcomes in healthcare sector, despite the huge amount of financial resources that go into the sector. It is suggested that inefficiency in resource utilisation was the reason for poor delivery and outcomes. This implies that a degree of inefficiency is at play within the system. It could be inferred that part of the challenge has been to redistribute scarce resources

more equitably among a growing population. For example, on average in African countries, 16% of government funds are allocated to the health sector of which only 4% is spent on the right health services. This allocation fails to ensure that public finances meant for the public sector are used for the correct purpose, and has negatively impacted public health service delivery (World Health Organisation, 2016:34). Those financial resources that are available for public health delivery, albeit inadequate, would go a long way towards health service delivery if there was efficiency in their use.

### 3.5.1 Management of procurements

Procurements consume a large percentage of financial resources. It is lamented that pitiable governance observed in some public procurement systems are a recipe for non-achievement of public goals, costly procurements and a waste of public financial resources (World Bank, 2013:3). Thus, governments fail to achieve public goals due to poor financial governance. McCue *et al.* (2015:180) provide a sound argument for inefficiencies experienced in public procurements, reporting that the monopolistic nature of governments is responsible for the public sector inefficiencies. This is because they do not face competition to motivate them to improve on quality and cut on prices. These facts indicate that the bureaucratic structure and domineering nature of the public sector contributes to financial inefficiencies including when undertaking procurements.

Since the public procurement function contributes to the delivery of goods and services to the public, how procurement is done and consequently, how financial resources are handled affect service delivery. It has been established in this study that the public sector in general and the public health delivery sector in particular, operate under constrained resources and that there is need to improve efficiency and effectiveness in financial resource use. As expenditure of goods and services consume quite a huge chunk of public resources through public procurements, procurement management should be improved so that the acquisition of goods and services for the public sector service delivery (including health) achieves value for money.

Because the public sector uses significant public resources to provide public services (health inclusive); it is emphasised that the public sector should ensure value for money when spending (Botlhale, 2017:285). Hence, the public sector is advised to devise procurement strategies that will result in high value procurements. Ibrahim *et al.* (2017:373) note that value for money is realised when procurement procedures are undertaken appropriately. Consequently, value for money procurements result in having goods and services that are economically, effectively and efficiently acquired. These can be achieved by complying to best practices in procurement or procurement rules as provided by the public sector. Deasy *et al.* (2014:25) concur and

recommend that institutions should adopt 'best practice' in procurement regardless of the size of the budget allotted to procurements if they are to maximise the financial value of the function. This recommendation suggests that institutions stand to get maximum value from any procurement by adhering to set guidance. Thus, Williams-Elegbe (2014:87) note that the goals embedded in public procurement legislation which include competition, transparency, integrity, best value and efficiency, drive best practices in public procurement. Thus, if these goals are achieved by an organisation, that should lead to the effective utilisation of financial resources a recipe for effective expenditure management.

Applying the agency theory, Bawole and Adjei-Bamfo (2019:302) argue that some practices prevalent in the public procurement environment in Africa attract agency problems in public financial management. Since public procurement is done by agents entrusted to discharge responsibilities in the public sector on behalf of their principals, agency problems emerge when these agents choose to use public financial resources in a manner that does not give best value for money procurements. Bawole and Adjei-Bamfo (2019:315) add that outcomes relating to public financial management reforms are lacking in Africa because of cultural values, economic variables and the governance structure that underlie the public procurement setup in the region. Thus, governance issues, organisational culture and the nature of the African economy have an impact on the extent to which reforms in public financial management are effective. For example, Carlson *et al.* (2015:16) explain that the Central Medical Stores Trust (CMST) is responsible for 'selling' medical drugs to hospitals, but due to a lack of budget management and appropriate communication on budget allocations, hospitals (which are cost centres) continue to procure drugs surpassing budget provisions. This entails that the budget, which is supposed to guide expenditures, is ignored when making procurement decisions. Consequently, products procured may not be according informed requirements, as they may be over or under-stocked. In Botswana, for example, Botlhale (2017:294) notes that public procurement is challenged with poor adherence to procurement plans, unauthorised procurements, insufficient supervision; and non-submission of activity expenditure reports. Noncompliance to rules of procurement leads to ineffective and inefficient public financial management. In Ghana, Ibrahim *et al.* (2017:383,384) found that public procurement faced issues of compliance with procurement regulations. For example, when procurement plans were produced, accountability was enhanced because it became possible to analyse the procurements and institutions could monitor planned and actual procurements as well as auditing procurement records. This is contrasted with situations where procurement plans were not produced and procurement was not linked to budgets or procurement

was at the mercy of the head of the institutions. The consequence was that contracts were given to non-qualifying providers who charged exorbitant prices and provided poor quality service. These facts indicate that compliance with procurement guidelines and regulations benefits institutions by providing an accountable and transparent environment, thereby safeguarding their financial resources.

Additionally, Carlson *et al.* (2015:6) found out that there were a number of factors that led to neglecting rules aimed at safeguarding resources, including low competence levels, employees' low wages and the general notion that public goods are free and lack ownership. Additionally, drivers of inefficient management of resources in procurements in the public health sector include weak supervision and accountability functions, absence of standard costs for costing and expenditure control purposes. It is, thus, implied that procurements in the public sector in general and the health delivery sector in particular should use finances better by obtaining value for money procurements if procurement regulations were adhered to by those entrusted in managing financial resources. As a result of not complying with guidelines, the public sector loses out on funds that could have otherwise improved health sector delivery.

### 3.5.2 Resource wastes and losses through thefts and pilferage

The public health delivery sector faces inefficiencies including resource wastages and losses, that contribute to poor health outcomes. It is claimed that until the factors contributing to the inefficiencies in the health sector are addressed, countries will keep pumping resources without improvement in health outcomes (Christian & Crisp, 2012:725). Thus, public financial resources are wasted due to inefficiencies in the public healthcare delivery sector. These inefficiencies result in poor health outcomes. According to West *et al.* (2014:873), waste reduction in hospitals is a priority; an entity should aim to enhance the prudent use of financial resources. Hence, hospitals working in constrained financial resource environments have a greater need to be more efficient in their financial resource utilisation.

In relation to waste of medicines, Gebremariam *et al.* (2018:148) claim that in Ethiopia, medicines are wasted as suppliers deliver almost expired products; medicine exchange mechanisms are insufficient, and so are pharmacy personnel. Similarly, Kagashe *et al.* (2014:100) identify the mismanagement of medicines as being caused by having excess quantities, pilferage, change of medication and death of patients. This shows that health facilities have internal challenges ranging from capacity and insufficient controls that contribute to wastage and inefficiencies as well as to some extent uncontrollable factors.

Carlson *et al.* (2015:8) found, immense wastage and misuse of resources in the Malawian public healthcare sector; it is recommended that an improved system is implemented to encourage good practices that discourage theft and wastage. Carlson *et al.* (2015:8) note that inefficiencies in budget management, lack of power over resource use by managers in the healthcare sector, meant that recurrent transactions items were prone to misuse. The authors suggest improvements in the health system to ensure that managers are more accountable, and that authority should be decentralised to hospital managers. These areas of potential resource waste require evaluations so that there are improvements in safeguarding them.

### 3.5.3 Financial leakages

Gauthier and Wane (2008:58) define a leakage as a part of resources allocated for a given exercise but that do not eventually reach the target. This implies that the plans supported by the budget allocations cannot be supported as there are less resources for them. Finances leak because of a number of reasons. For instance, in South Africa, Rangongo *et al.* (2016:7) contributes financial mismanagement to insufficient expertise for financial management, poor control and monitoring of usage of public funds, lack financial policies, carelessness, unavailability of financial policies and lack of integrity. These points demonstrate that there is a number of internal and externals factors that contribute to mismanagement of funds. Consequently, individual institutions should analyse their specific cases and address them accordingly. According to Myende *et al.* (2018:3), noncompliance with policy instructions on financial management functions such as segregation of duties also contributes to mismanagement of funds.

Regarding the supposition that the public sector is under-employing, this state of affairs could be attributed to understaffing where it is impractical to implement appropriate internal controls like segregation of duties. Rangongo *et al.* (2016:8) further recommend that for improved finance management, the following strategies should be considered: routine monitoring and control of expenditures; enhanced accountability through regular reporting; reporting financial misconducts; and training to those responsible for handling finances. Thus, applying the agency theory, the supervisor has a responsibility over the managers to ensure that managers act in the employers' best interest by undertaking the necessary steps to safeguard public resources. Rangongo *et al.* (2016:8) note that the mismanagement of funds cannot be completely wiped away, but it is possible to reduce it by ensuring that appointees are moral and ethical characters, and have an effective financial surveillance system and institute deterrent measures. Clearly, this calls for

financial management interventions aimed at ensuring effectivity and efficiency in the use of public resources.

### 3.6 Funding issues in the public healthcare delivery sector

A study by Top *et al.* (2020:66) indicates that a number of African countries are increasing resource allocations to the public health sector delivery service, but advise that decision-makers should be in the know as to whether there is efficient and effective use of the provided resources in the sector. Thus, governments have acknowledged the need for increased financial resources which, if they have to benefit the respective institutions, should be managed efficiently and effectively. Cashin *et al.* (2017:22) emphasise the importance of adequate and regular financial resources for the achievement of objectives, but note that for the health sector, consequences of shortfalls on budgets are disastrous in terms of disease management and death. As has been observed, it shows that public resources allocated to the public health sector are inadequate to cater for quality public health service delivery. This may be the reason that governments are beefing healthcare funding. Chireshe and Ocran (2020:146) claim that the poor health status in Sub-Saharan African countries arises due to financing challenges in the sector. Clearly, the African health burden can improve if there were sufficient finances that are well managed. Novak and Bridwell (2019:433) note that Africa has been tackling the improvement of healthcare provision of its people and realise that the statuses of healthcare differ amongst African countries. Generally speaking, the public health delivery sector is inadequately financed.

In a bid to enhance the economic and social situation in order to improve the public health delivery sector in Africa, African leaders made a declaration in Abuja to ensure that their countries should commit 15% of their national budgets to healthcare sector on the presumption that this allocation would be adequate for healthcare delivery (Alhassan *et al.*, 2020:1; Novak & Bridwell, 2019:433). However, Witter *et al.* (2014:451) ponder how the 15% of national budgets benchmark declared at the Abuja convention was arrived at. These authors argue that satisfactory funding should be able to cover healthcare delivery requirements and therefore, how much is allocated to health should depend on need. Accordingly, governments should procedurally establish the health requirements of their countries and strive to provide for the same. Mensah (2014:51) propounds that incomes for countries was dwindling, and as such healthcare resources should be used efficiently. Hence, efficient and effective utilisation of financial resources should make up for the limited resources. In addition, Mensah (2014:51) argue that countries in Africa should try to meet the Abuja target for public health expenditure of 15% of national budget by re-looking at their priorities in terms of resource allocation amongst spending departments. Thus, a country’s budget

allocations should dictate how much allocations the health sector should receive, rather than a blanket 15% allocation of national budget.

Indeed, health financial demands are spelt out by the need for various healthcare services. Khuluza and Haefele-Abah (2019:2) note that a growing population like Malawi necessitates governments to pump more financial resources to cater for the growing population. Additionally, focusing on Africa, Novak and Bridwell (2019:434) state that Africa's challenge in failing to provide quality healthcare is due to inadequate funding; the authors advise that African countries should endeavour to invest more in healthcare service provision and look for additional funding sources. These facts indicate that inasmuch as there is need for improved efficiency and effectiveness in the use of financial resources, an injection of resources is necessary where the population keep increasing. Yet, with reference to decentralised management, Yefriza (2015:147) states that local governments face challenges in providing public healthcare services due to limited finance resources. There is also significant reliance on funding from the central government, which at times is handicapped in terms of providing adequate funding. This proves that often funding to health sectors is limited, even in the light of restructuring the management of health service provision to a decentralised level.

However, Lauzán (2017:592) argues that it is not about the money available for operations; rather, what matters is how the money is utilised. Enhanced service delivery does not necessarily mean adding on finances, but rather relooking at how services are delivered and finding better and improved ways of adding value to service delivery. In other words, Lauzán (2017:592) claims that it is possible to provide better quality at a reduced cost only if health spending was really an investment not merely spending. This demonstrates the need for public healthcare service providers to be innovative in the use of the available financial resources and the emphasis is that in all that is done quality should not be compromised. Chu *et al.* (2019:35) observe a trend of increased healthcare expenditure over the years, whilst Islam *et al.* (2018:65) state that South Asian countries have challenges in utilisation of resources in order to offer quality and affordable services; in addition, these countries are challenged on allocation of funding constrained budgets. Thus, beyond Africa, resources for healthcare are constrained and utilisation of resources is as well a challenge which calls for countries to make improvements in these areas. To this end, Islam *et al.* (2018:66) propose that there should be more resources generated for health services delivery; improved equity and access for the poor, and enhanced resource allocations and utilisation efficiencies. These are some of the interventions that healthcare delivery sectors can embrace to bring improvements into healthcare financial management.

Some countries in Africa that are keen to provide improved quality of healthcare services have chosen to increase healthcare funding and looked into ways to better manage public health expenditure (World Health Organisation, 2016:16). This demonstrates that it is possible to make improvements in healthcare financial management and attain desired objectives. Chansa *et al.* (2018:324) opine that Malawi should intensify efficiency in its use of resources through improved public financial management and governance; the authors note that revenue increasing sources for the country are limited. Thus, the need for adequate financing in the public health delivery sector cannot be disputed and the situation is further exacerbated by the inefficiencies in financial resource management.

### 3.6.1 Inadequate funding

Rao (2018:6) laments that limited funding and low spending in sectors such as education and health have constrained enrichment of the poor and escalated inequalities among the masses. This means that adequate funding is vital for service delivery, especially in the public sector where mostly services are offered for free. For instance, Cashin *et al.* (2017:17) illustrate that despite improving coverage for access for healthcare, the chronic underfunding for Brazil has affected the quality of healthcare service provision and has increased out-of-pocket spending on health. Thus, constrained funding in the health sector has been seen to negatively affect healthcare service delivery and access to healthcare, both of which deter achievement of health outcomes. Discouraging reliance on out-of-pocket health spending to supplement public health expenditure, (Mchenga *et al.*, 2017:25; Myint *et al.*, 2019:129) reveal that the more the poor spend on health, the more the levels of poverty tend to worsen and the more limited is their access to health services.

Inadequate funding has led to a number of deficiencies in service delivery. For instance, it has been revealed that in South Africa, hindrances to provision of quality healthcare have been attributed to include inadequate financial resources (South African Lancet National Commission, 2018:1). Thus, limited funding leads to poor quality service delivery in the healthcare delivery sector specifically, and in the public sector generally. Mayosi and Benatar (2014:1346) adds that infrastructure in the South African public healthcare is of poor state due to the mismanagement of financial resources, neglect and under-funding. This entails that if resources are inadequate and are not managed properly, those entrusted with provision of resources will fail to discharge their set responsibilities. Capuno *et al.* (2018:93) note that merely increasing funding through the newly introduced sin taxes in the Philippines, for example, resulted in increased health sector funding, but did not yield the desired health outcomes since the additional collected funds were

not properly managed. This was the case because medical personnel need incentives to perform if health outcomes are to improve, and in addition the operating environment is infested with corruption. These issues suggest that apart from merely injecting resources in the public sector, governments should strive to provide conducive environment for financial management. With reference to personnel indulging in corrupt practices, Souliotis *et al.* (2016:160) reveal that this was also due to deficiencies in the system of health which include healthcare budget reductions, lowly paid providers of healthcare service, and weak or no corruption controls. Thus, financial mismanagement occurs due to system deficiencies which provide opportunity or employees to abuse resources. It has been noted that significant financial injections are unlikely to happen in the African region in the foreseeable future, and that it can be concluded this is all the more reason for the health sector to be more proactive in managing public health expenditures more prudently and efficiently (World Health Organisation, 2016:15). This may entail that financial resources continue to be a limitation in Africa, as such governments should be innovative enough to maximise benefits from the available finances.

A number of countries have come up with strategies to beef up income for the health sector. For instance, Viet Nam, Ghana, Peru, Mexico, and Indonesia introduced health insurance systems as a way of increasing resource availability in healthcare delivery (Myint *et al.*, 2019:129). Whilst Chu *et al.* (2019:39) mention heavy subsidies for the poor, whilst increasing national health insurance contributions, taxation on sugar sweetened beverages and on alcohol and tobacco and earmarking finances for the specific allocation of making them available to the health sector. Other efforts towards beefing up funding levels include tagging incomes from a specific tax category Cashin *et al.* (2017:36); or alternatively as South Africa does, earmarking for expenditures (Cashin *et al.*, 2017:37). Thus, an allocation towards public revenue collection is devoted to health. Interestingly, Kostyak *et al.* (2017:120) bring another dimension in the public health delivery sector in the area of improved finance availability in low and medium-income countries, namely public-private partnership for health. This strategy requires a conducive environment for cooperation between the public and private sector. This leads one to infer that institutions need to diversify revenue sources in order to cater adequately for healthcare service provision, instead of depending on a limited range of income sources. Thus, the present discussion herein demonstrates that public health expenditure can be supplemented in a variety of ways, depending on a country's situation.

### 3.6.2 Donor dependency

There has been growing demand for health resources to cater for the increased health needs of developing countries that cannot be adequately satisfied by government funding (because only a third of healthcare expenditure is received from the government) (Micah *et al.*, 2019:1). This demonstrates failures by governments to provide for the healthcare needs of their people and the subsequent dependence on other sources. According to Dieleman *et al.* (2015:2063), countries in the high-income category give financial aid to enhance low-income countries' health delivery sector. Thus, donor funds supplement public health sector funding. However, this is inadequate to effectively finance service delivery in the health sector. As Gauthier and Wane (2008:73) explain, external financial support reduces the effects of constrained public resources.

Hung and Hager (2019:5) advocate for diversified revenue sources to ensure financial resource availability. A diversified resource base and provides flexibility and acts as a cushion in resource access in situations where one source fails. The authors argue that with diversified resource sources, institutions can enjoy continued service delivery. This means with increasing demand for health services and lean government pockets, diversified funding sources would be ideal for sustainable funding in the sector.

Barwise and Liebow (2019:998) claim that donations made to the health service delivery sector are important, as they have funded construction of hospitals, health research centres and enhanced access to quality care. Donations have a supplementary funding role in the public health sector; without them, public health delivery institutions would not be able to deliver the same services that they do. According to Hung and Hager (2019:7), an organisation with a number of funding sources is at less risk compared to one with a single source as inability to fund by that sole source could have devastating consequences on operations. This is a case for the diversification of funding sources which serves as a cushion for funding.

Despite the availability of donors to support healthcare delivery, recipient countries experience challenges with donors. Dieleman *et al.* (2015:2067) observe that there was a trend by donors to earmark funding for selected illnesses such as HIV/AIDS, maternal and child health. In agreement, Cashin *et al.* (2017:27) lament that earmarked donor funds do not usually address a country's priority health requirements. Since committed funding caters for specified sections (which mostly are of interest to donors' agendas), the remaining healthcare requirements may be inadequately funded. Thus, health outcomes may improve in well-funded areas but poor outcomes may be found in the areas left out.

In support of the earmarking of financing, London (2016:225) established that there was a relationship between targeted donor funds that were given out and the countries' improved health measures. Nabyonga *et al.* (2009:2) note that Uganda preferred donor budget support which allowed flexibility in resource use. This implies that with flexibility in the management of donations, priority health areas for the country would be addressed in contrast to when donations are for specified healthcare areas. Furthermore, Nabyonga *et al.* (2009:1) divulge that in Uganda, donor aid was not predictable; expenditure did not match budgets; about half of the aid was implemented outside budget and was not part of the financial planning; and the donor aid did not cover investment in infrastructure and personnel. Similarly, Furukawa and Takahata (2018:482) lament that the overdependence on aid in Tanzania led to instability of funds' availability which is detrimental to service delivery.

Obviously, the challenges experienced with donors, handicap service delivery and result in financial management challenges. A comparative study on donor fund management and effectiveness in Nigeria and Ethiopia showed that for Ethiopia there is coherence and transparency in donor aid management, assigned and unassigned local and donor finances are all channelled through the ministry though some selected donor funding is managed separately in terms of its budgeting and reporting for the same (Shaw *et al.*, 2015:79). Thus, donor recipient countries should be encouraged to negotiate favourable terms for donations so that they can benefit most from them. In Nigeria, for example, it was found that the coordination of aid with government policies is poor, and there is no integration of aid funds with government budgeting and planning, because a higher percentage of aid funds is managed outside government's budget. In addition, a sizable portion of donor funding for health appears to be off-budget and not under government oversight, or it is undependable or low disbursements.

On the presumption that an assessment of financial reputation of recipient countries is done, it can be inferred that donors would impose stricter conditions for perceived high-risk countries compared to low-risk countries. Le Gargasson *et al.* (2014:1041) explain that often there is reluctance by donors to be part of a country's budget process due to the beneficiary country's reduced trustworthiness and lack of accountability and transparency in public financial management. Thus, countries should improve in the areas of accountability and transparency in order to attract and retain donors as well as get conducive conditions for the donations. On the other hand, Pallas *et al.* (2015:15) explain that having noted that Ghana was in need of aid, had constrained capacity in management in the government and the anticipated deficiencies with associated with increased donor funding; she adopted strategies aimed at maintaining the donors

whilst moving funds through rationalised approaches. These facts indicate the need for countries to flex how they manage their financial space and the related considerations in order to conform to the desired donor environment. Additionally, a study by Akortsu and Abor (2011:128) on financing of public healthcare in Ghana revealed that the public healthcare delivery sector is financed by government, internally-generated and donor funds, of which the internally generated funds were the most dependable of all the sources of funds. The worst dependable were the donor funds. The authors found hiccups in relation to the various funding sources, including late receipts of government funds, delayed reimbursements to service providers, governmental interference setting fees for hospital users and that donor funds have specific conditions attached to the funds.

This suggests very strongly that there are considerable challenges with government funding; but then it is clear that internally generated funding for public institutions cannot be much as out-of-pocket healthcare expenses are discouraged, since it causes financial hardships on the poorer general public. According to Gupta and Ranjan (2019:1), India's healthcare delivery sector does not rely on donor funds; however, this raises the issue that India needs to increase government funding in order not to put pressure on the public for personal health financing. On the supposition that funding for public healthcare is dependent on government, governments should ensure that this is adequately provided and managed for, otherwise the consequences of passing on healthcare cost can be devastating to the poorest of the society and can lead to disastrous consequences.

### 3.6.3 Delayed disbursements of funds

Goryakin *et al.* (2017:21) argue that the dependability of funding flows is a recipe for enhanced public healthcare service delivery. Thus, funding has to be reliable so that institutions can meet goals; more especially in the health sector where service delivery is usually spontaneous and cannot be delayed.

The health systems in Africa rely on government finances and usually the funds are inadequate and are not remitted on time giving rise to cash flow challenges (Asante *et al.*, 2006:105). Obviously, with shortages of funding and non-reliable cash flows, public healthcare service delivery is impaired or poor. For instance, late disbursements of funds is been cited as one of major challenges faced by officials in Tanzania and they explain that the delays impede decision-making and the implementation of plans, overall affecting performance of service delivery (Furukawa & Takahata, 2018:479). On the other hand, donors argue that the lateness in disbursing funds is due to the government reporting late. Thus, noncompliance with accountability

and transparency requirements is a contravention to donor condition. Le Gargasson *et al.* (2014:1036) emphasise that it is imperative to ensure that funds disbursements for operations are adequate, on time and dependable. Le Gargasson *et al.* (2014:1037) refer to delayed funding as bottlenecks; these deny service providers the funding they need to undertake planned activities. This entails that making allocations in the budget for service delivery is one thing, but Frumence *et al.* (2014:2) explain that Tanzania handled delayed funding by obtaining trade credit, taking money from other commitments and cost sharing on generate funds to manage delays in funds. Le Gargasson *et al.* (2014:1041) note that to boost funds flows, institutions resorted to apply emergency budget procedures which they also cautioned were subject to abuse. It is clear that institutions need to tailor make workable solutions for specific contexts.

### 3.7 Public health expenditure and public health outcomes

There are conflicting findings on the relationship between spending on delivery services and improvement of outcomes. Arthur and Oaikhenan (2017:526) claim that there is no empirical evidence on the impacts of expenditure on health to achieve health outcomes as evidenced from contradicting results from literature. In this regard, they illustrate that most studies on effects of health expenditure on health outcomes have not incorporated other factors that could also impact health outcomes. In other words, studies need to be comprehensive to include other possible factors that could have an impact on public health outcomes in order to determine the role of public health expenditure on health outcomes.

Farag *et al.* (2013:36) note that in some developed countries, spending on health services was not associated with conspicuous progress on health outcomes, whilst a number of studies reveal that there is a positive association between expenditure on health and health outcomes in others. Therefore, the contradicting findings on health expenditure and outcomes strengthen the case for further research on the factors affecting attainment of health outcomes. Studies in developing countries also provide contrasting evidence on the link between health expenditures and health outcomes. Furthermore, noting that some studies indicate that when there is a control or a limit on a country's income, the improvement in health outcomes is not that significant (Farag *et al.*, 2013:33). This implies that health outcomes are not improved by expenditures alone, but that other factors come into play. Boachie *et al.* (2018:60) claim that governments of developing countries have been keen to reduce public expenditures, including in public health delivery, which may have effects on the public sector service delivery. The authors further observe that whilst proclaiming that public health spending has a major role in contributing to a reduced child mortality rate, the strength of the relationship is a function of the degree of governance in a country. This

suggests that aside having ample resources, how resources are governed is salient for attaining health outcomes.

Applied to the education sector, Boateng (2014:536) argue that despite the crucial role that expenditure has on education, effective public financial management has a vital role in promoting education outcomes and that the emphasis on increased funding only is misleading. Thus, institutions should take note that it is not enough to increase funding and expect things to work for the better; there is also need to look at other aspects that could contribute to non-optimal utilisation of the financial resources. Furthermore, Boateng (2014:536) observes that public expenditure management impacts educational outcomes; this author agrees with other studies that the availability of funds without improved management of the public resources cannot improve outcomes. Rather, managers should look into resource allocations in priority areas and timely disbursement of funds if outcomes are to improve. This points to the conclusion that finances will allow institutions to achieve its set goals if they are managed properly, and it remains a fact that finances are a necessity for service delivery.

In contrast, a number of studies indicate that public health expenditure improves health outcomes. Ashiabi *et al.* (2016:1386) discovered that there was an inverse relationship between public health expenditure and selected health outcomes. This implies that as public health expenditure increases mortality rates reduce, suggesting that health expenditure improves health outcomes. In addition, Boachie *et al.* (2018:59) argue that public expenditure in public healthcare service delivery has impact on health outcomes as they determined that, for Ghana, an enhancement in health expenditure was positively correlated to health outcomes. The authors argue that enhanced income levels result in access to goods and services. Therefore, they hold that increased revenues improve health care provision.

Clearly, increased funding should mean increased services provided, but the concern remains the same: how are the funds managed? This is the case since poorly managed funds would not be serving the intended task and, therefore, not contribute to achievement of health outcomes. Similarly, Makuta and O'Hare (2015:933) uphold that government's financial contribution to the public health delivery sector is vital for improving the health status of the public. Seeing that the finances made available are used to purchase goods and services for service delivery, it follows that institutions need to ensure that these funds are used effectively and efficiently. Hlafa *et al.* (2019:14) found a strong relationship between health expenditure and outcomes in a study in South African health sector, although there were notable differences amongst provinces and

recommended policy amendment and customisation to suit individual provinces. These findings lead one to believe that for improved health, funding is necessary.

Researching on Sub-Saharan Africa, Buor and Bream (2004:926) identified the availability of skilled personnel; increased health expenditure; status of the national economy and life expectancy to be the major predictors of maternal mortality. The authors recommend adequate resources and training of skilled attendants. Clearly, the emphasis on resources as an element for enhanced health outcomes shows that finances enable attainment of health goals. Nonetheless, Ashiabi *et al.* (2016:1388) claim that increased health outcomes cannot be wholly attributed to increased expenditures on health service delivery. Assuming that there were no finances available, it would be interesting to debate how institutions would acquire improved health facilities, hospital drugs, ample training programmes and satisfactory remuneration to personnel which obviously are important in attaining health outcomes. Furthermore, (Arthur & Oaikhenan, 2017:532; Rezapour *et al.*, 2019:1) found that overall health expenditure is important in enhancing health outcomes. These authors appeal to governments to pump more resources for health. Therefore, this is an argument for improved financial resources for improved service delivery outcomes. Grigoli and Kapsoli (2018:397) point out that countries that are still emerging and developing spend less on healthcare delivery and consequently, achieve low outcomes on health. Just like increased spending assures improved health outcomes, so do improvements in spending efficiencies. The reasoning behind this is that improved efficiency means achieving more for less; in other words, resources are freed for other equally crucial expenditure items.

There has been debate on the relationship between public spending, governance and outcomes. It is said that if there is good governance in the management of resources, spending by public institutions would have experienced enhanced public health or public education (Piatti-Funfkirchen & Schneider, 2018:337; Rajkumar & Swaroop, 2008:96). This supports the view that well-governed financial resources would contribute to improved service delivery. Just as Farag *et al.* (2013:33) emphasise the need for good governance of public resources; Boateng (2014:536) also stresses that merely focusing on the level of public spending is not enough. Rather, public expenditure management has a crucial role in achieving desired outcomes. These facts indicate that finances enable service delivery if accompanied by proper governance and management of resources. Boachie *et al.* (2018:60) claim that governments of developing countries have been keen to reduce public expenditures including in the public health delivery sector; this may have effects on public sector service delivery generally. This also entails that the public sector experiences limitations in terms of resource generation, and may not be able to make the required

financial commitment for public service delivery. Such a situation calls for the public sector to critically manage its finances.

### 3.8 Chapter summary

Chapter 3 presented the conceptual framework that outlines the public expenditure management deficiencies that the public healthcare delivery sector in Malawi is challenged with. The conceptual framework for improved public expenditure management in public healthcare service delivery was developed from a review of the literature. The identified public expenditure management deficiencies were then discussed at a global level. An analysis was conducted on the concepts of public financial management and public expenditure management, public health service delivery and various applications of theories that underpin the study. The factors that determine public finance management deficiencies were identified and discussed.  The next chapter, Chapter 4, explores the research philosophies, methodology and methods that were followed in this study.

# CHAPTER 4: RESEARCH METHODOLOGY

## 4.1 Introduction

Chapters 2 and 3 reviewed literature on public expenditure management with a focus on the public healthcare services delivery sector. Management theories were deliberated, especially how they should bring in line the public expenditure management concept and its application in public healthcare service delivery. Chapter 4 details the research methodology by outlining the processes that were followed in order to address the study's research question. The purpose of this chapter is to explain the research methodology that was applied in this study. The chapter argues on the philosophical inclination of the study and furthermore, the chapter elaborates on the research design and strategy that were used to collect and analyse data in order to answer the specific research questions. The chapter further defines the study population, sampling techniques and the study sample, and ends with a discussion on research reliability, validity and ethical considerations.

Research methodology addresses matters relating to the reasons for undertaking a study, the manner used to identify the research problem, the formulation of the research hypothesis, the type of data gathered and the method or methods deployed to collect, data analysis and why it was analysed that way (Kothari, 2004:8). Furthermore, according to Mohajan (2017:63), research methodology offers researchers "the principles for organising, planning, designing and conducting a good research". It follows that research methodology is the path through which the researcher passes and the activities covered in the course of undertaking a research study.

Berryman (2019:272) states that research methodology and methods deployed in a study depend on the research question. The main research question in this study is 'What framework will enhance expenditure management in the public healthcare sector in Malawi?' Consequently, the methodologies and methods that were applied in this study are used to answer this question. This is applied research; Kothari (2004:3) opines that such research provides answers to dilemmas faced by a population. In this study, the problem is deficiencies in the management of expenditure in the public healthcare services delivery sector. The study examined the public expenditure environment and processes with a view of providing solutions for improvement.

## 4.2 Research philosophy

According to Ryan (2018:14), research philosophy is what the investigator recognises as the 'truth, reality and knowledge' and 'the beliefs and values' that shape the plan, data assembling and analysis in a study. This definition of research philosophy dwells on the principles and

convictions that influence the planning of a research study and data analysis. Creswell (2009:6) considers research philosophy or worldview as an overall view that a researcher embraces regarding the world. Saunders *et al.* (2009:107) view research philosophy as the development and nature of knowledge. Furthermore, the author claims that the philosophy adopted by a researcher is predicated on his or her suppositions about the world. Thus, the preceding definition of research philosophy demonstrate that what research position is adopted by a researcher, is a function of the view he has regarding knowledge creation. Furthermore, Abutabenjeh and Jaradat (2018:246) state that an investigator's philosophical belief dictates their choice of research approach as to whether it is qualitative, quantitative, or mixed methods. This leads to the notion that research philosophy addresses the way researchers undertake research studies in order to cultivate knowledge, and also what type of knowledge researchers come up with.

Depending on one's philosophical inclination, researchers could be post-positivists, social constructivists or pragmatists. Post-positivist research philosophers apply quantitative research strategies; whilst social constructivists use qualitative strategies (Abutabenjeh & Jaradat, 2018:246; Johnson *et al.*, 2007:113; Wu & Patel, 2015:101). On the other hand, mixed methods strategies are adopted by researchers holding a pragmatism philosophy (Abutabenjeh & Jaradat, 2018:246; Johnson *et al.*, 2007:113). Thus, one should embrace a specific research philosophy in order to deploy appropriate research method designs consistently. That is to say, a researcher would not claim that they are post-positivists whilst employing qualitative strategies, or believe in flexibility of research approaches but only deploy questionnaires for example in collecting data (as this would make a researcher post-positivist).

Ontology and epistemology are considered two major branches of philosophy (Neuman, 2014:94). Thus, a researcher should have a position regarding his ontology and epistemology in line with his philosophical position. One's worldview is recognised by how one answers questions relating to "ontology, epistemology, and methodology" (Wu & Patel, 2015:99). Epistemology relates to what is conceived as satisfactory and reliable knowledge (Allmark & Machaczek, 2018:1301; Harper & Thompson, 2012:4; Neuman, 2014:95; Saunders *et al.*, 2009:110). Hence, it is inferred that epistemology entails knowledge quality, and this knowledge is created depending on one's philosophical inclination. Wu and Patel (2015:99) argue that epistemology looks at the link between what is known and the one in the know; and how an epistemological question is responded to, depends on the ontological question. Ontology looks at what is reality (Neuman, 2014:94; Saunders *et al.*, 2009:112; Wu & Patel, 2015:99); whilst others view ontology as "the study of being"; that is, the notion that things are in existence (Allmark & Machaczek, 2018:1301;

Berryman, 2019:272). So, relating to knowledge creation, ontology is regarded as establishing the truth through following an established methodology of doing things. To clarify further, Saunders *et al.* (2009:110) state that reality or ontology is either subjective, where it is held that social occurrences are the a result of social insights of their creators; or it may be objective, where reality is not influenced by the external environment.

By inference, depending on one's philosophical inclination, truth or reality is generated with bias or established objectively. There are differing philosophies on the worldview and specifically on establishing truth or reality. Saunders *et al.* (2009:109) note that designing a research method requires a reflection of one's research question and hold that a research question does not usually belong to a single category of philosophy. Consequently, it is important that a researcher is systematic in their line of belief and design research that permit the uncovering the research question.

Post-positivism, social constructivism, advocacy/participatory and pragmatism are research philosophies (Abutabenjeh & Jaradat, 2018:246). So, holding a philosophical position may mean that a researcher could be a positivist, constructivist or pragmatist, depending on his or her worldview. The post-positivist worldview, also known as "positivist, empirical science, and post-positivism" underpins its belief in that, in solving a problem, the factors that influence the outcomes should be determined and are common in experiments and general quantitative studies (Abutabenjeh & Jaradat, 2018:246; Creswell, 2009:7; Ryan, 2018:15). Positivist thinking implies that the truth is out there, and should be found, that is, positivists need to design appropriate methods that would assist them to seek solutions for the problems they are trying to solve. In addition, it is believed that since the truth is out there ready to be discovered, quantitative methods are applied in order to answer the research questions and thus, determine the truth (Berryman, 2019:272; Wu & Patel, 2015:100). It can, thus, be inferred that the truth can be objectively determined by applying research methods that uncover truth without interference by the researcher.

Saunders *et al.* (2009:119) add that the ontology for a positivist study is external of the researcher; it is objective and therefore, free from bias. In terms of epistemology, the authors claim that reliable data is obtained through observable occurrences. It follows, therefore, that data created from a positivist philosophy is acceptable and reliable, since it is obtained independently without bias and influence from the researcher. With positivism, the belief is in the orderliness and regularity of the external environment, and confirming that the truth is objective and free of biases.

A key point is that results can be generalised (Winit-Watjana, 2016:430). It can be established that the generalisation of research outcomes is possible on the premise that there is objective determination of results and that research procedures can be replicated and lead to the same outcomes. Johnson and Onwuegbuzie (2004:14) explain that, with positivism, a social study is similar to that of a scientist. This implies that a researcher who applies positivism is a scientific scholar. However, in as far as this study is concerned, applying philosophical position of positivism may not be ideal, as the study unit operates in a complex environment which many not be adequately addressed by solely engaging a quantitative approach. This is the case as it is felt that there is need to first obtain a deep insight into the phenomenon under study, and data for this should be obtained qualitatively.

Constructivism, also referred to as interpretivist, holds that research outcomes stem from a deep understanding of participants' opinions of what is being studied, and as a result research outcomes tend to be subjective (Abutabenjeh & Jaradat, 2018:246; Creswell, 2009:8; Ryan, 2018:17). In contrast with positivism, research results in constructivism are dependent on the researcher and is subject to biasness and influence. As Ryan (2018:14) authors, 'relativists' hold that, how an issue is viewed depends on an individual's perception. Hence, coming up with an independent outcome with a qualitative study may not be completely achievable. Concurring with Ryan (2018:14), Saunders *et al.* (2009:109) explain that interpretivism entails inferring meanings from situations. It follows that outcomes are always subjective as two or more different people are bound to provide different meanings to a situation. Ryan (2018:15) further explains that reality for an interpretivist philosophy is relative, and that epistemologically, the truth is subjective.

Saunders *et al.* (2009:119) expound that reality can also change or be multifaceted. This argument leads one to believe that with constructivism or interpretivism, as the guiding philosophy, it is difficult to predict research outcomes due to the element of subjectivity that underlies the research process, and therefore, research results cannot be generalised. Berryman (2019:273) explains that with interpretivism, the truth is generated through "social constructions, language, shared consciousness"; therefore, the research questions tend to be qualitative. Implicitly, the processing of the qualitative questions and responses leads to subjectivity, whereby, two different individuals can give different interpretations of the same data.

In terms of relevance of theory, in post-positivist worldview, a study commences with theory application while, constructivism researchers develop theory (Creswell, 2009:8). It can be implied that positivism researchers test an existing theory to a situation they are researching on; whilst

constructivists generate theory from their studies. Winit-Watjana (2016:430) hold that interpretivism is the direct opposite of the positivism philosophy and argues that subjective realities provide “value laden knowledge”, unlike with positivism thinking. Therefore, there are deep insights obtained in qualitative studies due to the nature of the process of collecting, analysing and interpreting data. There have been arguments for interpretive philosophy being ideal for management and business studies due to their complexity which requires a deep understanding of the responses provided by respondents (Saunders *et al.*, 2009:116). This infers that most studies in business and management apply qualitative studies. However, recognising the complex nature of business and management research, obtaining a deep understanding in a study may not comprehensively answer a research question. Consequently, there is need to test underlying theories in order to effectively answer a research question.

Advocacy/participatory philosophy is another philosophical worldview. Researchers holding this philosophical view, study and pursue political agendas meant to improve people’s lives by including in the study, matters that affect the masses (Abutabenjeh & Jaradat, 2018:246; Creswell, 2009:9). Thus, with the advocacy/participatory philosophical approach, the focus is on a selected segment of the society. In that regard, Van der Riet (2008:546) declares that participatory research is inclusive, has a democratic character, and is politically and morally authoritative. Because the focus is on being advocatory and participatory, the subjects being studied are part of the research design to have their voice in the study. Abutabenjeh and Jaradat (2018:246) explain that the advocacy/participatory worldview fits in both qualitative and quantitative research. It can be inferred that the research design for an advocacy or participatory philosophy can either be qualitative or quantitative or both. The advocacy/participatory is not ideal for this study, because the intention is not to address the social and political issues of marginalised individuals in Malawi nor issues of power, discrimination, social injustice and oppression.

Creswell (2009:10) states that the pragmatist philosophy emerged from the works of researchers who put up a case for use of multiple research approaches. Pragmatism entails multiple research approaches and flexibility in choosing methods and designs to be used in a study. Whiteman *et al.* (2015:891) explain that research founded on pragmatism principles evades issues of ontology, and hence, transcends the duality of quantitative/qualitative; the so-called QUAN/QUAL debate.

The use of mixed methods in research incorporates both positions of ontology. Thus, both qualitative and quantitative assumptions are applied in such a study. In addition, pragmatism recognises that there are multiple approaches to undertaking a research study (Winit-Watjana,

2016:430). Thus, being a pragmatist implies that the researcher must be flexible in designing a research study by applying multiple methods. Pragmatists apply mixed methods research and form quantitative and qualitative assumptions when they engage in research (Abutabenjeh & Jaradat, 2018:246; Creswell, 2009:11). Consequently, a pragmatic study is a blend of qualitative and quantitative approaches merged in constructivism and positivist philosophies. Winit-Watjana (2016:430) expounds that studies embedded in pragmatism are both deductive and inductive, and use theory to articulate phenomena and then later test it. As such, the studies use both quantitative and qualitative methods. It follows that theory generation and testing are both applicable in a study that follows pragmatism principles.

The worldview of pragmatism forms the basis of this research as it perfectly addresses the study's research question. Govender (2017:249) advocates the use of mixed research methods as they are effective in solving real world situations. With the presumption that issues faced all over the world require solutions that are complex, neither constructivism nor positivism alone can ably resolve a research problem, and hence, pragmatism was selected for the present study. Public expenditure management in the public sector general and in the health sector in particular, is complex, and thus, the adoption of pragmatism approach to this study.

According to Allmark and Machaczek (2018:1307), pragmatism looks at a scientific study as a means of identifying functional theories that solve practical and/or intellectual dilemmas. Hence, pragmatism remains a procedural way of addressing researchable problems. Furthermore, pragmatism does not confine researchers to a selected method; rather it applies a mix of methods (Allmark & Machaczek, 2018:1307; Creswell, 2009:11). It follows that a pragmatic philosophical view offers flexibility to researchers to identify the methods, techniques, procedures and approaches that best allow them to provide solutions to the problem they are trying to solve. This study purported to evaluate expenditure management in a public sector set up, and it was based on a pragmatic worldview in order to benefit from the flexibility it offers in deciding how research should be conducted, and what methods to be applied in order to achieve research objectives.

### 4.3 Research approach

This study explores expenditure management in the public healthcare delivery sector. The approach adopted for this study is the mixed methods research, as it allows the application of various research methods that are appropriate to answer research questions satisfactorily. As per the debate herein, quantitative or qualitative approach alone may not adequately address a research question that involves a complex business environment. The focus is on the research question to be answered and then appropriate methods and approaches are chosen to answer it

(Abutabenjeh & Jaradat, 2018:246). Therefore, the study's research question leads to the selection of research methods, techniques and designs that best allows answering it. In this study, the main research question is, "What framework will enhance public expenditure management in the healthcare delivery sector in Malawi?" The use of mixed methods would be to answer the specific research questions comprehensively. This is the case as there is need to fully appreciate and explore the expenditure management environment in the public healthcare services delivery sector in Malawi; necessitating the use of a qualitative approach. Having explored the expenditure environment in the sector, the study proceeds to apply quantitative research approaches in order to infer study results to the whole sector. Molina-Azorín (2009:52) states that the main purposes of mixed methods research are triangulation, clarifying research results by using different methods, elucidating results obtained from different methods, and facilitation of research studies. It follows that mixed methods research has a number of uses meant to enrich research, for instance, use of multiple research methods increases research validity. This study intends to use mixed methods research, because mixed methods research makes both quantitative and qualitative assumptions (Abutabenjeh & Jaradat, 2018:246). Consequently, attributes of both qualitative and quantitative research are found in a study that uses mixed methods research. In agreement, Creswell (2009:10) points out that there is no commitment to a single research method or technique; rather, a researcher applies multiple methods and approaches for collecting and analysing data. This implies that a mixed methods research approach recognises and accepts multiplicity in research methods for the benefit of getting the best from a study.

Molina-Azorín (2009:47) points out that not much scholarship has been done on the use of mixed methods in business management research as preference has always been given to quantitative methods. However, Gobo (2015:229) argues that the use of only quantitative methods in social science research is no longer the norm. This argument leads one to believe that despite scanty empirical support for the use of mixed methods, studies in business and management studies are now mixing research methods.

Applying mixed methods strengthens research. Cameron and Molina-Azorin (2011:268) argue that, in order to gain an in-depth understanding, revolutionise and add value to multifaceted business and management issues, the use of mixed method research is more appropriate. Consequently, research enrichment, revamping and a detailed understanding of the complex business environment justify the multiple research methods approaches. Gobo (2015:331) further argues that the reasoning behind mixing research methods is that individually, qualitative or

quantitative methods are not adequate to address a phenomenon fully and need to complement each other.

Therefore, the use of mixed methods research is justified by the inadequacy of individual research approaches in complex business studies. Mixed methods designs are suitable for complex social science problems as the designs more ably answer research questions unlike quantitative or qualitative approaches which are singly insufficient (Jogulu & Pansiri, 2011:687). These arguments prove that neither qualitative nor quantitative research approach alone would address the complex business and management situations comprehensively; rather, a mix of methods would do.

Furthermore, Saunders *et al.* (2009:109) argue that the research question is what should dictate the epistemology, ontology and axiology. By inference, the research question justifies the research outlook in terms of the perception on knowledge creation. The present study is guided by the following major research question: "What framework will improve public expenditure management in the public healthcare delivery sector?", which requires both qualitative and quantitative approach in order to effectively answer it. This is the case because there is need to deeply understand the financial and expenditure management environment of the study and infer the findings from there.

### 4.4 Research design

A research design is a plan of the processes used to undertake research ranging from the wide assumptions underlying the research to the specific methods of collecting and analysing data which is based on the problem being solved, the experiences of the researcher, and who the study is meant for (Creswell, 2009:3). A research design covers the entire research process, and provides a systematic way of undertaking a study. A research design is described as an outline that guides the research process (Abutabenjeh & Jaradat, 2018:238; Kothari, 2004:31). It follows that a research study follows a predetermined set of activities, making it procedural in its approach. These varied but similar descriptions of research designs indicate that for a systematic research study, one must develop a plan that guides the steps and activities to be followed in undertaking it. Neuman (2014:165) adds that the way a research study is designed and conducted depends on whether it is quantitative, qualitative or a mix of the two. Whether it is quantitative, qualitative or mixed method, the approach defines the research design. The following sections discuss the research designs, including qualitative, quantitative and mixed methods, and establishes the appropriateness or not of any of these for this study.

#### 4.4.1 The qualitative design

Nowell *et al.* (2017:1) state that qualitative research as a paradigm is valued, and add that the complexities around qualitative design call for rigour for acceptable results. Thus, qualitative research demands thoroughness for acceptability. Qualitative research describes and construes experiences (Finlay, 2015:164). It follows that objectivity of study findings may not be attained, as different researchers are bound to interpret qualitative data differently. As such, how meaning is inferred by the researcher is crucial. According to Creswell (2009:4), qualitative research involves discovering and getting a deep meaning of responses to a research problem. This demonstrates that qualitative research transcends mere data transcription and helps to arrive at a deep understanding of data.

In terms of strengths, Johnson and Onwuegbuzie (2004:14) state that qualitative research reports are more detailed, rich in content, direct and informal. This entails that qualitative reports are value laden and do not have a standardised presentation format. Johnson and Onwuegbuzie (2004:20) note that qualitative research is applauded for providing a deep understanding of occurrences, allowing in-depth coverage of issues and permitting responsiveness to alterations in the course of the research. Qualitative research is suitable for studies requiring a deep understanding of a phenomenon, since such deep understanding and richness of a study phenomenon cannot be obtained if any other approach other than qualitative is used. Arguing for qualitative research, Barnat *et al.* (2017:4) note that qualitative studies using its in-depth data collection methods not only explore, but also differentiate between phenomena. Accordingly, qualitative methods remain useful in studies that require researchers to gain a deep understanding of a phenomenon.

Wu and Patel (2015:101) argue against qualitative research and claim that both researcher and participant are biased due to their "social status, educational background and life experience", which impacts on knowledge development. This is why qualitative research outcomes are associated with subjectivity. In addition to being subjective, Johnson and Onwuegbuzie (2004:20) claim that a qualitative research design is characterised by a lack of generalisation of its findings to other settings; challenges in making predictions; it is not appropriate to test theories; and it is time-consuming in terms of data collection and analysis. For these reasons, qualitative research is deemed to be limited. Wu and Patel (2015:99) found qualitative study designs fit to address their research question (to gain insights into corporate governance and accounting). Clearly, a research question dictates the research design. This study goes beyond gaining a deep understanding of the subject matter; it also establishes factors influencing public expenditure

management from different angles. It is felt that using a qualitative approach only would not be sufficient to answer such a research question.

### 4.4.2 The quantitative design

According to Johnson and Onwuegbuzie (2004:19), quantitative research allows the testing and validating of theories and generalisation of results to other similar settings. It renders predictions possible, data collection and analysis is relatively quicker, it is less subjective to researcher bias and may, thus, be more acceptable by other players. It is also suitable for large population studies. By implication, quantitative methods are more appropriate to studies that intend to apply theory, has a large population and, therefore, can generalise results. Despite the strengths of quantitative research, Johnson and Onwuegbuzie (2004:19) point out that quantitative studies are weak as they are less informative of the deep understanding of the respondents or the situation being researched and focus on theory testing. Therefore, when one needs a deep-rooted understanding of a phenomenon and specify study results to a setting, quantitative methods would not be appropriate.

Clark (2019:106), on the other hand, applauds quantitative research approaches; the author holds that they are suitable for "measuring the magnitude and frequency of variables, assessing relationships and differences across groups and time, and testing theories". As indicated by the merits of quantitative research, they fit studies that aim at quantifying variables in a study. This study quantified research variables and, therefore, the quantitative aspects are also vital. Twigg (2015:131) explains that quantitative research answers *what* and *why* questions. There is, however, a limitation on the applicability of quantitative methods as it means *how* questions cannot be effectively answered by quantitative studies. Basically, a pure quantitative design is not appropriate for this study as it does not effectively address the study's research question. This is because there is also need to gain a deep understanding of public expenditure management in the public health sector, which cannot be addressed by a quantitative study.

### 4.4.3 The mixed methods design

A mixed methods research design is defined as a research approach where there is integration of qualitative and quantitative questions, research methods and designs, data collecting and analysing techniques and outcomes (Pluye & Hong, 2014:30). This suggests that a researcher undertaking mixed methods research uses multiple ways of undertaking the entire study, and is not restricted to a specified research design. Clark (2019:107) claims that although a number of research questions can be addressed by using a single approach, there are some research questions that need contextualised results; including the identification of relationships as well as

theory generation and testing. Accordingly, the research design that a researcher uses is guided by the study's research question. The continued evolution and merits of both qualitative and quantitative research in social and human sciences has strengthened the case for use of mixed methods research (Creswell, 2009:203; Johnson *et al.*, 2007:113).

Of late, mixed methods studies have turned out to be the desired research design in social sciences studies. Researchers endorse the use of multi-methodological approach to research, because recently a larger proportion of research questions cut across paradigms and thus, researchers are encouraged to adopt methods that adequately answer their research questions (Creswell, 2009:203; Jang *et al.*, 2008:222). Therefore, a mix of qualitative and quantitative methods are ideal for addressing certain research questions and, consequently, produce relevant research results. Furthermore, Fetters *et al.* (2013:2135) state that researchers who use quantitative methodologies want to establish causality, achieve generalisability of results or determine size. On the other hand, qualitative research methodologies determine why or how a situation occurred, or indeed to develop a theory. With mixed methods, both qualitative and quantitative objectives can be achieved. Mixing research methods involves blending the various stages in qualitative and quantitative approaches in a research in order to achieve the functions of each approach, effectively and comprehensively.

Johnson and Onwuegbuzie (2004:17) confirm that a significant feature of the mixed methods research is the use of multiple research methodologies in which case both quantitative and qualitative research techniques, methods, approaches, concepts or language are combined in a single study. Perhaps the backing for mixed research methods in this study is further strengthened by Leitch *et al.* (2010 :60) as these authors explain that research questions in the social sciences do not have basic answers, given the complexities of the social environment and the differences in ontology between positivism and interpretivism. In other words, the complexities of social science studies cannot adequately be addressed by single research approaches. Researchers view quantitative and qualitative research approaches as opposite ends of the spectrum, but a focus on the strengths of each one of them can make them complementary to each other (Anessi-Pessina *et al.*, 2016:501; Clark, 2017:305; Pluye & Hong, 2014:29). The complementary attribute of mixed methods research is significant. This is apparent in recent studies where most research questions address complex issues that cannot be ably answered using one research approach.

Creswell (2009:205) looks at the purpose of mixing research methods from another angle by explaining that mixed methods research is used to widen the understanding of a research issue

or to enrich research by allowing the results of one approach to build on results of the other. Thus, the two research approaches are connected when results obtained from one approach inform the next phase; this could be considered as an enrichment of the research outcomes. The use of mixed methods in this study aims to deepen the understanding of expenditure management in the public health sector in Malawi using a qualitative approach and use qualitative results to inform the quantitative data instrument.

Clark (2017:305) further clarifies that studies that use mixed research designs benefit from the complementary benefits of the two methods. The importance of mixed methods research is seen when the strategic combination of qualitative and quantitative data results in refined, interconnected and authenticated conclusions. This infers that mixed methods offer synergistic benefits to research studies. According to Johnson and Onwuegbuzie (2004:14), the multi-research method application makes mixed methods more superior than single method studies, because it draws on the strengths and reduces the weaknesses of the single method approaches.

When using mixed methods, triangulation of results is possible and, therefore, there is enhanced validity (Molina-Azorín, 2009:49). The validity and triangulation of research results are some of the merits of using mixed methods research results. Accordingly, at times, mixing data collection methods may result in inconsistent data being collected. If this were to happen, the results should be used to examine the study further instead of viewing it as an unreliable research (Jogulu & Pansiri, 2011:688; Molina-Azorín, 2009:49). Anessi-Pessina *et al.* (2016:503) state that when addressing research issues, research methods should be selected to confirm that the study area is relevant for the society and practitioners which necessitates engaging relevant information resources. This entails that a researcher needs to use methods that allow study goals to be achieved. Johnson and Onwuegbuzie (2004:15), therefore, argue for the adoption of a mixed methods approach for more effective research results, as research has become more "interdisciplinary, complex, and dynamic". Consequently, mixed methods have been seen to be ideal for studies that cut across disciplines and are complex. Furthermore, in support of mixing research methods, (Clark, 2019:107; Whiteman *et al.*, 2015:890) emphasise that mixing methods in research allows the study to benefit from the strengths of each of the methods. Therefore, it maintains the independence and trustworthiness of the research by considering how best the research question can be addressed. Research results from mixed methods are often of a high quality, because they are trustworthy as a result of applying multiple methods. Jogulu and Pansiri (2011:690) explain that with mixed methods, qualitative results explain quantitative results in a

study and thus improves the reliability and validity of the study. Thus, studies using mixed methods are value-rich and the results are valid and reliable.

Mixed methods have a number of other merits. These include that narratives and images can enhance numeric meanings, thereby enriching information generated. In a single study, therefore, both theory generation and testing would be possible. Due to the application of multiple methods, one can address a wider collection of study questions; there is stronger evidence of research findings; and results and knowledge emanating from these studies are generalisable (Johnson & Onwuegbuzie, 2004:21). Thus, mixed methods research designs are often deemed superior as they benefit from the strengths of the individual research designs.

Notwithstanding the merits of mixed research, it also presents challenges to researchers. Neuman (2014:165) observes that using mixed research designs is advantageous but time-consuming; it also makes the research process more complex. This means that mixed methods research is quite cumbersome and involving than when individual research designs are pursued. Clark (2019:107) points out that regardless of the fact that mixed methods research can handle multifaceted research questions, its challenge lies in the fact that researchers require the ability to produce creative and logical research designs which can yield concrete inferences and deductions. The implications are that, considering the merits of mixed method research, and despite its shortfalls, the role played by mixed methods research designs in research cannot be downplayed as this has allowed complex and multidisciplinary studies to be comprehensively carried out. Pluye and Hong (2014:30) state that the need to interpret quantitative results qualitatively; generalise results to some extent and understanding a phenomenon establishing trends, as well as causes and effects necessitate use of both qualitative and quantitative methods. This proves that the use of mixed methods designs is not out of choice, but rather necessity in response to particular research questions. Furthermore, defending the use of mixed methods research, Govender (2017:248) argues that for enhanced research results in public administration, there is a need to approach such studies with a real life contextual appreciation and a multi-level outlook within the 'social cultural context'. Thus, mixed methods research offers improved rigour and comprehensiveness in research.

In this study, the research question "What framework will improve public expenditure management in public health service delivery in Malawi?" is pursued. To answer this question, a number of sub questions were addressed. For instance, "What is the funding situation for the public health sector in Malawi? How can efficiency in utilisation of financial resources in public

health sector in Malawi be enhanced?" These required an in-depth understanding of the financial operational environment in the health sector. The argument put forward is that individually quantitative or qualitative methods in this type of study may not be adequate to answer a set research question. This study focuses on the complex area of public expenditure management and public healthcare delivery sector in Malawi. There are a number of complexities faced in this setup for example, public expenditure management has its own complexities due to the nature of public sector management environment to which it belongs. On the other hand, the healthcare delivery sector is a complicated sector. This complexity calls for multiple methods to address the issue of public expenditure management framework for the public healthcare delivery sector.

This study is centred on public sector management and around public budgeting. Anessi-Pessina *et al.* (2016:501) demonstrate that research relating to public sector budgeting apply qualitative research to enable "analysis of issues, events, or practices"; and quantitative research that yields "frequencies and distributions of issues, events, or practices". Accordingly, mixed methods are well supported and suitable for public sector research. It is further observed that the application of theory in their study on public budgeting was mixed (Anessi-Pessina *et al.*, 2016:493). The preceding discussion demonstrates that mixed methods research is appropriate for studying complex situations which cannot be comprehensively addressed by using one method. Therefore, this study advocates for mixed methods research as it is argued that such research design is deemed appropriately address the study question.

#### 4.4.3.1 Types of mixed methods designs

There are a number of mixed methods design strategies used in mixed method research. Creswell (2009:209) identifies sequential explanatory, sequential exploratory, sequential transformative, concurrent triangulation, concurrent embedded and concurrent transformative strategies.

According to Creswell (2009:211), the sequential explanatory strategy involves quantitative data collection and analysis followed by qualitative data collection and analysis, which build on the quantitative results. Thus, with a sequential explanatory design, quantitative results enrich qualitative research outcomes. Regarding the sequential exploratory design, Berman (2017:5) states that, researchers first collect and analyse qualitative data, the outcome of which is used to develop a quantitative data collection instrument that is applied for further research problem exploration. Therefore, qualitative and quantitative designs connect at the 'qualitative data analysis' and the 'quantitative data collection'. The researcher uses data collected at the qualitative stage to develop a data collection tool probably because of inadequate or unavailable instruments in the area of study. The sequential transformative strategy commences with either a quantitative or qualitative phase which is followed by either qualitative or quantitative phase respectively; and it uses a theoretical viewpoint to direct the study and explores problems to do with the marginalised groupings (Creswell, 2009:212). Thus, the sequential transformative strategy which collects qualitative then quantitative data consecutively or vice versa, focuses on advocacy/participatory studies, and is therefore transformative.

Furthermore, other research designs can be applied concurrently. Clark (2017:305) explains that qualitative and quantitative methods are simultaneously applied in order to attend comprehensively to the complexity of a phenomenon. Thus, simultaneously combining research designs enable achieve completeness in solving a research question. According to Creswell (2009:213), when applying the concurrent triangulation approach, the researcher collects quantitative and qualitative data at the same time, and the two data sets are compared to establish the extent of their agreement. For example, in triangulation, statistical results are compared with qualitative results, which may or may not confirm to the quantitative results. This implies that if the two data sets provide the same information there is enhancement of validity and reliability of results; furthermore, if they do not agree, that provides room for further improve of the study.

Creswell (2009:214) describes concurrent embedded design whereby quantitative and qualitative data collection is carried out concurrently but there is a dominating method, which could be either qualitative or quantitative. The author illustrates that with this design, embedding entails that a

part of the research question is addressed qualitatively; whilst the major remaining part applies quantitative approach or vice versa. It follows that the distinguishing attribute of the concurrent embedded strategy is the domination of one research method over the other.

The other strategy is also referred to as a concurrent transformative approach. According to Creswell (2009:215), the concurrent transformative approach is similar to the sequential transformative model in that it is guided by the same philosophical position, the advocacy/participatory viewpoint, but differs in that, with the concurrent transformative approach, both qualitative and quantitative data is collected simultaneously. Thus, the concurrent transformative strategy has both qualitative and quantitative data collected simultaneously and applies these to an advocacy/participatory philosophical viewpoint.

Creswell (2009:206) notes that there are four factors that need to be considered when designing mixed methods studies: 'timing, weighting, mixing, and theorising'. Researchers using mixed methods should consider how they handle the integration by incorporating the specified factors.

In terms of timing, (Abutabenjeh & Jaradat, 2018:246; Creswell, 2009:206) point out that researchers need to determine the point when qualitative and quantitative data is collected, that is whether in phases or simultaneously. Therefore, the timing of mixed methods designs can be concurrent or sequential. Moreover, the reasons for mixing the research designs guide the timing of data collection. For instance, if research methods have been mixed in order to enhance the validity and reliability of research results, data is usually collected concurrently. According to Jang *et al.* (2008:223), concurrent mixed methods research use qualitative and quantitative methods simultaneously, and allow theory verification and generation by blending results from both approaches.

Sequential designs use qualitative and quantitative approaches consecutively, and are used to guide question formulation, instrument development or hypothesis testing. Where qualitative data is collected before quantitative data, the researcher purports to discover a research problem and then quantitatively answer it. On the other hand, if the researcher commences with quantitative data and proceeds to look at qualitative data, he/she probably intends to test the variables gaining quantitative data and then qualitatively probe the research question in more detail (Creswell, 2009:206; Molina-Azorín, 2009:50). Clark (2017:305) explains that a sequential mixed methods study may commence with a quantitative approach which determines predictors in a phenomenon, but cannot provide insights for the descriptions found and then the qualitative method comes in to fill that gap, this is the explanatory sequential design (Creswell, 2009:209).

The explanatory sequential design allows qualitative methods to fill in the gaps left by the quantitative study. Creswell (2009:209) further elaborates that, in a qualitative approach, meanings and interpretations are obtained but cannot determine issues like prevalence. In such a case, a quantitative approach fills in the gap, and thus the sequential exploratory design (Creswell, 2009:209). With exploratory sequential research design, on the other hand, if qualitative design does not provide the desired data, the quantitative phase supplements the missing part.

Researchers also need to consider the weighting or significance attached to either quantitative or qualitative research in mixed methods research design (Creswell, 2009:207). The author notes that a study can give equal weighting or attach more importance to either the qualitative or quantitative aspect. A mixed methods study could be more qualitative or quantitative or balanced, depending on the weight placed on either approach. How qualitative and quantitative research is prioritised depends on the research question, data collection limitations and flow of data (Molina-Azorín, 2009:50). Thus, due to the dictates of the research question and data requirements, mixed methods research may be biased towards either of the research methods. This means that depending on the weighting attached to either research approach, research could be more qualitative or quantitative, or a balanced blend of the two. This study has an equal balance of both qualitative and quantitative designs as neither of the two designs are considered to be more important than the other.

Another factor to be taken into account in mixed method research is how qualitative and quantitative data is mixed. As Creswell (2009:208) explains, mixing data may entail merging of qualitative and quantitative data at the start of the range; or data is handled separately at the end of the range; or the data is be combined in a desired way. The author further explains that separate qualitative and quantitative data can be connected at data analysis phase of the first stage and data collection phase on the second stage; thus, where data from one approach feeds into the collection phase of the other (data connecting); or data might be merged by giving the qualitative data a quantitative base and analysed quantitatively (data integration); or where data collected from one approach is considered to be the main data and the data from the other is meant to support the available information (data embedding). Thus, mixing as a factor of mixed research design looks at data integration in a study. Creswell (2009:208) states that it is important for a researcher to consider if a theoretical viewpoint directs a research design, and this consideration could be implicit or explicit. In mixed methods studies, the theories dictate kinds of questions asked, the participants from who data is collected, how the data is collected, and the

inferences made from the study. Therefore, data collection should be planned in terms of how it is to be integrated into the study appropriately. In this study, qualitative and quantitative data are connected at the data analysis stage of qualitative data and the quantitative data collection where qualitative data provided input into the quantitative data collection tool.

#### 4.4.3.2 Exploratory sequential design – the preferred methodology

This study used exploratory sequential design in order to gain a deeper understanding of public expenditure management in the healthcare delivery sector in Malawi through a qualitative approach. Thereafter, the qualitative results were used to develop a quantitative instrument, and that entailed a quantitative study. Qualitative data was explored and analysed first, then the results were used to develop a quantitative data collection instrument. Having discussed the weaknesses of the individual research strategies, this study settled for mixed methods study. This was the case as it was felt that combined qualitative and quantitative approach to studies would be more suitable in this case. The need to get an in-depth understanding of the public expenditure environment thus, using qualitative approach was imperative. The reason for such a position was that there was scanty literature on public finance management specifically in the public healthcare delivery sector. In addition, the application of a quantitative approach to the study was to allow gather data from a larger population and be able to make inferences.

Accordingly, the findings obtained at the qualitative stage can be used to develop a valid and reliable quantitative study data collection instrument; to develop novel variables and to discover and develop classes of information that could be further explored at the quantitative stage (Creswell, 2009:246; Molina-Azorín, 2009:52). This shows that in an exploratory sequential design, qualitative research results enrich and inform the quantitative phase. Furthermore, Onwuegbuzie and Collins (2007:291) hold that sequential designs are suitable if they are intended to be used for instrument design as the results from one stage are meant to feed into the next stage through the second phase instrument development. Thus, for an exploratory sequential design, the link between the qualitative and quantitative phase is the analysed data from qualitative study and the quantitative data collection instruments development.

This study used an exploratory sequential design; that is, it commenced with a qualitative approach, and its findings were used to develop a quantitative data collection instrument (Berman, 2017:5). In Malawi, there are few studies on public financial management in general and public expenditure management in particular; more so relating to the public healthcare service delivery sector. The aim of collecting the qualitative data was to obtain a detailed understanding of public

expenditure management in Malawi and then use those results to develop a quantitative data collecting instrument. Diagrammatically, the design that the study followed is as portrayed in figure 4.1. where the research process for the study flows along phases 1 and 2.

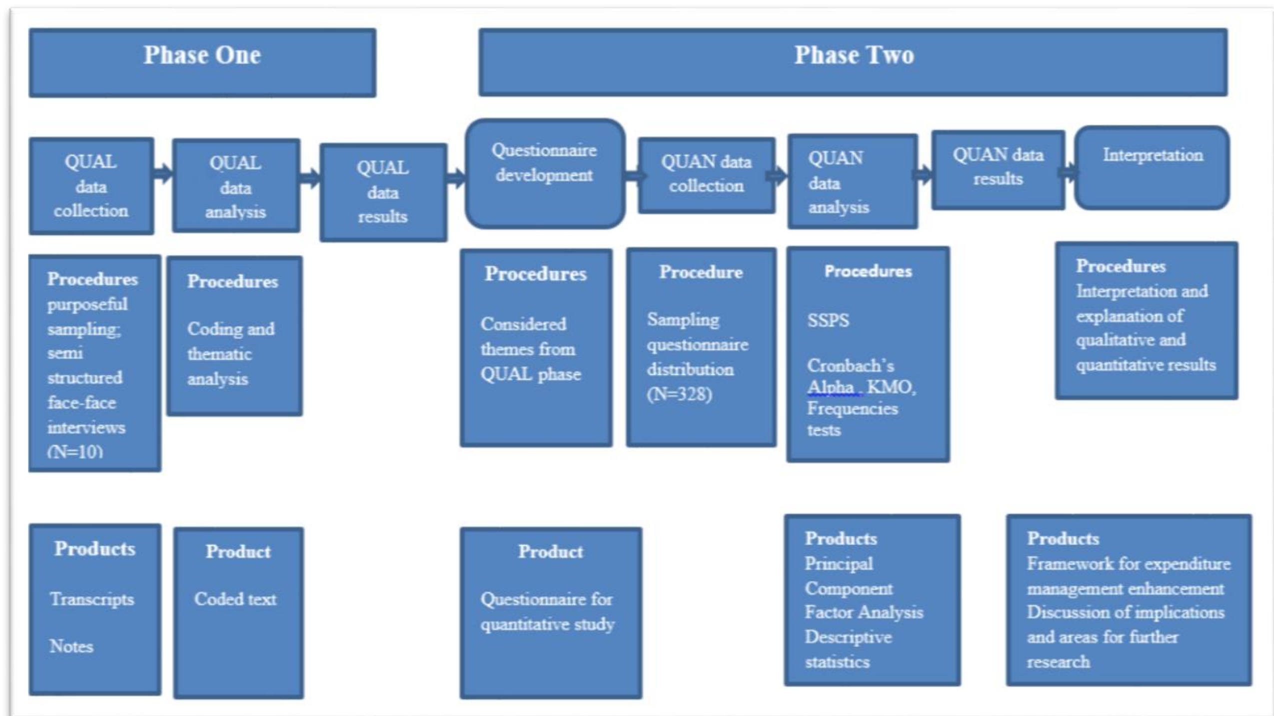



**Figure 4. 1: Exploratory sequential mixed methods research design flow diagram**

**Source:** Adapted from Berman (2017:5)

Researchers combine qualitative and quantitative approaches, because qualitative methods allow a deeper understanding of a phenomenon, whilst quantitative methods permit measurement of extent, trend, causes and effects (Pluye & Hong, 2014:30). The complementary aspect of mixed methods is perhaps the more reason it is considered ideal for studies that seek richness and detail and also measures trends and effects of variables. This approach suited this study, as it sought an in-depth understanding from key players in public expenditure management in the public healthcare delivery sector in Malawi. Therefore, in this study, in-depth interviews were conducted to gain deeper insights into the phenomenon under study, followed by questionnaire development based on identified variables as well as any additional variables discovered from literature reviews. The exploratory sequential mixed methods design was chosen for this study as there are scanty studies in Malawi relating to public expenditure management and, therefore, there is a lack of literature, instruments and evaluation tools in this sphere.

In summary, this study used an exploratory sequential design with equal weighting between qualitative and quantitative approaches. Qualitative data connects with quantitative data at the quantitative data instrument design stage.

### 4.5 The study population

According to Dulock (1993:155), a study's desired population has to be defined and that the research participants should be members of an identified population. The author adds that the study subjects should be knowledgeable, prepared and capable to provide information to the researcher. In addition, Wu and Patel (2015:105) state that people involved in providing information in a research should be knowledgeable in the subject matter and are drawn from various categories to bring in a range of views, thereby, generating an all-inclusive data set. Thus, the latitude of a study dictates the study's target population. This is a study on expenditure management in public healthcare delivery sector in Malawi and drew its participants from individuals involved in the management of finances in the hospitals. Table 4.1 draws a comparison of population and sample characteristics and research strategies adopted for a number of identified related studies for adoption and comparison with this study.

**Table 4. 1: Comparative studies and related research strategies**

| The study | Strategy used | Comparison with this study |
|---|---|---|
| Rangongo (2016:125)<br><br>'Role players' understanding of the role of principals' legal responsibilities regarding financial management in Limpopo' | Deployed a mixed methods research study design. Firstly, did a qualitative study through semi-structured interviews purposively sampled principals, finance officers and departmental officials and then proceeded to do a quantitative study by issuing out questionnaires to randomly selected individuals of the above identified categories. | This is a mixed methods research (Qual-Quan) study using semi-structured interviews, of purposively selected participants: Heads of hospitals, hospital accountants, external and internal auditors, Civil Society Organisation, local government officials. The qualitative study was followed by questionnaire instrument development for the quantitative study which targeted the District Health |

| | | |
|---|---|---|
| | | Management Teams, Councils officials and Programme Coordinators. |
| Rabotapi (2013:49) 'Budgetary control as a mechanism for promoting good governance and public expenditure management in the Ngwathe Local Municipality' | A mixed methods research study. Undertook structured interviews with institutional players like the budget officers and budget committee members. Questionnaires were then distributed to both the institutional members who are the budget officers and budget committee members and the community. | This study undertook semi-structured interviews with institutional role players and Civil Society Organisations and collected quantitative data from questionnaires distributed to randomly selected role players in public finance management. |
| Ajibolade and Oboh (2017:230) 'A critical examination of government budgeting and public funds management in Nigeria' | Data was collected from archival records. Data was analysed using descriptive and inferential statistics including narrations coupled as well as regression analysis. | This study collected quantitative and qualitative data. Qualitative data was analysed thematically whilst quantitative data was analysed using Principal Component factor and univariate analysis. |
| Bakalikwira *et al.* (2017:6) 'Accountability in the public health care systems: A developing economy perspective' | This was a quantitative study whose data was collected from top hospital management (Hospital Directors and Accountants). Sample was 52 Government Hospitals was generated using Krejcie and Morgan, and data was collected using questionnaires. | The quantitative data for this study was collected from hospital management and Councils' officials from different randomly selected district hospitals. The sample size was 328. |

| Borghi *et al.* (2018:82) 'Health financing at district level in Malawi: an analysis of the distribution of funds at two points in time' | Undertook a qualitative study and conducted interviews with officials from Ministry of Finance, Ministry of Health, District Council Director of Finance, District Health Officer, District Medical Officer, District Nursing Officer, District Health Accountant, District Reproductive Health coordinator/Safe Motherhood Coordinator. The qualitative data was analysed thematically. | The qualitative phase of this study involved conducting interviews with Directors of Finance, Directors of Health and Social Sciences, Hospital Accountants, Internal Auditor, External Auditor, Executive Director of the civil society organisation, Financial Management analysist for the National Local Government Finance Committee (NLGFC). The qualitative data was analysed using thematic data analysis technique. |
|---|---|---|
| Frumence *et al.* (2014:5) 'The dependency on central government funding of decentralised health systems' | For this qualitative study, researchers conducted key-informative interviews and focus group discussions. Data was collected from Council Health Management Team (CHMT) and key players of the Local Government Authority (LGAs) | Qualitative data was collected from District Health Management Teams, Civil Society Organisations and officials from the Councils involved in financial management of the district hospitals as well as representatives of the public |

**Source:** (Ajibolade & Oboh, 2017:230; Bakalikwira *et al.*, 2017:6; Borghi *et al.*, 2018:62; Frumence *et al.*, 2014:5; Rabotapi, 2013:49; Rangongo, 2016:125)

The public healthcare service delivery sector in Malawi is divided into levels: community, primary, secondary and tertiary. These are linked through a referral system (Ministry of Health, 2017b:13). Secondary, primary and community healthcare service provision is managed in district hospitals, whilst tertiary healthcare level is managed in central hospitals. This study focuses on district health hospitals whose management is decentralised at the local government level. The central hospitals command their own unique structure and fall outside the scope of this study. In this

case, the district hospitals are the target unit of analysis as both the community and primary health facilities fall under the overall management of the district hospitals. At the district hospital level, the District Health Management Team, which is a multi-cadre group, is responsible for planning and implementation of all activities related to the health sector at district level encompassing the community, primary and district level health service delivery. According to Makwero (2018:2), there are twenty-six public district hospitals in Malawi, which cover the scope of the study.

Rowley (2014:309) states that in organisational, business and management research, study participants are chosen as representatives of their organisation or industry or indeed in their own capacities. In this study, research participants are selected in their capacity as representatives of their institutions. Therefore, this study's targeted population are individuals with roles that relate to health advocacy or finance in terms of decision making and implementation of financial resources management in the public healthcare delivery sector in Malawi. These individuals exercise delegated authority to manage public finances and hence, their behaviour and decisions have an impact on how the resources are managed. Qualitative data was collected from Directors of Health and Social Services, District Medical Officer, hospital accountants, external auditor from the National Audit Office, internal auditor and Financial Management Analyst from the National Local Government Finance Committee, Directors of Finance, Civil Society Organisation; whilst quantitative data was collected from members of the District Health Management Teams, Programme Coordinators and Council officials. These are individuals who are involved in making decisions for healthcare service provision at district level and consequently, affect or are affected with finance management issues for the health sector. Additionally, Civil Society Organisation was included for its advocacy role in public service delivery, being the mouthpiece for the public.

### 4.6 Sampling and sampling techniques

As it may not be possible to collect data from an entire population due to cost and time constraints or appropriate in terms of giving useful data to the study, (Kothari, 2004:55; Saunders *et al.*, 2009:210) explain that selected members of the population should be sampled using appropriate sampling techniques. There are two sampling techniques, probabilistic and non-probabilistic (Saunders *et al.*, 2009:213). This study used non-probabilistic and probabilistic sampling techniques for the qualitative and quantitative phases respectively.

#### 4.6.1 Sample for in-depth interview participants

For in-depth interviews, the study used a non-probabilistic sampling technique to determine sample participants. To this end, the sample determined for the qualitative study was purposively selected, as it was not concerned with generalisation of statistics (Guest *et al.*, 2006:79). This

phase of the study aimed at obtaining an in-depth understanding of the public expenditure management environment in the public healthcare services delivery institutions; as such, it targeted participants who have a role in public finances management and insight knowledge of finances in the public healthcare services delivery sector. This is the case, as it was envisaged that these were able to provide detailed information. The participants were purposively selected.

Arguing for purposive sampling, Marshall (1996:523) holds that in qualitative research, information loads among targeted participants, and thus, they are likely to provide insights to the area of study at different depth levels. Consequently, only those individuals who are considered informed enough for the subject matter were considered to participate in a study. It is recommended that data collection should continue until there is no additional information obtainable from additional interviews, i.e., data saturation (Guest *et al.*, 2006:59; Marshall *et al.*, 2013:11). Thus, it can be established that for qualitative studies, there is no predetermined number of participants, but participants have to be added on to a study sample until the collected data is saturated. The definition of data saturation that is held in this study is, according to Guest *et al.* (2006:77), the point in data collection and analysis when no additional information is extracted from further interviews. Different studies require different sample sizes because of the differing stages at which the data is saturated, and quite likely due to the varying levels of information richness of the study participants. For instance, Alkaraan (2018:590) in a study on 'PFM reform: an on-going journey' undertook in-depth interviews of two key players; whilst Le Gargasson *et al.* (2014:1038) in their work on 'budget process bottlenecks' used six interviews with key officials; Rangongo *et al.* (2016:4) in a study to address 'Causes of financial mismanagement in South Africa public schools' conducted 18 interviews, and Tsofa *et al.* (2016:263) interviewed twelve participants when looking at 'Health sector operational planning and budget processes in Kenya'. These examples suggest that there is no established sample size for qualitative interviews; as long as a saturation point is reached, data collected would be considered complete. In this study, data saturated at ten participants. The ten participants provided qualitative information through semi-structured interviews.

#### 4.6.2 Sample for questionnaires respondents

The population of this study included all individuals with roles in financial decision-making in the twenty-six public district hospitals in Malawi. Respondents to the study were District Health Management Teams, Programme Coordinators and Council Officials from randomly selected districts in Malawi. Each of the districts were considered as clusters, and the clusters were randomly selected. The participating districts were randomly selected by sending letters of

consent to all the twenty-six districts. Sixteen districts responded in the affirmative and formed part of the study units. Consequently, their District Health Management Teams, Programme Coordinators and Councils Officials formed part of the study respondents. Breakdown of the population:

**Table 4. 2:** Study population breakdown

| DHMT members | 26x8 | 208 |
| --- | --- | --- |
| Council officials | 26x7 | 182 |
| Programme Coordinators | 26x25 | 650 |
| | **Total** | 1,040 |

**Source:** Own source

Krejcie and Morgan's table was applied to determine the study sample. According to Krejcie and Morgan (1970:608), a sample size for a population of around 1,040 is 285. However, in this study a higher sample was deliberately considered, and 400 respondents were targeted. Out of the 400 questionnaires, 328 were completed and returned. Thus, the sample size for this study was 328 respondents giving a response rate of 82%.

### 4.7 Data collection instruments

Suitable methods of data collection results in obtaining useful data that addresses the issue being examined (Wu & Patel, 2015:96). Hence, selection and development of appropriate data collection instruments is vital for good research outcomes. Furthermore, Tillyer *et al.* (2010:71) note that depth and type of data collected is important as that determines identification of areas where there are problems. Being a mixed methods study, data was collected using different methods. The researcher collected data using interviews (using an interview guide) for the qualitative study and self-administered questionnaires for the quantitative study.

#### 4.7.1 Qualitative data collection

According to Berman (2017:7), qualitative data is gathered from a variety of sources in order to get data that is rich and deep in meaning. Hence, qualitative data can explain a phenomenon in detail. Rangongo *et al.* (2016:4) conducted in-depth, semi-structured interviews to collect data on principals, finance officers' and departmental officials' perceptions and experiences of the possible causes of financial mismanagement in public schools. This, they held, was because the identified respondents were key in the management and were responsible for utilisation of school funds. Accordingly, in this study, semi-structured interviews were held with individuals involved in

public expenditure management in the public health sector and possessing in depth knowledge of financial issues in the sector.

#### 4.7.1.1 Qualitative data collection - Interviews and interview guide

Interviews can be structured, unstructured and semi-structured. According to Qu and Dumay (2011:244), in a structured interview, the questions are predetermined with restricted response groupings. Inasmuch as it is easy to quantify and organise study findings using structured interviews, Qu and Dumay (2011:244) critique these for being inflexible and biased because the researcher is the one designing the interview instrument. Structured data collection instruments are not flexible, and do not provide opportunity for additional data generation; neither are they completely objective. With unstructured interviews, the researchers develop and generate questions that reflect the purpose of the study right there in the interviews (Qu & Dumay, 2011:245). Therefore, unstructured interviews offer flexibility and generation of unlimited information due to the openness nature of the questions.

In semi-structured interviews, questions that relate with pre-established themes are prepared in advance to ensure that the general themes of the study are covered in the course of the interviews (Qu & Dumay, 2011:246). Hence, semi-structured interviews are a moderation between the structured and unstructured interviews. Zhou and Nunes (2013:422) add that the predesigned questions are not fixed as such they allow the researcher to appropriately add and/or remove questions during interviews. Consequently, semi-structured interviews are flexible and maintain consistency of data collected than the two extreme options. Berryman (2019:274) notes that qualitative methodology allows research to be conducted on a phenomenon by obtaining an understanding of the participants in the subject matter using open-ended questions, among others.

In this study, semi-structured interviews with open-ended questions were conducted. This is because semi-structured interviews provide ample data that could be covered in-depth and are flexible in sourcing information, unlike structured interviews (Kothari, 2004:98). That is, unlike closed structured questions which limit the solicitation of data, the flexibility presented by semi-structured interviews allows for gathering of additional data that emerge spontaneously during interviews. In addition, Berryman (2019:274) explains that qualitative methods allow researchers to get a deep understanding of the phenomenon under study, hence, the use of open-ended questions. Equally, Qu and Dumay (2011:246) hold that semi-structured interviews are commonly used as they are flexible, reachable and dig up underlying information that a structured interview

would not. Hence, semi-structured questions are deemed to be better that unstructured or the structured questions. Additionally, (Pedersen *et al.*, 2016:631; Wu & Patel, 2015:104) applaud semi-structured interviews as they maintain consistency of data to be collected, thereby, enhancing data analysis efficiency. Thus, a further advantage of semi-structures questions is that consistent information is solicited from participants on top of it being flexible in making further enquiries. Therefore, this study undertook semi-structured in-depth interviews with sampled key informants to gather detailed information about public expenditure management in the public healthcare services delivery sector. An interview guide containing structured open-ended questions was developed. The interview guide is appended in this document as Annexure A. The interviews were audio recorded after being granted permission to do so by the participants. The interviews were mostly conducted at a time that the COVID-19 was at its peak in Malawi. In addition, the interviews targeted health personnel who were engaged in healthcare provision or individuals who were pre-occupied with investigations relating to the misuse of COVID-19 funds to the hospitals. As such, most interviews were conducted by phone.

#### 4.7.2 Quantitative data collection - questionnaire

In this study, questionnaires were used in the quantitative data collection phase. Questionnaires' main advantage is its reach to a dispersed population as in the case of surveys (Rowley, 2014:309). The study's population covers all the public district hospitals in Malawi and questionnaires were deemed most appropriate. A self-administered questionnaire was used to collect data that addressed the objectives of the research (refer to Annexure B in this document). Furthermore, according to Rowley (2014:309), questionnaires are a common way of data collection in quantitative studies more so, in business and management research. Thus, questionnaires are seen to be suitable for studies in business and management like the current study. This is the case as data collected through questionnaires allow profiling and frequency determination or making predictions (Rowley, 2014:310).

The questionnaire was developed with guidance from a statistician and instrument development expert from the North-West University. The development of the questionnaire was dependent on data obtained from qualitative study and literature review. The questionnaire instrument adopted suggestions by Kant and Dalvi (2017:365) for questionnaire development. These include literature outcome and factor finalisation, instrument scale and questionnaire piloting, and testing for validity and reliability. The purpose of undertaking all the stages in the development of the questionnaire is to have a reliable data collection instrument that was appropriate to collect data that informed

framework design in the quest of enhancing public expenditure management in public healthcare services delivery sector in Malawi.

Rowley (2014:314) notes that questions in questionnaires can either be closed or open-ended. The author explains that data from closed questions are likely to boost response rate as they are fast to be completed and easy to code and analyse; whilst open ended questions are good for collecting in-depth insights into a phenomenon, but they take time to complete and analyse. This means that closed-ended questionnaires speed up the data collection and analysis processes, unlike open-ended questions. The questions in the questionnaire were, therefore, close-ended. The questionnaires were made easy to complete for the respondent as they used simple language to ease understanding of questions (Rowley, 2014:314). Thus, questionnaires have to be simplified in language and presentation to ease effective data collection. Furthermore, Rowley (2014:316) guides that questionnaires should be piloted on colleagues and members of the population in order to confirm clarity and ease of completion.

Despite being known for low response rate, self-administered questionnaires were preferred in this study as a quantitative data collecting tool since they are convenient for the respondents as they can attend to them at their convenient time and eliminate biasness in providing responses directly to the researcher (Kothari, 2004:100). Self-administered questionnaires enhance objectivity of research data as there is independence on the part of the participant in providing data. The perceived low response rate that arises out of using questionnaires was managed by the use of trained personnel in questionnaire administration from the district hospitals and this assisted in attaining a high response rate.

### 4.8 Data analysis

Data collection is followed by data analysis. Kothari (2004:122) explains that once data has been collected, it has to be processed and analysed. The author specifically identify data processing as a function that comprise data editing, coding, classifying and tabulation so that the data conforms to analysis, the analysis itself relates to calculations of indicators whilst looking for relationships existing in data groups. Accordingly, data analysis involves processing of research into meaningful information. Wu and Patel (2015:98) explain that validity of data interpretation is enhanced if the design of data analysis processes is done properly. Effective data processing is crucial if the information being produced is to be valid. Being a mixed methods research, both quantitative and qualitative data was collected and analysed using appropriate techniques.

#### 4.8.1 Qualitative data analysis

Because qualitative research entails an evaluation of attitudes, opinions and behaviours subjectively, the data generated is not quantitative and therefore, is not analysed with quantitative rigour (Kothari, 2004:5). This implies that qualitative data generated from qualitative research was analysed qualitatively without involving quantitative techniques of data analysis. In addition, Creswell (2009:184) explains that qualitative data analysis is done concurrently with data collection and reporting. This means that with qualitative studies, data is processed as it is collected.

##### 4.8.1.1 The types of qualitative data analysis

Braun and Clarke (2006:78) categorise qualitative data analysis methods into two: those that have a theoretical or epistemological stand, like interpretive phenomenological analysis and grounded theory; and those that are independent of any theoretical and epistemological position such as thematic analysis. For example, Braun *et al.* (2015:186) illustrate that interpretive phenomenological analysis would dictate that phenomenology, a research philosophy, should underlie the research; even direct the questions to ask and how data should be collected to how it should analysed. It follows that qualitative data analysis is either restricted by a theoretical position or would be unconfined to any theory. Smith and Firth (2011:53) categorise qualitative data analysis methods into those that discover 'use and meaning of language' referring them to sociolinguistic methods which include discourse and conversation analysis; whilst there are those that focus on theory development like the grounded theory; and those that explain and construe views of participants such as content and thematic analysis. Braun and Clarke's classification of qualitative data analysis is based on whether the method is inclined to specific theoretical position or not; whilst Smith and Firth's qualitative data analysis is based on the function of the analysis.

##### 4.8.1.2 Thematic analysis

Thematic data analysis is a method of analysing qualitative data and forms the basis for a lot of forms of qualitative data analysis (Braun & Clarke, 2006:78). Thematic data analysis is a common form of data analysis for qualitative studies. Nowell *et al.* (2017:1) consider thematic analysis as an appropriate method of analysing qualitative research. This type of analysis is a preferred way of analysing qualitative data due to the fact that it does not pin a researcher to a specified theoretical framework.

Thematic analysis is defined as a way of pattern recognition and analysis in qualitative data (Braun & Clarke, 2006:79). This entails that with thematic analysis, the data analyst establishes

emerging themes from the data. Braun and Clarke (2006:86) highlight that thematic analysis entails looking across a set of data to establish recurring styles of data interpretation. This shows that there is need for a researcher to be analytical to recognise the issues that arise from the data that is being analysed. According to Joffe (2012:212), textual and data collected from verbal interviews are most appropriate for thematic analysis. Since the qualitative data collected in this study were gleaned from personal interviews which were audio recorded and transcribed, this study analysed the data using thematic analysis as it was considered most appropriate.

#### 4.8.1.2 Merits of thematic data analysis

Thematic data analysis method is favoured for its theoretical flexibility (Braun & Clarke, 2006:78; Braun *et al.*, 2015:184). A researcher does not have to stick to a prescribed theoretical position, as thematic analysis is just a technique applied in data analysis. For instance, Braun and Clarke (2006:80) note that regardless of the fact that thematic analysis, interpretive phenomenological analysis and grounded theory all look for styles in the data, only thematic analysis is not bound by any theoretical framework. In addition, Braun and Clarke (2006:97) claim that thematic analysis is easy to learn and apply, and thus, it is applicable to researchers with less qualitative research experience. Therefore, thematic analysis is favoured because it is a simple qualitative data analysis technique because of its flexibility.

#### 4.8.1.3 Undertaking thematic data analysis

Braun and Clarke (2006:86) state that thematic analysis comprise persistent recursive movements between the data set, the coded data excerpts and the actual analysis. Thus, continuous writing becomes part of the analysis and therefore, process iteration is an important feature in thematic data analysis. Braun and Clarke (2006:87) outline the following phases in thematic data analysis: data familiarisation which leads to data transcription; code generation; theme searches; reviewing themes; defining and naming themes and report production. Therefore, for a comprehensive, procedural and complete thematic analysis, the stated steps need to be followed. This study followed all the six phases as guided in undertaking thematic data analysis.

#### 4.8.1.4 Data familiarization

It is important for a researcher to acquaint themselves with the data in order to establish emerging themes (Braun & Clarke, 2006:87; Rowley, 2014:326). Braun and Clarke (2006:87) note that there is a great deal of reading in this phase which is time-consuming but worth the effort, as the data

familiarisation phase forms the foundation of analysis. A researcher who is in the process of analysing qualitative data needs to invest time to get accustomed to the data they have collected. Furthermore, if a researcher is working on verbal data, the first thing would be to transcribe the data into written format and commence the process of analysis from there (Braun & Clarke, 2006:87). This means that the reading of the transcribed data has to be done with an understanding in order to deduce the major issues being revealed by the data. Rowley (2014:326) notes that since analysis of qualitative data is subject to researcher bias, it is recommended to allow another researcher to confirm on the classifications and the coding to enhance data validity. This enhances objectivity by involving independent eyes on the data is a part of quality assurance in qualitative data analysis. This study collected qualitative data through interviews which were transcribed into texts and then the researcher went through the data in order to be familiar with it and commence initial coding and theme establishment.

#### 4.8.1.5 Code generation

Creswell (2009:187) notes that in general, in as far as coding is concerned, a researcher may allow codes to emerge during data analysis or one can predetermine the codes. However, in social sciences, it is preferred to allow the codes to emerge during the data analysis (Creswell, 2009:187) instead of predetermining them. In this study, codes were not predetermined, they emerged as the themes were being processed. On the other hand, Braun and Clarke (2006:89) mention that to a large extent, data coding depends on whether the themes are data or theory driven. The authors further illustrate that, data driven themes depend on the collected data; whilst theory driven themes generate themes depending on the questions that the researcher so wishes to code around but emphasise that all data extracts should be coded. Thus, the coding of data which depend on either data themes or theory driven themes is an integral part of thematic data analysis. Coding can be manual or one can use software. According to Wu and Patel (2015:110), manual coding and sorting of data is preferred rather than reliance on software as it permits researchers to intuitively develop ideas on the data unlike using software. Accordingly, this study applied manual coding.

#### 4.8.1.6 Theme searches

Theme generation is a shared attribute of qualitative data analysis (Smith & Firth, 2011:54). This infers that qualitative data analysis produces themes. Braun and Clarke (2006:89) state that with the initial data coding and collation there is identification of codes and this stage focuses on data themes which entails classifying the codes into possible themes. In other words, from the many

codes identified, they are narrowed down to themes that emerge as the codes and data are being classified. Elaborating on searching for themes, Berryman (2019:274) notes that in qualitative data, data analysis involves textual analysis, data interpretation, and themes and patterns are established. Thus, qualitative data analysis basically handles textual data which is generated into themes.

#### 4.8.1.7 Reviewing themes

According to Braun and Clarke (2006:91), theme review commences with a set of proposed themes and a deliberate attempt to refine them where some themes have to be merged, broken down, removed or added as appropriate. This shows that establishing themes requires moving back and forth through the draft themes until they are refined enough. Thus, the themes generated during the theme generation phase are further scrutinised to determine theme redundancies, inadequacies or incomprehensiveness. After such cleaning has been done, standing themes are identified.

#### 4.8.1.8 Defining and naming themes

Theme definition and naming entails refinement of themes to be included in the analysis and the analysis of the data in the themes in the process ensuring that the theme is not crowded nor complex (Braun & Clarke, 2006:92). Names given to themes should be concise enough to guide the reader understand what the theme is addressing. For clarity, the themes have to be properly sorted so that the analysis report can be easily followed. To achieve this, the collated data excerpts were reviewed and organised to achieve data coherence.

#### 4.8.1.9 Report production

After completing the thematic data analysis, a report was produced and is presented in chapter 5. The report provided a comprehensive narration of the findings from the qualitative study. The report did not only narrate the findings, but also presents the results in relation with the research objectives and questions.

### 4.8.2 Quantitative data analysis

Quantitative research requires subjecting generated data to rigorous numerical analysis and inferring the research findings to a study population (Albers, 2017:215; Kothari, 2004:5). Thus, whereas qualitative data analysis involves an in-depth understanding of data, quantitative data analysis applies quantitative techniques when analysing data in order to allow projections and inferences of phenomena. Quantitative data underwent factor and univariate analysis. According

to Rowley (2014:325), univariate analysis is basically presented by frequency tables, charts or diagrams. Included in the quantitative data analysis is the use of factor analysis, having undertaken the principal component analysis (PCA). Vogt *et al.* (2014:337) explain that factor analysis is correlational and more appropriate for most questions in the social and behavioural sciences. Consequently, the quantitative data is subjective to more complex analysis, the factor analysis, in order to analyse further the relationships amongst the variables. Furthermore, Vogt *et al.* (2014:334) explain that factor analysis has been applied by researchers to improve the "measurement of latent variables or constructs". Hence, the use of factor analysis is to enhance quantitative data analysis by focusing on assessment of variables. Factor analysis is applied in quantitative data analysis if there is a perceived association between the data variables and that it describes variation of possible low number of unnoticed variables (Twigg, 2015:147). Therefore, the condition for application of factor analysis is that there is an observed relationship amongst variables.

**4.9 Validity and reliability**

Having reliable and valid data collection instruments is a significant consideration in research as the type of data collected impacts on the research outcome in terms of its dependability. Such being the case, this research considered matters of instrument and data validity and reliability as important. Noble and Smith (2015:34) claim that research results should be valid if their findings are to be relied upon to inform practice. Therefore, research results need to be valid and reliable for acceptance by users. Kothari (2004:73) states that validity is an indicator of the extent to which what was measured is what was meant to be measured. Thus, the validity of research is a quality aspect of research findings. Dulock (1993:155) explains that research data should be valid and reliable as such instruments used to collect data should be tested and calls upon researchers to ensure that the instrument design is valid as well reliable. Consequently, the quality of data collection instruments determines the extent of reliability and validity of research outcomes. Accordingly, validity is concerned with the data collection instrument as to what it measures and how well it measures that; whilst reliability looks at the consistency of a research instrument (Kothari, 2004:74; Mohajan, 2017:59). Without establishing the validity and reliability of a research instrument, is not possible to determine the effect of errors, hence, usability of results. It is worth noting, therefore, that a researcher needs to be systematic in his or her approach in undertaking research if the research output is to be of acceptable quality. It is imperative, therefore, that before research data is collected, the researcher should ensure that the instruments that have been used for the data collection exercise allow for the collection of valid and reliable data. Otherwise, the study is bound to yield false results, being not representative of issues on the ground. It is advised

that to ensure that the research output is valid, reliable and has credibility, multiple sources of data should be used (Mohajan, 2017:60; Riege, 2003:42). Whereas, quality of data collection instruments contributes to credibility of findings, sourcing of data from multiple sources enhances validity and reliability of findings. The study collected data through interviews and questionnaires. Tillyer *et al.* (2010:75) point out that whatever data collection method is deployed, researchers should pilot test their data collection instruments in order to detect errors in instrument design. This being the recommendation, both instruments were pilot tested before being put to use. This means that efforts were made to ensure that there is consistency in the results by ensuring that the data collection instrument was reliable; data analysis, findings, interpretations and recommendations was systematically done and that the boundaries of the research was defined, hence, stating scope of generalisation.

### 4.9.1 Validity and reliability for the interview guide

Validity for the interview guide was attained by consulting experts to comment on the data collection instrument to confirm that it would indeed collect the data that it was meant to. In addition, before the interview guide was used on the actual samples, it was piloted to ensure that the wording is correct and clear for respondents. Thus, piloting of data collection instruments add value to the instruments as feedback from mock respondents was used to refine the instrument. As explained by Wu and Patel (2015:106) piloting of the interview guide was done to eliminate misunderstanding and ambiguity of the interview guide to make it useful and effective. It follows that subjecting data collection instruments to a trial refines the instrument, thereby, enhancing its usability. Pilot studies were conducted on individuals possessing knowledge on public expenditure management in order to use their feedback to perfect the data collection instrument.

### 4.9.2 Validity and reliability for the questionnaire

Nouri *et al.* (2018:992) used both qualitative and quantitative assessment to determine validity and observed improvements in the questionnaires. This demonstrates that questionnaires should be assessed for validity both qualitatively and quantitatively. For the most part, quantitative research applies statistical methods in order to determine the validity and reliability of research results (Noble & Smith, 2015:34). Thus, there are statistical measures that assess whether the results are valid and reliable. Validity for questionnaires in this study was achieved firstly by running a pilot test on individuals who are able to determine the appropriateness of the data collection instrument to assess whether the questions' content and wording are clear. The first phase of measuring validity and reliability of results is thus pilot testing the data collection instruments. The questionnaires were piloted on 53 individuals with characteristics of the actual

sample. These included programme Coordinators, Council and hospital management. The intention was to check the instrument's appropriateness of language, length, duration, clarity of questions and reliability of the instrument, (refer to the extended section of the questionnaire in Annexure B, adapted from Machera (2020:399). Thus, piloting of questionnaires serves as a quality measure.

Kothari (2004:73) differentiates between external validity and internal validity, where external validity is the possibility that research findings will be generalisable. External validity looks at the applicability of a study's results to other similar settings. On the other hand, internal validity, which is reliability, is the ability of a research design to measure what it intends to measure (Kothari, 2004:73; Mohajan, 2017:70). Reliability entails the ability of a study to measure what it intended to. Sampling adequacy was measured using the Bartlett's test of Sphericity and Kaiser-Meyer-Olkin test (KMO) was used to measure reliability of the questionnaire as a data collection instrument. In addition, Cronbach's Alpha was computed to confirm "similarity, accuracy, predictability and reliability of the results" of various public expenditure management constructs being addressed in this study. These measurement and assessment tools on validity are adopted from (Nouri *et al.*, 2018:992,993). Moreover, the use of Cronbach's Alpha reliability coefficient for confirming reliability is a common internal consistency measure in the social sciences (Mohajan, 2017:70). The procedures discussed in this section were to ensure that the research was done systematically and that the results could be relied upon by users to make decisions in as far as management of expenditure in the public healthcare services delivery sector is concerned.

### 4.10 Ethical considerations

Ethics refers to moral principles that direct actions and they stem from philosophical theories (Neuman, 2014:145). Thus, it is imperative that researchers are ethical in undertaking their research to have a study that is morally acceptable. These principles are identified as "integrity, rigour, respect, trustworthiness and responsibility" (Bond, 2015:102). This means that research studies that lack these principles are ethically and morally challenged and deemed unacceptable.

Pulverer and Armbruster (2017:13) view research ethics as the applicable standards of ethics and behaviour during the research process and includes the absence of false statements, fabricating information and plagiarizing others' intellectual property. Research studies should be conducted with integrity. Saunders *et al.* (2009:183) maintain that consideration of ethics should be made throughout the research process, from planning the research to reporting. Accordingly, ethics should be applied at every stage of the research. Researchers have moral and professional obligations to ethically conduct their research even though the research participants are not

bothered about ethics (Neuman, 2014:145). Thus, the onus of acting ethically during a study lies with the researcher. Bond (2015:101) claim that nearly all research is informed by ethics. Therefore, when researchers abide by research ethics, the research results are approved and acceptable. Acceptability of research results motivated the researcher to comply with research ethics provisions. There are a number of research ethical considerations that a researcher should abide by and they include privacy of participants; non coercion of participants to participate in a study or freedom to withdraw from participating if they so wished; and maintaining data confidentiality and anonymity of participants (Qu & Dumay, 2011:253; Saunders *et al.*, 2009:187). It is imperative, therefore, that researchers should comply with the provisions of research ethics.

### 4.10.1 Permission to conduct study

Before any data was collected, the necessary approvals were obtained. Permission was sought from the appropriate authorities of all participating district hospitals. Furthermore, approval for ethical clearance conduct from North-west University was obtained (refer to Annexure C). It is a requirement from the Government of Malawi that all research should first obtain approval from the National Research Committee in the Social Science and Humanities before data could be collected. This requirement was duly complied with as evidenced in Annexure D.

### 4.10.2 Informed consent

Informed consent is defined as the knowledgeable voluntary agreement to participate in a study by participants without any coercion (Orb *et al.*, 2001:95; Weinbaum *et al.*, 2019:19). This means that a participant in a study should agree to take part in a study freely without being forced to and having knowledge of the implications of participating in such a study. That is the reason Saunders *et al.* (2009:190) explain the difference between implied and informed consent. Implied consent is where the participant is not really in the know as to his or her rights, but the consent is inferred from his conduct; whereas with informed consent, a participant gives permission to participate of their own will and has adequate information as to their rights as a research participant. This entails that informed consent surpasses implied consent. It is imperative that informed consent is obtained from research participants prior to the research (Neuman, 2014:148).

Qu and Dumay (2011:254) point out that researchers should not use deception when informing participants about the request to participate in a study. This principle indicates that study participants should know what is being asked of them and what they have agreed to participate in. In this study, an effort was made to explain and make the participant understand their rights and enlighten them as to how data collected would be used. Assurance was given that reporting of the study results will maintain their anonymity and confidentiality. Annexure E and F are the

informed consent forms for qualitative and quantitative participants respectively that the respondents were presented with before data was collected from them.

### 4.10.3 Confidentiality and anonymity

One of the research ethical requirements is that researchers should maintain the confidentiality and anonymity of researchers. Neuman (2014:155) holds that researchers should maintain ethical protection by safeguarding research data from exposure to the public as well as ensuring that the processed data does not allow linkage to participants. Therefore, researchers are obliged to ensure that there is protection of the identities of the participants and the information they provide. In addition, in ensuring that researchers are anonymous, Neuman (2014:154) stresses that research participants should not be named and their identities should not be disclosed. The researcher should make sure that when reporting study results, the particulars of those that provided information should be kept unknown. In this study, participants' names and identities leading to them are not divulged in data collection and reporting and the questionnaires did not require them to give their names.

### 4.10.4 No Harm to participants

Qu and Dumay (2011:252) state that research should not bring harm to study respondents and to guarantee this objective, research studies commence with an endorsement of a governing body or research board. The primary principle of overseeing research participants' protection is that participants should be protected from any harm arising from their involvement in a study (Leavy, 2017:32).

According to Qu and Dumay (2011:253) the relationship of a researcher and participant implies underlying obligations, one of which is that the data collected by the researcher should bring no harm or danger to the participant. It is the responsibility of the researcher to ensure the protection of the interviewee by safeguarding the collected data and concealing the participants' identities. Neuman (2014:147) states that a social study can present physical, psychological, legal, as well as economic harm to participants. Accordingly, participants have to know their rights; for example, that they may withdraw from a study, more especially when they do not feel comfortable to respond to certain questions or indeed not at all responding to those questions that make them uncomfortable. Exposing participants to any harm is unethical and, as Neuman (2014:149) points out, may deter participants to comply with future research. Thus, researchers should endeavour to avoid any practices that bring harm to participants during research. Saunders *et al.* (2009:186) illustrate that among others, how issues of confidentiality, collection and analysis of data and reporting are done in a study, could cause harm in form of stress. This bears out the point that a

participant should be protected from harm at every point where the participant is involved. This study took into consideration these issues by ensuring that participant identity is concealed, data collected during the interviews was and continue to be protected. In addition, presentation of research findings is in such a way that it does not link with anyone who has provided information.

### 4.10.5 Equity and justice

Justice entails equality and fairness among research participants. A gist of this principle is the non-exploitation and avoidance of abuse of study participants (Orb *et al.*, 2001:95). Thus, researchers are required to exercise equity and justice to all participants and not to discriminate anyone on any grounds when collecting data. Weinbaum *et al.* (2019:24) note that discrimination of participants in a study is not acceptable, and that this may result in skewed results. As a result of discriminating against participants, there could be subjectivity and invalidity of research findings due to the unsuitability of participants that are part of the study. In this study, equity and non-discrimination were achieved by including all the role-players in public expenditure management in health as part of the study population and that for both qualitative and quantitative studies, all participants were asked similar questions from the interview guide and questionnaires respectively.

## 4.11 Chapter summary

Chapter 4 detailed the research methodology of the study. The philosophical position for the study was identified and defended. The pragmatic paradigm was the chosen philosophical position for this study. It was chosen as it agrees with the mixed methods research that was deemed fit for the study. Furthermore, the mixed methods research design applied for this study is the exploratory sequential design. This is the case as it was planned to use the qualitative data to develop the data collection instrument for the quantitative phase. A purposive sampling technique was used to identify research participants for the qualitative study, whilst quantitative respondents were chosen from randomly selected district hospitals. Data collection was done through semi-structured interviews using an interview guide for the qualitative design and self-administered questionnaires for the quantitative phase. Validity and reliability were maintained by undertaking pilot studies to ensure data quality. In terms of abiding to research ethics during data collection, the ethical code of conduct provided North-West University was upheld throughout and appropriate approvals and consent were sought from the relevant authorities.

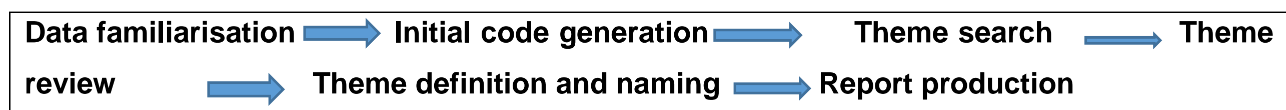
## CHAPTER 5: QUALITATIVE RESULTS ANALYSIS AND DISCUSSION

### 5.1 Introduction

Chapter 4 discussed the research methodology of the study, and explained the exploratory sequential mixed methods research approach which was used in the study. Chapter 5 presents results from the qualitative data analysis. The presentation of the qualitative results is in form of themes extracted from the qualitative data that was generated during qualitative data collection phase of the study. Research participants granted consent to be interviewed and be recorded. The recorded interviews were then transcribed. In the qualitative frame of research, the semi-structured interviews were used to explore the expenditure management environment and the status of the public healthcare service delivery sector in Malawi. Thematic analysis was used to analyse the data that was obtained from the semi-structured interviews. This was done because thematic data analysis allows for sound data reliability and helps to gain an in-depth understanding of the topic under discussion. An inductive approach was used in identifying the themes and patterns of meanings across the collected data. Verbatim quotations from participants have also been included as part of the analysis to maintain data integrity and the ethical status of the study. Constructs and variables that were extracted from the qualitative study phase formed part of the questionnaire development in the quantitative study phase.

### 5.2 Thematic data analysis – The technique applied in qualitative data analysis

This study was an exploratory sequential mixed study design. The exploratory stage of the study collected qualitative data from semi-structured interviews. There is a need for systematic analysis of qualitative data, if the results from the study have to provide meaning and be useful (Attride-Stirling, 2001:386; Nowell *et al.*, 2017:1). Following on these remarks, the qualitative data in this study was analysed using the thematic analysis technique. There are steps provided in analysing qualitative data using thematic analysis, thereby, providing a methodical approach to data analysis (Attride-Stirling, 2001:391; Braun & Clarke, 2006:87). Thematic analysis was selected, because it enhances the reliability of data and provides an in-depth understanding of the phenomenon under discussion. Thus, the qualitative data collected at the exploratory phase of the study applied the recommended procedures of thematic data analysis. The qualitative data was analysed by adopting the six steps prescribed by Braun and Clarke (2006:87) when conducting thematic data analysis, namely:



### 5.3 Demographics for the research participants

Participants who took part in the interviews for the study were purposely selected individuals. Their selection was based on the roles they play in the management of expenditure in the public healthcare services delivery sector, specifically the district hospitals. For the purposes of maintaining anonymity and confidentiality, each one has been assigned a code which serves as their means of identification.

Table 5.1 presents the list of interviewees who participated in the study. The individuals have crucial roles in the management of public expenditure in the health sector of Malawi. A purposeful or non-probabilistic sampling technique was used to identify appropriate participants who would provide insights into the management of expenditure in the public healthcare delivery sector in Malawi. The participants have worked for their organisations and in their roles for at least three years, which is considered adequate to provide insightful and reliable information. All the participants had basic qualifications for the positions that they hold. The composition of the research participants was diverse to allow for collection of data relating to expenditure management from different perspectives, thereby, enriching data collection. The participants were drawn from the district hospitals, Councils, the National Local Government Finance Committee, National Audit Office and Civil Society Organisations.

**Table 5. 1: Demographics for research participants**

| Serial # | Code | Position | Institution | Length of Service (no. of years) | Highest Qualifications |
|---|---|---|---|---|---|
| 1. | FA01 | Financial Management Analyst | National Local Government Finance Committee | 8 | Masters |
| 2. | DHSS01 | Director of Health and Social Services | District hospital | 3 | Bachelors |
| 3. | ACC01 | Assistant Accountant | District hospital | 10 | Bachelors |
| 4. | DoF01 | Chief Accountant | Council | 10 | Bachelors |

| 5. | DHSS02 | Director of Health and Social Services | District hospital | 7 | Bachelors |
|---|---|---|---|---|---|
| 6. | DMO01 | District Medical Officer | District hospital | 4 | Bachelors |
| 7. | ACC02 | Senior Accounts Assistant | District hospital | 26 | Diploma |
| 8. | NA01 | Audit NAO | National Audit Office | 14 | Masters |
| 9. | IA01 | Internal Auditor | National Local Government Finance Committee | 6 | Bachelors |
| 10. | CSO01 | Executive Director | Civil Society Organisation | 5 | Masters |

**Source:** Research Data

### 5.4 Discussion of the qualitative data

The study focuses on expenditure management in the public healthcare services delivery sector in Malawi, specifically the district hospitals. The researcher set out to evaluate the expenditure management environment in the public health service delivery sector in this country. This section describes the themes and sub themes as captured in Table 5.2. In addition, quotes extracted from the interviewees are included to provide clarity to meanings in respect of the transcribed data from findings. In order to eliminate chances of data manipulation, the cited quotes were presented as narrated by the interviewees. This allowed to maintain data integrity. Furthermore, the data analysed was validated with reference to the literature. The data was collected from individuals with various roles in the management of expenditure in the public healthcare sector in Malawi. Codes were generated for the participants as follows: Director of Health and Social Services = DHSS01 and DHSS02; District Medical Officer = DMO01; Hospital Accountant = ACC01 and ACC02; Director of Finance = DoF01; Financial Analyst (National Local Government Finance Committee) = FA01; Internal Auditor (National Local Government Finance Committee) = IA01; National Audit Office Auditor = EA01 and Executive Director, Civil Society Organisation = CSO01. (Refer to Table 5.1 for more details relating to the participants). The participants were identified by means of codes in order to uphold participant anonymity in line with ethical requirements. The analysis of the qualitative data involves a discussion of the themes emerging from the data and

moved on to detailed analysis of the sub themes. Table 5.2 presents a summary of the themes and sub themes as determined from the analysis.

**Table 5. 2: Themes and sub-themes**

| Theme | Sub-theme |
|---|---|
| **Theme 1:**<br>• Funding situation | 1. Funding sources<br>2. Challenges with funding sources |
| **Theme 2:**<br>• Status of public expenditure management in the public health service delivery sector | 1. Budgeting and budget management<br>2. Strengths<br>3. Challenges |
| **Theme 3:**<br>• Vital functions in expenditure management | 1. Legislation<br>2. Procurement and supply chain management |
| **Theme 4:**<br>• Management and personnel factors | 1. Management attributes<br>2. Personnel requirements |
| **Theme 5:**<br>• Strategies towards achieving improvements | 1. Improving hospital funding<br>2. Improving public expenditure management |

**Source:** Research data

### 5.5 The link between themes and research objectives

The main objective of the study was to evaluate the expenditure management situation in the public healthcare services delivery sector of Malawi and to develop a framework aimed at enhancing public expenditure management. Four specific research objectives were derived from the main objective. The data that was collected satisfied the requirements of the main research objective and the specific research objectives. Table 5.3 highlights the connection between the themes that emerged from the data analysis and the specific research objectives that was generated to guide in addressing the overall research aim.

**Table 5. 3: Themes and research objectives**

| Theme | Sub-theme | Research objective |
|---|---|---|
| **Theme 1:**<br>Funding in the public healthcare service delivery sector in Malawi | 1. Funding sources<br>2. Funding challenges | **Objective 1:**<br>Determine the funding situation for the public healthcare sector in Malawi. |
| **Theme 2:**<br>Status of public expenditure management | 1. Budgeting and budget management<br>2. Strengths of the public expenditure management environment<br>3. Public expenditure management challenges | **Objective 3:**<br>Establish the extent to which budgetary systems are utilised in the effective management of expenditure<br><br>**Objective 2:**<br>Ascertain factors that influence optimization of expenditure management in the healthcare sector in Malawi. |
| **Theme 3:**<br>Vital functions in expenditure management | 1. Legislation<br>2. Procurement and supply chain management | **Objective 2:**<br>Ascertain factors that influence optimization of expenditure management in the public healthcare sector in Malawi |
| **Theme 4:**<br>Management and personnel functions | 1. Attributes of managers<br>2. Personnel requirements | **Objective 2:**<br>Ascertain factors that influence optimization of public expenditure management in the public healthcare sector in Malawi |
| **Theme 5:**<br>Improvement strategies | 1. Enhancing the funding situation<br>2. Improving public expenditure management | **Objective 1:**<br>Determine the funding situation for the public healthcare sector in Malawi.<br>**Objective 4:**<br>Explore ways of enhancing efficiency in utilisation of financial resources in the public healthcare sector in Malawi. |

**Source:** Research data

Table 5.4 is a matrix of specific research objectives. It is used to link the individual research objectives, the overall theme and the sub themes that emerged from the study.

**Table 5. 4: Specific research objectives matrix**

| | Research objective | Key assigned |
|---|---|---|
| 1. | Determine the funding adequacy for the public healthcare sector in Malawi. | 1 |
| 2. | Ascertain factors that influence optimization of expenditure management in the public healthcare sector in Malawi | 2 |
| 3. | Establish the extent to which budgetary systems are utilised in the effective management of expenditure | 3 |
| 4. | Explore ways of enhancing efficiency in utilisation of financial resources in the public healthcare sector in Malawi. | 4 |

Table 5.4 presents the matrix capturing the research objectives and assigned a key to each one of them.

The key produced in Table 5.4 was used to link the research objectives and the themes identified from the qualitative data analysis. That was done to confirm the achievement of research objectives. Each research objective was assigned a number (refer to Table 5.4) which was linked to the themes that emerged from the analysis.

Table 5.5 presents a summary of the thematic analysis that was obtained from open-coding themes.

**Table 5. 5: Themes and sub-themes from the thematic analysis**

| Description | Common themes | Research objective aligned with |
|---|---|---|
| **Funding situation in the public health service in Malawi** | | |
| **Funding sources** | • Government<br>• Donors<br>• Council | **1** |
| **Funding challenges** | • Inadequate funding<br>• Late funding<br>• Dwindling donor funding<br>• Lean government pocket<br>• Weak generation capacity for the Councils<br>• Earmarked donor funding<br>• Uncertain donor funding | **1** |

| Status of public expenditure management | | |
|---|---|---|
| **Budgeting and budget management** | • Government guidelines in budgeting<br>• Budget consultations<br>• Budget allocation restrictions and funds disbursements<br>• Budget implementation<br>• Budget reviews<br>• Determinants of funding allocations | **3** |
| **Strengths** | • Availability of an accounting system<br>• A move towards recruitment of qualified personnel<br>• Availability of procedures for budget virements<br>• Team work<br>• Spirit of consultations<br>• Standard guidelines<br>• The use of health committees<br>• Vibrant civil society<br>• Well-articulated procedures for financial management | **3** |
| **Public expenditure management challenges** | • Inadequate funding<br>• Staff shortages<br>• Lack of capacity of staff<br>• Weak oversight functions<br>• Inflexibility of budgets<br>• Poor governance<br>• Bureaucracy<br>• Poor control of expenditures<br>• Poor allocation of resources<br>• Central control<br>• Un-mandated expenses<br>• Performance management weaknesses<br>• Mismatch between public audit requirements and services provided by the outsourced audit firms<br>• Overstretched external audit function | **2, 3** |
| **Vital functions in public expenditure management** | | |
| **Legislation** | • Lack of compliance<br>• Lack sanctions for violation | **2** |
| **Procurement and supply** | • Monitoring and capacity challenges<br>• Funding limitations<br>• Price increases | **2** |

| **chain management** | • Non-compliance to procedures | |
|---|---|---|
| **Management and personnel functions** | | |
| **Attribute of managers** | • Managers should be effective in financial management<br>• Achieving organisational goals | **2** |
| **Personnel requirements** | • Adequate staffing<br>• Competency, knowledge and skills of staff<br>• Integrity of staff | **2** |
| **Improvement strategies** | | |
| **Enhancing funding situation** | • Introduce paying sections<br>• Lobby the government<br>• National health insurance schemes<br>• Enhance revenue generation capacity of Councils | **1,3** |
| **Improving public expenditure management** | • Strengthen capacity for oversight functions (Audit committees)<br>• Increase funding<br>• Enhance motivation for management<br>• Increase budget flexibility<br>• Increase staffing<br>• Extend consultations on funding allocations to staff<br>• Enhance use of ICT<br>• Decentralize Councils and make them independent<br>• Enhance cost control<br>• Increase on public awareness on budgetary issues<br>• Improve and clarify on the fund allocation formula for the hospitals | **4,3** |

### 5.6 Theme 1: Funding situation in the district hospitals

The analysis provides an insight into the funding environment in the public district hospitals in Malawi. It has been deduced from the analysis that public district hospitals realise their funding from various sources. The analysis has also revealed that in the course of public healthcare services delivery, public hospitals have encountered various constraints relating to funding that impact on expenditure management and, consequently, service delivery. Low and middle income countries need support to have sufficient and reliable funding in the health sector (Grépin *et al.*,

2017:68). Thus, it is stressed that one of the critical factors in public service delivery and specifically health service is health funding. The findings are as follows:

1. ***Funding sources:***
    - *Government funding*
    - *Donor funding*
    - *Council funding*

2. ***Challenges in funding***

- *Inadequate funding*
- *Late funding*
- *Dwindling donor funding*
- *Lean government pocket*
- *Weak income generation capacity for the Councils*
- *Earmarked donor funding*
- *Uncertain donor funding*

### 5.6.1 Sources of funding

#### 5.6.1.1 Government funding

The analysis shows that the government funds the public district hospitals. This agrees with an observation by Yefriza (2015:148) that governments have prominent roles in providing resources for public health service delivery. This is the case it has been established that the basic role of public finance at the minimum is to deliver ‘‘public goods’’ which the markets may not be able to provide (Rao, 2018:113). Thus, the Government is the default and certain source of funding for the public district hospitals.

In confirmation the following are the common themes reported verbatim:

**DoF01** stated that:

> “*The major funding source of the district hospitals is the government”*

**DHSS01** agreed that the government is the main and certain funding source.

> *“The main fund that we have is ORT which is from the government so that’s the one that you are assured that it will come and you budget on that”.*

**ACC02** reiterated that:

> *"Funds for the hospitals are received from the government through treasury."*

It is noted from the analysis that it is the responsibility of the government to provide funding and it does provide to the public district hospitals. In terms of significance, government funding being the expected source of funding, is far much less than the funding from the other sources as participants provide estimates of the proportion of funding.

For instance, **DMO01** reported verbatim that:

> *"The government funds about 30% of the budget; implementing partners fund about 70%"*,

Whilst **NA01** estimated that:

> "*Donors cover around 60% of total health expenditure in Malawi, the Malawi government comes around 40%".*

This concurs with observations by Micah *et al.* (2019:1) that despite the government being the primary funding source, funding from governments for countries in sub-Saharan Africa is about a third. It could be said that government funding is the most reliable source of funding to district hospitals, in terms of certainty as managers are assured of receiving it; however, it covers only a small portion, as about a third of the total funding availed to the district hospitals are from the government.

#### 5.6.1.2 Donor funding

The analysis established that district hospitals are also funded by donors. Participants recognise the role that donors play in provision of finances to the district hospitals. Participants were in agreement that donors are a source funding to public district hospitals.

**DMO01** said:

> *"We have support from the non-governmental organisations which is sort of unpredictable and not very flexible"*.

**FA01** is in agreement and said:

> *"There is a consortium of development partners who put the resources together"*

**ACC02** explained that:

"*Some donors may wish to support us with their funds by picking certain activities that they can support the hospital. But other donors as I have said, they support us from DIP* (Development Implementation Plan) *activities. They take those activities from our development implementation plan that we have prepared for that specific year."*

**DoF01** further added that:

*"UNICEF sometimes funds the hospitals, this other one called KFW funds the hospitals at times, …. there are several funding organisations, it depends on the district."*

It has been noted further from the findings that donor funding constitutes a larger proportion of public health funding as explained by the study participants.

**DMO01** explained that:

*"...implementing partners fund about 70%",*

**NA01** said:

*"Donors cover around 60% of total health expenditure in Malawi".*

It emerges from the analysis that hospitals usually expect funding from donors in the public healthcare services delivery sector. This is confirmed by Borghi *et al.* (2018:60) where they point out that hospitals in Malawi depend on donors to a large extent. The donors complement government funding. Akortsu and Abor (2011:128) established that the public healthcare delivery sector in Ghana sector is as well funded by donors, but find them the least reliable. Nonetheless, donor funding is a significant component of health funding.

#### 5.6.1.3 Council funding

The analysis further revealed that Councils are another source of funding for the district hospitals. However, the analysis provides an insight into the shortfalls of Council funding to the public hospitals. As per the narrations of the participants, the district hospitals could as well be funded by Councils, only that their income generation capacity is low.

The participants have been quoted as saying:

**FA01** said:

*"The policy is, Councils are supposed to support, ok they can get the monies from locally generated revenue and pump in to support the health sector but the current situation on*

*the ground is that Councils' collections are very low to the extent that they fail to pay even their own direct staff."*

**DoF01** said:

*"Using the local revenue of the Assemblies. But it depends on the understanding of the District Commissioner. Because if the District Commissioner does not tolerate that, then health sector ends up borrowing. For health say we budget K200 million for health sometimes we can find that we can spend more than K200 the reason is we find ourselves in situations where we are sourcing money from the secretariat."*

**DHSS01** said:

*"If council comes to help it's usually through, maybe accounts like CDF and maybe DDF so this is the district development fund and constituency development fund of which some of them they are still looking at the money that comes from the central government so we will still revert back to the same pocket."*

**ACC02** said:

*"If the ORT money, the funds that are meant to support operations are not yet in they sometimes borrow us money maybe from the DDF account* (District Development Fund account) *so that the hospital should keep on running for example fuel, you talk of water, they have doing that I think for the past year.*

In summary, the analysis shows that public district hospitals are principally funded by the government and donors. The Councils which house the health sector are ideally supposed to finance operations of health facilities; however, the Councils at the moment do not generate adequate resources to extend to the health sector. The findings of the analysis in relation to funding sources compare with Akortsu and Abor (2011:128) who established that in Ghana, the major funding sources for the public health care delivery are the government; internally-generated and donor funds. Piatti-Funfkirchen and Schneider (2018:336) refer to fragmented funding sources as a stumbling block to service delivery. This is probably because each of the funding sources has its own constraints that the funded institution has to address. However, Hung and Hager (2019:5) advocate for a diversity of revenue sources, because this ensures the availability of funding plus flexibility in sourcing funding.

### 5.6.2 Constraints/challenges of funding sources

The analysis also revealed that the public district hospitals face challenges in regard to funding. These challenges cut across all the three sources of funding. The challenges pose a hindrance to access adequate resources, consequently, impacting service delivery.

#### 5.6.2.1 Declining donor funding

The study shows that donor funding has been declining over the years. This pose a great risk to operations as has been noted in this study that donor funding constitutes the greatest proportion of funding to the health sector.

Below are the extracts from some of the participants:

**FA01** said:

> "*Over the years, donors have also reduced their funding. Yes! significantly initially they were paying for the service level agreements, they were paying for food rations and then utilities. And initially they were paying only 100% of the current bills but over the years they have reduced from last year and this year they are only paying 45% of the current bill meaning they are weaning off themselves".*

**EA01** said:

> "*Again, maybe just an issue of donors lacking trust in our financial management or governance. All that relate to the decline in donor support. Donors have lacked trust on how central government has managed health expenditure. But recent times, 4 years down the line, donors support has been declining I think now we around 55%."*

#### 5.6.2.2 Inadequate government funding

Participants held a common view that funding to the public health service delivery sector is far below health facilities' needs. Inadequate funding cripple operations and disturbs, service delivery.

**DMO01** stated that:

> "*It's way below our needs. Way…way below the needs of the hospital".*

**ACC02** explained that:

> "*The government, to be frank does not meet the ideal situation of the hospitals, the services are being compromised because of the resources. But the gap is huge. Normally*

*an ideal situation in our economy is to keep the hospitals running, there is fuel, the ambulances should keep running, we are unable to pick patients from referral hospital maybe from here to Blantyre."*

**CSO01** added that:

> "*We realise that the district hospitals are not getting the required budgetary allocation that would help them to plan properly and achieve what they want to do and this is resulting in them accumulating huge debts. So this is a concern for us".*

**DHSS02** said:

> "*Now what that means now is that the funding that we get that comes from the national budget is the amount of money for you to barely survive so the figures are far from being enough to the point that they do very extremely routine things most of the time is when the year comes to an end and we have run out of funds for paying locum, for paying others maybe fuel and other stuff."*

**DoF01** said:

> *"Over the years, so far I have worked in Balaka, Mchinji and Mwanza in as far as my interactions with districts is concerned. In those years I felt like the funding was low compared to the number of people the district hospital is catering. They always fall behind schedules in as far as in payment of bills… utilities, drugs and all that. So we might say our full budget for the year is say 700million but the government has given 200 million or 300 million and when a partner comes then you add to that so you can have a complete budget."*

**ACC01** said:

> "*The ceiling is just too little. Because our budget goes to 500 million, but we are given a ceiling of 230 million, almost half."*

**DHSS02** said:

> "*In as much as we keep on complaining about efficiency, effectiveness as well is an issue in terms of the actual quantities of the monies that we get because the amount of money is not enough because we can barely do anything… We just do barely routine there are very basic issues that we do, we can't do other innovative things most of the times."*

The analysis further showed that despite that participants observed that there are increases in funding trends over the years in the public district hospitals, this is merely nominal increase and does not translate into any significance in monetary value.

For instance,

**DHSS01** said:

> "*I would say that the funding trends have been … well, it increases every year usually it does increase to a certain percentage but still more we feel like the increase is not meeting the required amounts so to speak".*

**ACC01** said:

> *"I think there is not much increase, because in 2013 the district was receiving around K13.5 million now we are receiving K19 million and with the increase in prices you can see that the increase of 6 million in 6 years is not significant".*

**DHSS02** said:

> "*Funding trends over the years has been a constant increase about 10% nominal increment but with inflation this is no increase in value."*

**ACC02** said:

> *"Not an ideal situation, just to keep the hospital running because from my experience I have seen there has always been an increase of about 5 to 8% in the ceiling every year. It doesn't go beyond 10. So, you look at the issues of inflation, so many things."*

**EA01** said:

> *"Up to 2015, 2014/2015 funding levels were low but beyond 2014/15 funding levels were rising. In terms of quality, for example, if we look at maybe per capita generally there has been a minimal rise. So, the rise has been very minimal."*

Inadequate funding is a hindrance to achievement of health goals. This is the case as Kumar (2005:1393) identifies sufficient funding as a critical element in the success of health service delivery.

#### 5.6.2.3 Earmarked donor funding

The results of the interviews also reveal that funding from donors lack flexibility for use as they are tagged for the specific use of the donors desired activities. This finding is in line with Akortsu and Abor (2011:128) as they also established that donor funding is provided with specifications which govern their use. This may result in under-delivery in areas not preferred by the donors' but probably crucial to the hospitals.

**ACC01** said:

> "*Their funding goes to specific projects like cholera, HIV/AIDS. But we cannot ask them to pay for electricity or to buy foodstuffs."*

**DHSS01** said:

> *"So, some districts have got the advantage that they do have partners who are…maybe I would say more free in a way. let's hope a partner comes next month and at times you rarely see a partner coming to renovate your administration block or renovate your ward very few partners do that but most of the partners want to see how you are doing with child mortality and would want to improve on that so if you have … their money would likely be focusing on that."*

**FA01** said:

> "*Norway came in and then they said okay we will be financing the health sector but we will be financing on specific items, so we want the Councils to open separate bank accounts".*

**DMO01** said:

> "*But usually, the activities that are supported, are to a large extent determined by the donor, so we can discuss with them how that can be done but actually the targets are determined by them. We have support from the non-governmental organisations which is sort of unpredictable and not very flexible".*

#### 5.6.2.4 Late government funding

The analysis revealed that government funding comes in late, thereby impacting service delivery. In another study, Borghi *et al.* (2018:59) confirms that government funding is usually received late by the district hospitals in Malawi. The experience is shared with other nations for instance,

government funding in Nigeria also delays to be remitted to the health facilities (Akortsu & Abor, 2011:128). Delayed funding cripples operations.

Below are participants' quotes confirming the same.

**FA01** said:

> *"There are also instances where councils are funded late. For January funding, they got the January funding in the very last week of January so those are some of the scenarios so as the time funding is delayed the hospital has to continue running they can't say we have halted the operation because of funding."*

**DMO01** said:

> "*The times at which the monies come through that's the one that delays. I will give an example, for our February funding is not yet in at the moment, and this is march."*

**ACC02** said:

> *"So ideally what I can say is there are always delays in the funding. I have to be frank there is a problem on timeliness because you look at when you are given the funds. For example, the funds for February, the figures were communicated to us on 25th of February and assuming they want us to run from 1st February to 28th February but even if you check with the banks as of …when we were going for the holiday, the money was not yet in."*

**EA01** said:

> *"Government doesn't fund on time."*

**IA01** said:

> *"…and then the timing of the funding the government takes maybe 30 days before funding. I will give you an example, I was saying it will take 30 days for funding for that month."*

**ACC02:**

> *"The challenge is that as a hospital, the hospital needs to run each and every time, we have a lot of activities, the timeliness of the funds leaves a lot to be desired. We receive funds mostly very late, and we have dire need of essential items."*

#### 5.6.2.5 Limited government coffers

Participants observed that government pockets are not unlimited. As such there is need to diversify income sources for the hospitals if the hospitals are to be effective and sustainable.

Participants were quoted saying:

**FA01** said:

> "O*ur resource envelope as a nation is lean so you may want, you may wish to have more but you don't have the actual resources on the ground, so you are limited to what is available."*

**ACC01** said:

> "*But maybe the first thing to consider would be how much in our resource baskets because we can keep on asking to increase the funding but maybe our resource basket is too thin."*

**DMO01** emphasised the need for government to make extra effort in improving funding for the district hospitals:

> "*I know increasing funding for health would mean getting funding from elsewhere so maybe affecting other sectors but having a healthy population is a priority because only healthy people can contribute to the development of the country."*

#### 5.6.2.6 Uncertain donor funding

The analysis shows that donor funding is uncertain. That is hospitals may not be in a position to ascertain its availability and extent in the year. As such planning becomes hazy. This is probably why hospitals would have a detailed plan regardless of resource availability just to ensure that if a donor comes; they are able to sell the hospitals' plans for the year.

In that regard,

**DMO01** said:

> *"We have support from the non-governmental organisations which is sort of unpredictable and not very flexible".*

**DHSS01** said:

> *"Usually most of the activities are not handled because a partner hasn't come and then we don't have enough funds from ORT. Because you wouldn't know whether you are*

*going to get a partner so you are not sure whether it will happen. then you just assume that its partner supported which is part of the DIP and then if a partner comes in the district say I would be looking at maternal child health then we have to align which activities are you bringing because they can't just bring something completely new, they have to follow what the district want to achieve that year so you mostly sell those activities."*

#### 5.6.2.7 Weak revenue generation capacity of Councils

Despite that the Councils are expected to extend funding to the health sectors, the data analysis reveals that the Councils fail to generate adequate revenue and, consequently, fail to fund the hospitals.

**DHSS01** was of the view that Councils' revenue generation capacity was low and said:

*"The Councils, honestly we have devolved, yes, but Council does not have the capacity to like help because at the moment. They have salary arrears just because maybe they are under-collecting so most of the districts say for example here you will find that there are not a lot of businesses going on, no companies so the collection is little."*

**FA01** further added that:

*"But the current situation on the ground is that Councils' collections are very low to the extent that they fail to pay even their own direct staff they are failing to pay their own staff so they cannot even extend because they have arrears others have salary arrears so extending a hand to health sector will be a problem."*

In summary, the analysis from the theme has shown that public district hospitals are funded by the government, donors and Councils to some extent. Furthermore, the analysis has also shown that district hospitals experience funding challenges which impact on service delivery as well as expenditure management. The challenges are late government funding; inadequate funding; declining donor funding; uncertain donor funding; earmarked donor funding; weak revenue generation capacity of Councils and limited government coffers. Theme 1 addresses specific research objective number 1: "To Determine the funding situation for the public healthcare sector in Malawi." As Akortsu and Abor (2011:128) opine, developing countries need their hospitals to be well funded so that healthcare is effectively delivered and, consequently, achieve their goals. Thus, this is a call and basis for provision of adequate finances for the health sector in Malawi.

### 5.6.3 Implications for quantitative data collection tool

The theme contributed to the quantitative data collection tool by establishing variables for funding sources and the challenges that the public healthcare services delivery sector face with funding.

## 5.7 Theme 2: Status of public expenditure management

Theme 2 provides an insight into the status of the expenditure management in the public healthcare service delivery sector in Malawi. Specifically, the theme discusses aspects of budgeting and budgetary control, the strengths of the public expenditure management environment as well as the challenges specific to expenditure management. The results of the analysis are as follows:

**1. Budgeting and budget management**

- *Government guidelines in budgeting*
- *Budget consultations*
- *Budget allocation restrictions and funds disbursements*
- *Budget implementation*
- *Budget reviews*
- *Determinants of funding allocations*

**2. Strengths of public expenditure management in the health service delivery sector**

- *Availability of an accounting system*
- *A move towards recruitment of qualified personnel*
- *Availability of procedures for budget virements*
- *Team work*
- *Spirit of consultations*
- *Standard guidelines*
- *The use of health committees*
- *Vibrant civil society*
- *Well-articulated procedures for financial management*

**3. Challenges of expenditure management in the public healthcare service delivery sector**

- *Inadequate funding*
- *Staff shortages*
- *Lack of capacity of staff*
- *Weak oversight functions*

- *Inflexibility of budgets*
- *Poor governance*
- *Bureaucracy*
- *Poor control of expenditures*
- *Poor allocation of resources*
- *Central control*
- *Un-mandated expenses*
- *Performance management weaknesses*
- *Mismatch between public audit requirements and services provided by the outsourced audit firms*
- *Overstretched external audit function*

#### 5.7.1 Budgeting and budget management

This sub-theme analyses data relating to the budget process and budget management aspects in the public health service delivery. As Ajibolade and Oboh (2017:218) allude, governments need to restructure their approach to budgeting and adopt approaches that are appropriate and specific to them. Anessi-Pessina *et al.* (2016:493) propound that budgets assist in administering responsibilities of managers and ensuring that accountability is discharged. Thus, the discharge of operations is likely to be affected by how financial planning is done.

##### 5.7.1.1 Government guidelines in budgeting

The budgeting process in the public healthcare service delivery sector in Malawi, is confined to laid down guidelines as directed by the government. Thus, government institutions inclusive of the district hospitals are compelled to abide by the set guides. In other words, there is uniformity in the budget process in all public district hospitals. This is as pointed out by the following participants during interviews:

**EA01** stated that:

> *"The Ministry of Health would provide guidelines. Ok, since we have the National Health Policy, that document guides the hospitals including the district hospitals what to prioritize in their health budgets. The Ministry of Health has to communicate through its policy and other circulars so that district facilities should actually put those in spotlight when they are doing their budgeting."*

**IA01** pointed out that:

> *"At the beginning of each year, they give a policy guideline for budget that year so that the Councils have to do their budgets according to policy."*

**DMO01** added that:

> *"We are given guidelines to say, for example, how much of that money will go towards, say utilities. There is a guide as how much funding goes towards internal trainings for example."*

**DHSS02** further illustrates that:

> *"Within the same amount you are told some cut-offs so say for example you want to do what you call internal travelling and require some allowances. DSA that shouldn't be more than 30% of your funding and if it's things to do with procurement about 70% has to go procurement so within the different line items you are also informed of the limits."*

Thus, budgeting in the public district hospitals is standardised through guidelines that stipulate funding allocations for the various expenditure items. The assumption here is that there are standard requirements of needs in the hospitals. However, as has been noted, what donors fund depends on their interests, which may result in duplication or under-charging expenditure items in the hospitals.

#### 5.7.1.2 Budget consultations

From the analysis it emerges that the budgetary process is a bottom-up approach. This entails that budget players at the lower end are involved in determining resource requirements. This approach has the benefit that the indicated resource requirements reflect the extent of the needs.

Participants had this to say in confirmation:

**EA01** said:

> *"Health facilities like the district health facilities to sit down together and brainstorm which specific activities should be included as the Ministry of Health has prioritised."*

**DMO01** elaborates that:

> *"Our health centres again have to compile their activities and see what needs to happen at the various centres. So, from there the various departmental heads we have the District*

*Medical Officer, the District Environmental Officer, we have the District Nursing Officer, so these are departmental heads responsible for the different sections of the health system."*

**DoF01** said:

*"At the district level we have consultative meetings. Yes, we consult people at the community there the village development committees, area development committees... These people are consulted especially by the elected members of the council... Yeah, they consult their people in their constituencies or their ward on what they need sometimes people need a health clinic in their location"*

**DHSS02** said:

*"Basically, when we are determining hospital budgets it really starts from the ground because we go to the health centres, I understand that may be we are talking of the districts as composed of health centres as well as health posts."*

The analysis reveals that the lower levels from the public and user departments are involved in consultations to determine budgetary requirements. This results contrasts findings by Frumence *et al.* (2013:20983) where they lament that in Tanzania the health sector budgeting planning lacked participation of the community. The conflict in this set up is that, despite that there is the bottom-up approach that is upheld for recognising the need to involve the lower levels, the directives from the central government defeats all that the consultations have achieved.

#### 5.7.1.3 Budget allocation restrictions

The analysis further shows that despite the extent of need for the hospitals, Government announces 'ceilings" in other words budgetary limits. This means that the determined requirements may not be covered if they are over the ceilings. Participants were quoted lamenting over the same as follows:

**CSO01** said:

*"But as much as we know that the Councils come up with good budget plans there are also huge cuts at the central government. For example, if the Council presents a budget of K100 million, the central government will cut it by either 60% or 40%. So that also is one of the issues."*

**IA01** added:

> *"Yeah, we start with the ceiling to the hospitals and then they do the budget based on the ceiling they have been given."*

**ACC02** said:

> *"We are restricted by the ceilings communicated to us by Treasury. Normally the ceiling is what restricts us that we should not do all those. But normally we trim the budget projected on the various activities because of the ceiling."*

**FA01** narrated that:

> *"The ceilings come from Treasury. Although Councils would budget using the ceilings that they have been given but practically when they start implementing the budget you will find that they are meeting a lot of challenges. Sectors at council level will be given their ceiling and each one of them they have to budget within available ceiling and in terms of prioritising the activities to be undertaken in a particular year they have also it will be up to them.*

**DoF01** said:

> *"The ceiling does not allow us to get all our needs. We do budget basing on the ceiling that the government gives to us."*

**ACC02** said:

> *"The budget, what we call the other recurrent budget on which normally we are restricted to the ceiling the Treasury is going to give us. So it depends on the resources the government has, so if the government does not have the resources on their projections so they give us the ceiling."*

**DMO01** said:

> *"Our ceilings from the government to say for the next financial year this is your ceiling you can only budget as far as these despite the needs that we have so that is the first step."*

The results of the analysis on budgetary ceilings reveal that the ceilings are announced as budget preparations commence. Furthermore, the ceilings represent the funding levels of each of the district hospitals. However, the ceilings are pronounced without any link to hospital needs. Thus, the ceilings are not reflective of the hospital needs. That is to say, despite the observations from

the analysis that hospitals are funded according to their ceilings, the ceilings are restrictive in that they do not represent the need on the ground.

In summary, the district hospitals budget to the extent of a predetermined budgetary allocation which usually do not reflect the hospitals' needs. It may follow that government could be lobbied to increase budgetary ceilings to health services delivery. On the understanding that there is still room for enhanced public financial management, resources could be freed from other sectors and channelled to health service delivery.

#### 5.7.1.4 Budget implementation

The study analysis reveals that hospitals receive funding according to the approved amounts which is a positive thing. Despite that, this is based on the constrained budgetary allocation and at times the hospitals are affected by previous commitment on the resources. The participants had this to say:

**FA01** said:

> *"What the Councils have been given as ceiling they have been funded 100% for health sector okay excluding these two which they have do not control over but for operational budget what they have been given as a ceiling at the end of the day at least treasury has made sure that councils are given 100%."*

**ACC01** said:

> *"Funding allocation it's based on priorities and needs of that department for that particular month. Because sometimes like say ESCOM people would like to cut off their electricity because of their unpaid bills let's say they want to take 6 million from 19 million it means we are all affected so as a team we sit down and discuss the needs of the department the priorities of that department for that particular month."*

**DHSS02** said:

> *"So really for the time I have been here in (location withheld) we haven't seen much changes most of the funding have been according to the cash flow. I know in 2015/16 where funding was not coming as expected but 2017/18 …2019/2020 I think in the health sector funding has been consistent with the cash flows."*

**DMO01** said:

> *"Yes, the monthly funding we have been getting according to cash flow."*

However, one participant had contrasting position in relation to funding where he says that disbursement of funds in hospitals is not reflective of the submitted cash flow requirements. He had this to say:

**DHSS01** said:

> *"What if our funding shall be 50 million and the other months say 4 million or 10 million 10 million but usually for the past 1 or 2 years I have been in the office, I haven't seen that happening they just divide by 12 and give you a constant number although in our budgets they are those variations because the activities that you want to implement cannot be the same what you implement in March or February".*

#### 5.7.1.5 Approval process

The budget approval process is seen to be a rubber-stamping exercise at the top levels so long as the budgets are within the set ceilings. This practice is not ideal as the approved figures are not realistic and do not represent reality on the ground.

**FA01** pointed out that**:**

> *"Once Councils have done their budgets, these budgets are approved at Council level, but they are sent to Parliament just for noting."*

**IA01** stated that:

> *"So, the hospital sector comes up with the budget and submits to the Council secretariat who in turn submit it to the Audit subcommittee of the Council and the budget is approved by the committee of Councillors of the district Council. And when that is done, the budget is brought to the NLGFC for consolidation and then it is sent to the government for another approval or rubber stamping."*

#### 5.7.1.6 Determination of funding allocation

The analysis reveals that those with a role in expenditure management in the district hospitals are not clear as to how funds are allocated amongst the district hospitals. Furthermore, there are observations from the participants that whatever method is used to share the funds at the national local government level is lacking in certain aspects and needs to be improved.

**DHSS02** observed that the allocation reflects a mere increase over the previous year's figure:

> *"So that ceiling most of the times is determined by either the previous year funding, so they increase it by maybe 10… 5% and when you are given that ceiling you are told to budget within that amount of money that you have been given."*

Further he questions the reality of the formula applied.

> *"I think the other way would be to see how they do the allocations for the funds to say do they really reflect the population that we have? Does that really put into consideration the distance in referral facilities, for example, the district has the furthest health centre a distance of about 200kms and another one the furthest health centre maybe 50km… others maybe have 200kms to the central hospital … that also affect how much they get and with other environmental issues for example geographical issues for example the district has got a lot of catchment areas, would that determine how much they are funded? If it has quite a lot of facilities accessible or there is no facility would that affect how much money they would get in a financial year. I would really like to see if those are factored in. even to say if the district does have a district hospital and one that doesn't have a district hospital does that affect how much money they get for funding those are some of the issues that I would to see them quite clearly.*

**EA01** was of the view that population is a major determining factor of funding allocations as he said**:**

> *"The key driver has been in terms of rise in population. Key driver now is the headcount. So, you look at population size that again will determine the kind of services, volume and quality would that particular area require. So basically, you look at the population in that particular area it determines how much to allocate and again even age. But again, even age also plays a key role."*

**FA01** said:

> *"So, we use this formula, Intergovernmental Fiscal Formulae. This formula among other issues it looks at the population of the area. There are a number of areas that they look at; they look at population, they look at geographical area, they look at whether the district has got a district hospital, well established district hospital, they look at issues like prevalence of diseases, they look at bed space, all these factors are given weighting."*

There is recognition of the need for governments to devise a combined method in allocating financial resources, which includes both demographic and non-demographic considerations in the health sector, (Servan-Mori *et al.*, 2016:1). This would ensure that the diversity that the various district hospitals have, is addressed and that equitability in resource distribution is attained.

#### 5.7.1.7 Budget amendments/reviews

Budgets are supposed to guide expenditure in a given period. Budget reviews are done to afford users flexibility where the assumptions at the budget preparation do not hold true. The analysis, however, reveals that budget users are accorded one opportunity to make amends to the budget and these only involves moving financial resources from one budget line to the other and not necessary accommodate increased demands for financial resources. In agreement with Piatti-Funfkirchen and Schneider (2018:336), budget management in the public sector is faulted for being inflexible in provision of additional resources, some participants felt there was need to increase the frequency of virement and budget allocations in order to attain the financial flexibility that the health sector requires. This may be more appropriate in the healthcare delivery sector, because often there are needs that cannot be estimated with certainty, as is the case with Covid-19 pandemic.

**FA01** explained that**:**

> *"At implementation now the Councils, they are allowed to do virements. At midyear they are allowed to do virements but basically these virements, they probably have made a provision higher say for utilities but then probably they have seen that they need to reallocate. So most basically is just reallocating within the ceiling."*

**DoF01** added that**:**

> *"We do the review of the budget. We do virements whereby areas where we budgeted more or we underestimated some budget lines we are given room to take money from other areas where we feel we may not utilise."*

**DHSS02** said:

> *"There is a bit of flexibility because as we are operating by the 6 months of the financial year that is December or there about you see that one area you have overspent or you think you need to reallocate some funds you have what we call virements and with these virements you are at liberty to be done at any percentage provided you are not changing the bottom line figure so you are allowed to move money from for example water to*

*electricity or water to fuel provided you are able to justify that and that the area you are taking money from is not going to suffer within the next six months."*

**DMO01** stated:

*"But what it means with virements is that already within the budget we request the government to say, in our approved budget was this amount of money should be used for the purchasing of fuel for ambulances but we have seen that according to our consumption, we may not be able to use all that money so can we move some of that money so that we can use that to maintain hospital buildings so that is the sort of thing we can do we can request for what are called virements".*

**EA01** said:

*"From experience no amendments. Normally when the budget has passed in parliament around June… July, there's minimal room to increase the allocation."*

**ACC01** said:

*"Not necessarily amendments but budget virements. Like electricity you budgeted for 25 million but midyear you have spent 10 million, you can remove something from electricity and put it in another vote."*

**ACC02** said:

*"An ideal situation would be to review the budget every quarter. To review how much activities have you reviewed over the quarter and get a guide as to how you are going to proceed in the next quarter."*

#### 5.7.1.8 Disbursement of funds

In terms of disbursing funds to the hospitals, participants marvelled that the health sector gets its monthly funding allocation usually according to cash flow projection. This contrasts with the experience with other sectors like education. In confirmation, participants said:

**IA01** said:

*"The funding comes in accordance to the cash flow that we submitted so maybe if there was poor planning in the cash flows projections, there would be problems."*

**EA01** said:

> *"The government makes sure that whatever has been allocated they try to fund between 95% to 100%. They make sure that they fund them what they budgeted for. I think from my experience close to 100% funding. The government gives them whatever they budgeted for."*

**ACC02** said:

> *"I think normally over 6 years normally the government funds the health sector according to the cash flow. If you need more resources normally especially at the beginning of the year so many issues happening out of districts and other things. So normally the government is giving us funds according to our cash flow which is not the case with other sectors. They might trim but normally for the health sector they normally meet as per cash flow."*

**DMO01:**

> *"Yes, the monthly funding we have been getting according to cash flow".*

**DHSS02:**

> *"I think in the health sector funding has been consistent with the cash flows."*

In summary, the analysis shows that the budgetary process is consultative, and that budgets are subject to set limits by the government, funds are disbursed to hospitals in accordance to submitted cash flows. Anessi-Pessina *et al.* (2016:493) established that the budget is a tool used in "bargaining and allocating power and resources, for planning and controlling, and for ensuring transparency and stakeholder involvement". In this analysis, this function for bargaining and allocation for resources and stakeholder involvement could hold true for donor funding. This is the case as the government would allocate healthcare services delivery funds depending on the amount of funds it has and not necessarily what is required; whilst for donors it is basically what activities are being sought to be done and the donors interest.

### 5.7.2 Strengths

The analysis also revealed the strengths that the public expenditure management environment specifically in the public healthcare sector has. These are the enablers of public expenditure management.

#### 5.7.2.1 Application of an integrated accounting system

**FA01** said:

*"Councils have got a system, the IFMIS system the budget is loaded into this system and then within the system there is a budget rule, basically the budget rule enhances the budget to make sure that councils do not overspend on budget provision so if at the beginning of the year the council has said we will spend 3 million on utilities, then if they want to spend 3.5 million on utilities, the system will not allow them because of this budget rule within the system.*

**DHSS02** added that:

*"IFMIS now that would be a control measure as no one would get into the system as no one would just post without being approved."*

**EA01** explained that:

*"Use of computer-based accounting system, the IFMIS, it's a strength, they are able to monitor transactions as they occur."*

However, it is noted from the analysis that hospitals do not effectively use ICT and the accounting system for enhanced reporting as was captured from a participant.

**EA01** said

*"The other is better use of ICT, IFMIS, as we are saying can help produce these reports more quickly so that the Councillors and internal auditors can scrutinize them so that they can help improve their performance".*

Having looked at the IFMIS as a strength in public expenditure management, participants bemoan the lack of ICT resources to fully use it due to lack of resources. For instance,

**DMO01** said:

*"We don't have resources in terms of technological hardware so, for example, our transactions have to be transacted in what we call IFMIS but we don't have enough computers."*

#### 5.7.2.3 Recruitment of more qualified personnel

**DoF01** mentioned of a move towards recruiting qualified personnel**:**

*"Right now, the government is employing is recruiting qualified people and they have been promoting some people to create room for other people. Like I remember when I was joining the government, I found the reports were behind as in up to 2006 yet we were in 2010 but today I can tell you we are within I mean within the reporting period."*

**DoF01,** however, noted that other structures within the system lack competencies which tend to compromise on goal achievement.

*"The politicians, the councillors the people who do politics for Council I wish there was minimum education for these people, good enough for them to understand strategies and good enough for them to head an organisation because most of the problems that we Councils … and even district hospitals have. Mind you, there is a certain team that manages and oversees hospitals and this is the Health Committee which is headed by big politicians most of the politicians some of them have only MSCE and they are not able to understand the plans for the hospital. If these people who are spearheading the health sectors have got qualifications, I'm telling you it can be better. It can just cement what the government is doing."*

#### 5.7.2.4 Some budget flexibility

The data analysis reveals that there is recognition that the financial management regulations provide for some flexibility in terms of budget management versus reallocation of finances.

**DHSS02** appreciated the availability of procedures for virements as he said:

*"The flexibility for management to do virements, I think that's a good thing. We just did one a month ago."*

**DHSS02** also applauded the practice of consulting in allocating funds for the various activities in the hospital once the resources are in.

*"I think the other thing is about, where you sit down and you are able to look at the budget and allocate funds for that particular month, that is also a good thing".*

#### 5.7.2.5 Coordination and teamwork

The study results show that management at the hospital and Council level portray coordination and team work.

**ACC02** explains of the coordination and teamwork in the management.

> *"…our strength, there is a good coordination and whatever is being transacted within the month is what is contained in the minutes which is discussed during the meeting."*

#### 5.7.2.6 Availability of budget guidelines

**EA01** talked of the standard guidelines provided to all the district hospitals:

> *"Since we have the Health Policy, National Health Policy that document guides the hospitals including the district hospitals what to prioritise in their health budget. The Ministry of Health has to communicate through its policy and other circulars so that district facilities should actually put those in spotlight when they are doing their budgeting."*

#### 5.7.2.7 Use of health committees

**EA01** mentioned of the use of health committees:

> *"The other strength is the use of the health committee of councillors can help improve expenditure oversight.*

#### 5.7.2.8 Vibrant Civil Society

**EA01** noted the vibrancy of the civil society:

> *"And now we have the civil society organisations. They are also interested not in just getting the reports but some also do social audits they also find out from the communities, 'are you happy with the services and so on?' and the communities are able to tell whether they are happy with the services or not. And the civil society improve on public expenditure management."*

This sentiment agrees with the position of Basheka and Phago (2014:154) that the citizenry and civil society organisations have a role in achieving public accountability.

#### 5.7.2.9 Availability of financial management procedures

**IA01** mentions of the availability of financial management procedures as a strength:

> *"I think there are well articulated procedures for financial management in the Council."*

From the analysis there have emerged the following strengths in the public health services delivery sector in Malawi: the presence of an integrated accounting system; a move towards a qualified workforce; establishment of procedures aimed at providing flexibility in the expenditure

management; institution of control structures i.e., the Health Committees; provision of standard guidelines on funds allocation in the hospitals; and leadership that upholds teamwork.

### 5.7.3 Challenges in public expenditure management

The analysis has revealed that the public healthcare service delivery sector in Malawi faces a diverse range of challenges which impact on public expenditure management.

#### 5.7.3.1 Inadequate funding:

**FA01** said:

> *"The biggest challenge has been related to expenditure and probably it emanates from inadequate funding. The DHMT has to balance because sometimes nurses and clinicians if they are not being paid their locum, they withdraw their services. You heard such stories in the media, so they withdraw their services then you are crippling the health system".*

**DoF01** said:

> *"They always fall behind schedules in as far as in payment of bills… utilities, drugs and all that".*

**FA01** explained:

> "*Councils continue to have a lot of arrears. So how are the arrears coming in? The arrears actually are a sign, having arrears is a sign that the budget that Councils are operating on is not adequate to finance their recurrent expenditure, so you have got sometimes you would find that, probably the Councils are forced probably to get more supplies, maybe for food and rations to say we will be paying you as monies come but as funding come you find that they are deferring and are accumulating arrears."*

**DHSS02** added that:

> *"The first challenge I would say in as much as we keep on complaining about efficiency, effectiveness as well is an issue in terms of the actual quantities of the monies that we get because the amount of money is not enough because we can barely do any… We just do barely routine there are very basic issues that we do, we can't do other innovative things most of the times."*

**ACC02** said:

*"But another challenge as I have said is the government, to be frank does not meet the ideal situation of the hospitals the services are being compromised because of the resources."*

**CSO01** said:

*"We realise that the district hospitals are not getting the required budgetary allocation that would help them to plan properly and achieve what they want to do, and this is resulting in them accumulating huge debts."*

#### 5.7.3.2 Shortages of technical and support staff

**FA01** said:

*"There are inadequate personnel in the districts. Now because they are inadequate, they have to cover other people, they work in shift or locum basis, like extra hours and they are paid they are supposed to be paid and they are paid from the budget from the Council."*

**DMO01** said:

*The money that is used to pay locum comes from ORT and I said amongst the guidelines that comes from government guides how much should go to locum. Now for example in (location withheld) our overall vacancy rate is at about 56%. Now what it means for clinicians and nurses is we have to engage staff that we already have on the ground and pay them locum and that is a lot of money."*

**ACC02** said:

*"Even we also…, because of the shortage of hospital attendants, we still lobby some casual workers they. They bring them in the hospital, maybe in the maternity or in the male ward or the children's ward. So an ideal situation would be… what I would love to is for the government to have a cross cutting review of all the vacancies in the hospitals and see how best they can do on those vacancies and they could come in with the additional resources. The ideal budget we did when we were starting the financial year, could not be met because of the ceiling because we use a lot of staff in nursing, a lot of staff in clinical."*

**DMO01** said:

> *"In our case we have a challenge in human resource, we don't have adequate accounts personnel."*

**5.7.3.3 Lack of capacity of support staff**

**DoF01** said**:**

> *"Most of the junior staff in the Councils especially in finance of course in the other departments it's the same thing. Most of them they don't have enough school for the work they are doing, in a way it affects management of transactions. I will give you an example, say I have got an accounts clerk and the accounts clerk they only have JC or they have got MSCE and they are able to do their work just because they have been on it for some time. But you know the way I value my documents is not the same way this person will value the documents. That is why you normally hear of losing documents in Councils or maybe failure to file documents properly because this person does not know the value of keeping the documents after payments he feels he is done but when a document …. Historic records are valuable."*

**IA01** said:

> *"I will take the finance section if you look at the establishment that the hospitals must have say a principal accountant, accountant, 2 maybe assistant accountants. But mostly the hospitals have a senior person like or senior assistant accountant. So that would be a major challenge in staffing levels."*

**5.7.3.4 Weak oversight functions (audit committees)**

**DoF01** said:

> *"The politicians, the Councillors the people who do politics for council I wish there was minimum education for these people, good enough for them to understand strategies and good enough for them to head an organisation. Mind you, there is a certain team that manages and oversees hospitals and this is the health committee which is headed by big politicians. Most of the politicians some of them have only MSCE and they are not able to understand the plans for the hospital. If these people who are spearheading hospitals like health sectors have got qualifications is I'm telling you it can be better. It can just cement what the government is doing to the… they are trying as much as possible to employ*

*qualified people, but these elected members don't have the qualification they would frustrate whatever the government is doing on the technical side."*

**EA01** said:

*"The challenge with these internal audit functions is that they lack organisation. As I said these internal auditors are supposed to be reporting to district Councillors but if you are reporting to somebody who doesn't follow, they really don't appreciate the importance of internal audits. Our Councillors, they may not have the education and experience to scrutinize health expenditure, so generally poor governance. At a higher level, Ministry of Health also has its own audit functions but in most cases these auditors at ministry level they are also preoccupied so they are not audited that regularly."*

With such weak capacity, the role of Councillors as stewards of financial resources is compromised. This is as observed by Basheka and Phago (2014:154), that elected persons have not done justice in their role as stewards of public resources. Thus, as long as the capacities of Councillors does not change, not much value is added by the audit committees on efforts to enhance expenditure management in the public sector.

#### 5.7.3.5 Overstretched national external audit function

**EA01** said:

*"National audit alone cannot do it. Sadly, the National Audit Office for the past 5 year has been outsourcing these services to private auditors. But capacity is not just numbers, even competence. So, it appears these private firms do not have the required expertise to audit public expenditure. And what public entities need is value for money audits and not financial audits. And these is whereas oversight institutions we are getting it wrong. So if we want to strengthen the oversight or control of these public health expenditure I think National Audit need to take a bigger role or a central role, other than 100% outsourcing."*

#### 5.7.3.6 Inadequate staffing in the internal audit functions

The study results indicate that the internal audit function is both inadequate and lack competence.

**DHSS01** said:

*"Internal audits, we don't have them even where I was working previously is not vibrant so even here we don't have an internal auditor but sometimes when they are issues, we do call for one to do the internal auditing."*

**ACC01** said:

*"Currently we don't have an internal auditor but sometimes we receive internal auditors from Lilongwe they were here I think two weeks ago."*

**IA01** said:

*"For the Councils who have internal auditors, the auditors are supposed to have quarterly audits and produce reports. Currently we have 28 district councils and that means we have 27 and soon we will 28 district hospitals including Phalombe, so out of the 28, its only 12 councils which have internal auditors, the rest do not have."*

#### 5.7.3.7 Inflexibility of budgets

**DHSS01** said:

*"When unforeseen issues have come in place and you can just move the budget without Virement, though that comes as an issue. Though it is a control measure but sometimes it becomes difficult, you can't respond to emergencies as you could if the budget was free."*

#### 5.7.3.8 Performance management weaknesses

**DHSS02** said performance management does not yield to anything:

*"Evaluation of your performance doesn't really affect the funding that you will get in the subsequent years. For example, we realise that we are struggling to do some key issues, some basic issues and you have that report would that really determine whether they would get more funding so that also is another challenge that we have on the budget."*

#### 5.7.3.9 Poor governance

**EA01** explained that:

*"And that is where our health facilities need to improve on, in terms of efficient management of these health funds. I clearly remember the drug budget, government reached a point where… that was around 2015, the government directed that the drugs budget would not be handled by the health facilities but literally by the ministry of health and local government finance committee, just because they were not buying drugs. And the other observation I have made is that you know hospital is about capital expenditure they have to buy drugs, they have to buy medical equipment, but generally 10% or below of government funding is allocated for the procurement of those things that's why the*

*government decided to withdraw to say you just concentrate on providing services, but regarding procurement of drugs and medical equipment, we will be providing. So generally, there is poor governance. There is no respect for management of these health funds.*

#### 5.7.3.10 Bureaucracy

**ACC01** said:

*"Some challenges that we encounter are control systems so we can't want to change the control systems. But I would love if management would have a proper system in our day today challenges that we encounter whenever they are out of office because we are tools down whenever they are away so they may need to put someone."*

**EA01** explained that:

*"I think the key challenge for them is bureaucracy. So where you have bureaucracy, oversight becomes a problem. If the other challenge is bureaucracy, if there are 2 levels for a transaction to be approved, people resorted to bypass, to override the controls. So the thing is you have 4 or 5 levels in order to have a transaction approved chances are people device shortcuts. The other challenge with bureaucracy that again increases the cost of administering because all those levels … As I am saying if you have too many controls that will increase the cost of administration, so that's the challenge. So you have like so many administrators getting allowances, getting whatever, but at the end of the days you have system bypassed, that's what I was trying to say."*

#### 5.7.3.11 Poor control of expenditures

**EA01** said:

*"Number one is the control of expenditures which I have said, poor governance. Instead of delivering quality services."*

#### 5.7.3.12 Poor allocation of resources

**EA01** said:

*"And the other challenge is resource allocation, much as budgets and procurement plans are there to guide on how to spend, but then most of those don't go as prioritised. The other last challenge is what I was just saying the issue of productive efficiency, how*

*efficient are we in allocating these government resources or how we are using the assets of the healthy facility."*

#### 5.7.3.13 Central control

**FA01** said:

> *"On the other hand, as one of the directives from Central Government particularly, Treasury to say the controlling officers or any public officer is not supposed to overcommit the government meaning they are not supposed to get things on credit. They are supposed to operate on cash basis so you have got such kind of scenarios where Councils have lean budget but they are to continue operating, particularly health sector is very delicate."*

#### 5.7.3.14 Un-mandated expenses

**DoF01** explained that:

> *"You know we plan to say this is how we are going to plan our year the Central Government has its plans as well. You find with their plans they get into ours and disturb our plans. We decide to have a certain activity but the Central Government says you should all come to Lilongwe for a certain meeting, but you should fund yourself that was not in our plan we end up doing a thing that was not in our budget."*

**DHSS01** added that:

> *"The ceilings we have given them now we get that and you find that that year you did not know that you will have an activities ABC along the lines you have done your budget they have approved it and they have given you say 100 million and under activity say travelling, internal travelling, they have approved K4 million and within one week you get a directive, for example, from the Central Government that we have invited 10 clinicians to attend a meeting in Lilongwe funded by Council. Now the letter has come …but if you look in your budget the time you were developing this there was nothing like you will need … for travelling.*

**CSO01** said:

> *"One of the challenges could be as I said government's reluctance to fully devolve the functions from Central Government. And again, the inefficiencies that are there."*

**FA01** said:

> *"Technically on the ground, I think they have not, because the budgets are still controlled by the Centre ok, the payments are done at the Centre."*

In summary, the public healthcare delivery sector faces the following challenges which impact on public expenditure management. These are central control, partial devolvement, un-mandated expenses, poor control, poor allocation of resources, inadequate funding, staff shortages, lack of capacity for technical staff, weak oversight functions, inflexibility of budgets, performance management weaknesses, poor governance and bureaucracy. The theme assisted in addressing the following research objectives: Explore ways of enhancing efficiency in utilisation of financial resources in the public healthcare sector in Malawi and (ii) Establish the extent to which budgetary systems are utilised in the effective management of expenditure.

### 5.7.4 Implications for quantitative phase

The theme assisted in, among other findings, identifying the constraints that the public expenditure management environment faces. The determination of those changes assisted in designing solutions for the betterment of expenditure management. Such solutions informed the enhanced framework for public expenditure management which is the focus of this study. The questionnaire, therefore, extracted the challenges that have been revealed by this study.

## 5.8 Theme 3: Vital functions in public expenditure management

This theme discusses factors that have significance in optimization of public expenditure management. These functions have a key role in providing a conducive environment for improved utilisation of public resources and, hence, enhance public expenditure management.

### 5.8.1 Legislation and public expenditure management

Legislation has a role in the achievement of effective and efficient public expenditure management. The analysis shows that legislation that guides public finance management and supporting legislations are lacking in ensuring enforcement of public officers to comply with provisions as well as stipulating appropriate measures for offenders.

**CSO01** explained on the weakness of the legislation:

#### 5.8.1.1 Lack of enforcement on compliance

> *"I think that is very clear, like we have the Public Finance Management Act which clearly stipulates what is expected of the Controlling Officers in terms of reporting and accounting for the resources. But what we have seen is the lack of compliance.*

#### 5.8.1.2 Lack of deterrent penalties on offenders

> *"And our concern has been that perhaps the Act 2003 is weak. It doesn't spell out stiffer penalties for violation. For example, what we have seen is a Controlling Officer, or finance officer or any other officer for a district hospital who abuses public funds, what we see is that if they were at Dedza district hospital they are transferred to Dowa district hospital or they are transferred to any other district hospital so it's like we are just transferring a problem from one facility to another."*

#### 5.8.1.3 Oversight functions lack powers (National Audit Office)

**CSO01:**

> *"And what we are proposing is that like this, if the Auditor General were given some teeth, so that they are able to bite. Unfortunately, they cannot. And then they get the same recommendations year in year out."*

In summary, the analysis reveals that participants were of the view that the laws that govern matters of finances do not provide deterrent penalties for offences committed; do not enforce compliance and that oversight functions do not have powers. Tsheletsane and Fourie (2014:43) had similar concerns as they explain that South Africa face numerous cases of poor accountability and financial management as a result of poor implementation and enforcement of the legislation, despite the presence of laws that oversee management of public finances.

### 5.8.2 Procurement and supply chain management

It emerges from the analysis that procurement activities in the district hospitals are challenged. The limitations faced range from noncompliance to procedures, price increases, inadequate funding, lack of adequate monitoring for procurement activities as well as constrained capacity in terms of procurement professionals.

#### 5.8.2.1 Monitoring and capacity challenges

**CSO01** states of monitoring and capacity challenges for public procurement:

> *"Let me start with the Office of Procurement and Disposal of Assets, I think for me what I see is that they are overstretched. Because if you look at them, they don't have a representation at the Council level. So what it means is that districts have to work with the central part of the ODPP. So, if they had a representation at least with the district level then they would monitor how procurements are done at the district level because this is*

*where the government is investing billions, a lot of money and unfortunately these are no proper mechanisms of accountability".*

#### 5.8.2.2 Public procurement compliance issues

**DoF01** added that the district hospitals usually do not comply to procurement procedures i.e. procurement plans**:**

> *"Whenever we are doing a budget, we produce work plans and we produce procurement plans. So, when we are spending, we spend according to the procurement plan. But this thing is not followed that much. Because like I said we follow cash-based transactions."*

**ACC01** on being asked about compliance to procurement procedures, responded that**:**

> *"It's a tough question! 50%! We always want to move by the plan, but we meet a lot of challenges. So many emergencies to do with maintenances. Maintenance of motor vehicles, maintenance of buildings."*

#### 5.8.2.3 Funding issues

**DMO01** explained that despite having a plan; funding limitations coupled with unforeseen needs disturb compliance to procurement plans**:**

> *"When we are doing the budget, we so also produce a procurement plan for that financial year, but one thing is obvious a lot of times, needs come in that might have not been planned for".*

**ACC02** revealed that the district hospital does not always comply to standard procedures due to restricting resources situation that they are always faced with.

> *"It all depends normally on resources because all the procurements are not done as per procurement plan because of the resources. We normally procure those items that are actually needed so that, the critical ones, so that we should keep our institution running. For example, the other time we had planned that we should buy a new gen-set, but it couldn't materialise, the issue of planting a new mortuary that couldn't materialise because thought we put them in the DIP, we could not implement them looking at the status of our funds.*

**EA01** noted that the procurement plans are alongside budgets, though complying to the procurement plans is a challenge.

*"So, you have to budget, you have procurement plans, but now when it comes to implementation they get funds monthly and for them to allocate funds, that has been a challenge."*

**EA01** echoed that procurement plans are not followed:

*"And the other challenge is resource allocation, much as budgets and procurement plans are there to guide on how to spend, but then most of those don't go as prioritised."*

**CSO01** stated that there is no transparency in procurements:

*"Procurement processes are not transparently done as we would want to see."*

#### 5.8.2.4 Price increases

**IA01:**

*"One of the common challenges in procurement is the unforeseen changes in prices of items."*

In summary, theme 3 presented constraints/weakness relating to the legislative and procurement and supply chain management. Procurement and supply chain management weaknesses emerging are increasing prices, noncompliance to funding issues, procurement procedures and planning and lack of monitoring. In Botswana, a study by Botlhale (2017:293) established public procurement challenges which included low adherence to procurement plans, poor supervision and enforcements and weak capacity. For public expenditure management to be effective these supportive functions have to be flawless. Relatedly, Ibrahim *et al.* (2017:371) explain that despite that procurement is regulated in many developing countries, there are arguments about the ineffectiveness of its legislation due to challenges inherent in implementation processes. This entails that there are prevalent weaknesses in the legislations.

### 5.8.3 Implications for the quantitative phase

There are questions included in the questionnaire derived from the findings on the state of the legislative and procurement and supply chain management functions. From the deduced weaknesses or constraints of the public procurement and supply chain management function and legislation, important considerations for the framework include: what aspects should be improved or added to make public expenditure management efficient and effective?

## 5.9 Theme 4: Management and personnel issues

### 5.9.1 Management Attributes

The analysis has also shown that there is need for management to reform on how they manage hospital resources to improve on achievement of goals. Obiwuru *et al.* (2011:100) explain that the level to which employees participate in resource management depends on the managers and leaders that they have. In agreement and specifically to health sector, Anselmi *et al.* (2018:27) opine that health administrators have a crucial role in achieving effective and efficient resource management. Thus, managers and institutional leaders, as resource managers, are key in the management of finances. Furthermore, those entrusted to manage resources need to possess pre-requisite knowledge, skills and attributes if they have to discharge their responsibilities as desired (Roach, 2016:29). Hence, it can be established that for effective public expenditure management the management and their support staff should be of the right calibre.

#### 5.9.1.1 Managers should be managing finances

The study's findings reveal that managers and leaders in the healthcare sector need to be concerned with resource management. This observation is in agreement with Kumar (2005:1395) who holds that having managers with improved managerial efficiency and accountability is critical to the success of the health system.

**EA01** explained that:

> *"I don't see that, but amongst the health professionals, this is what they are supposed to appreciate if they want to improve quality of health services, if they have to improve on how they are running these facilities they have to manage financial resources. Just walk around our health centres, the premises are not tidied up, they have no drugs that will give you a picture of how the money health expenditure is handled in Malawi."*

**EA01** also notes that managers should be effective in financial management:

> *"So, these medical professionals should be actually like a burden to say we need to provide quality healthcare and the only way to provide quality healthcare is to improve on how we are managing these finances including the assets themselves."*

#### 5.9.1.2 Managers should be pursuers of organisational goals

**EA01** further explained that managers and leaders should be geared towards achieving organisational goals.

*“What we are saying is, if you want to improve health expenditure, health professionals should also appreciate that it’s not just a matter of prescribing drugs, you have to supply the drugs. We have to prescribe the drug, provide the drug, give them the advisory service the community require.*

#### 5.9.1.3 Managers should be consultative, team workers and continuously monitor operations

**DHSS01** stated that:

*“Some DCs would require a report on how they have spent their money so then we do and we start with quarterly meeting which is a sectoral meeting so this includes the management the DHMT; and after that you look at your data you look at the finances why are you having debt? Why have you spent so much on fuel? Why you have spent much on utilities? So we dissect that and we say, ok, see if we can do better if we can this let’s do ABCD so after this management meeting we go for a sectoral meeting so that whatever is discussed should be a reflection of what management has agreed and not what the DHO wakes up and says I think we spent so much because of ABCD.”*

#### 5.9.1.4 Managers should have supportive attitude towards management controls

**DHSS01** also said:

*“I would say actually for me, I think working with one or 2 DCs it depends on the management at Council level for example like here we have a new DC who advocates orderly meetings and at every meeting every sector has to give a report on how they have spent their money”*

Thus, the analysis has established that managers have a role in effective management of financial resources. The study shows that managers need to support the available management controls, monitor operations, consult and work in teams, be financial managers as well as be focused in order to achieve organisational goals.

### 5.9.2 Personnel attributes

#### 5.10.2.1 Staff should have integrity

**CSO01** was of the view that staff should be well qualified to maintain integrity:

> *"Because again one problem that we see is because of limited resources at the Council, they are forced to recruit low quality staff as maybe procurement officers who can easily be manipulated."*

#### 5.9.2.2 Adequate staffing levels

**IA01** indicated that:

> *"The staffing levels would improve the situation in the hospital as well as the technical."*

#### 5.9.2.3 Staff should be well qualified for their job

**DoF01** said:

> *"Most of the junior staff in the Councils, especially in finance, of course in the other departments it's the same thing. Most of them don't have enough school for the work they are doing in a way it affects management of transactions it even affects."*

**DoF01** confirmed that:

> *"And with recruitment of this qualified people there is going to be a great improvement."*

In summary, this theme has shown that there are certain management and personnel attributes that are important for public expenditure management to be effective and efficient. Public expenditure management is through and by people, as such it is worthwhile to consider or aim to move towards having leaders/managers/personnel who possess the desired qualities or features. The analysis has shown that managers need to be team workers, goal achievers, consultative, financial managers and controllers. Furthermore, personnel need to be qualified; have integrity and be adequate to be able to provide effective and efficient expenditure management environment. This theme addresses research objective 2: Ascertain factors that influence optimisation of public expenditure management in the public healthcare delivery sector in Malawi and research objective 4: Explore ways of enhancing efficiency in utilisation of financial resources in the public healthcare delivery sector in Malawi.

### 5.9.3 Implication for the quantitative data collection tool

The analysis from this theme provided variables to the questionnaire on management and personnel attributes.

### 5.10 Theme 5: Improvement strategies

Theme 5 is about solutions/improvements/strategies that would address the identified constraints/limitations/challenges in relation to public expenditure management. It is felt that, if the strategies are adopted, public expenditure management would improve. The improvement strategies are in 2 sections. Strategies relating to the funding situation in the district hospitals and those that relate to public expenditure management in general.

#### 5.10.1 Improving funding in public district hospitals

##### 5.10.1.1 Introduce paying sections

**DHSS01 said:**

> *"As a hospital here in (location withheld) we are looking at how maybe we can have private sections which has proved to get results, for example Queens has done it, Zomba they are doing it. There are realising quite a lot of funds which can be pumped into the system either procuring of medicines, making renovations but of course we are to face challenges in terms of maybe patronage to these paying services because in the district councils a bigger chunk is community that is not earning a lot a few people may be the civil servants which maybe now we are talking of the health insurance for civil service that we are talking about".*

**DoF01** added that:

> *"I recommend for the government to introduce a fee. People should be paying. Now if the government introduced ... you have been to hospitals like ABC where they have sections and other section of people who are able, they can pay. I have always wanted the government to introduce that system, whereby those people who are living below dollar they have their section where they can access medication on subsidy from the government. And these other sections where other people who are capable, they can be accessing medication on at a fee".*

**DMO01** said:

> "*So one of which we are working on at the moment is to introduce paying services for the outpatient department so that's something we are working on at the moment. We are also working towards introducing the paying services will include the outpatient but also inpatient department. And we are looking at some more ways at which we can generate more income for us."*

**ACC02** said:

"*Currently, there was a hospital management team that went to Zomba to learn how they are doing in terms of the paying ward because that's another area that we want engage in maybe the hospital can get additional funds so that they should see where are the gap and what can we do with the funds generated from the paying ward".*

**EA01 said:**

*"We have noticed of late that out-of-pocket expenditures, health insurance has been rising. That shows that there is demand for healthcare, better health care and that can give government an opportunity for the citizens to pay for the services they enjoy. Health care quality is an issue now we can pay for these services. We pay for these services at the private hospitals, why can't we pay at the government hospitals. As I said there is evidence that out of pocket, health insurance costs are rising."*

**IA01 said:**

"*The first one the way I see is to introduce paying services, because hospitals much as we are saying they are patronised by the poor community, but there are people who have money, who can afford to be paying. The hospitals can do studies and come up with a programme whereby some of the services should be … that some clients should be paying".*

**5.10.1.2 Introduce national health insurance schemes**

**DMO01** said that:

*"Maybe we should diversify our funding for the health system in Malawi. Maybe we are so limited in the funding that we get because we are relying on donors and government but maybe if we could have maybe a contributory health system where the citizen also contributes something. so maybe in one way or the other we may need a national health insurance system."*

**DHSS01** added that:

*"They are realising quite a lot of funds which can be pumped into the system either procuring of medicines, making renovations but of course we are to face challenges in terms of maybe patronage to these paying services because in the district councils a bigger chunk is community that is not earning a lot a few people may be the civil servants*

*which maybe now we are talking of the health insurance for civil service that we are talking about."*

#### 5.10.1.3 Enhance revenue generation capacity of Councils

**FA01** explained that**:**

> *"The current situation on the ground is that Councils' collections are very low to the extent that they fail to pay even their own direct staff they are failing to pay their own staff so they cannot even extend because they have arrears others have salary arrears so extending a hand to health sector will be a problem."*

**CSO01** said**:**

> *"What is required is to make that the district councils are independent as the decentralisation process is preaching. I will give you an example we have been recently seeing the government mounting toll gates, but if you look at all the revenues that they intend to collect no single tambala will be going to the district council. All the money will be going to the central government. So, if we could make the councils independent. Part of these funds to go to the councils and the councils would be able to adequately plan for it operations."*

In summary, the study findings suggest that Malawi should diversify funding sources for the public district hospitals. Akortsu and Abor (2011:128) state that Ghana's public health sector is funded by a mix of funding sources like government funding, social insurance, private health insurance and individual charges. This means that diversity in funding sources in the health sector is the norm.

### 5.10.2 Public expenditure management improvement strategies

The analysis presents various strategies for improving public expenditure management as can be noted from the direct quotes of the participants from the interviews.

#### 5.10.2.1 Enhance capacity for oversight functions

**DoF01** said:

> *The politicians, the Councillors the people who do politics for Council I wish there was minimum education for these people, good enough for them to understand strategies and good enough for them to head an organisation because most of the problems that we councils …,and even district hospitals … mind you, there is a certain team that manages*

*and oversees hospitals and this is the health committee which is headed by big politicians most of the politicians some of them have only MSCE and they are not able to understand the plans for the hospital."*

#### 5.10.2.2 Increase funding

**IA01** said:

*"I want to see the hospitals being funded adequately, because of the foodstuffs and utilities arrears I have talked about. Basically, the government should increase the share to the health sector."*

**DHSS02** said:

*"The first thing I would say we need more funding."*

**DMO01** added that:

*"There is what is called the Abuja declaration, governments committed that they will be increasing funding towards health to 15%. I know increasing funding for health would mean getting funding from elsewhere so maybe affecting other sectors but having a healthy population is a priority because only healthy people can contribute to the development of the country. So that's an area I would want to see change, increase funding for health".*

The analysis indicates that participants are of the view that hospitals should increase funding. Basheka and Phago (2014:154) state that "adequate finances are needed to deliver a whole range of public services." It is an undisputed fact that resources will never be enough more especially in the public sector where demand for goods and services are enormous. However, the dire underfunding of the public hospitals in Malawi render service provision almost impossible.

#### 5.10.2.3 Enhance motivation for management

**DHSS02** stated that there is need for some motivation for the managers.

*"So, motivating those that have done financial management better they would get more support there and those who haven't let them be supported. Say, if you use your funds prudently like this then, you will get a little more funding I think that would also great, need some motivation."*

#### 5.10.2.4 Increase budget flexibility

**DHSS02** said:

> *"The other thing I would want to see change is the virements instead of them being done every 6 months, we should be allowed to do every 3 months I think it would give more of flexibility".*

**ACC02** *adds that:*

> *"An ideal situation would be to review the budget every quarter. To review how much activities have you reviewed over the quarter and get a guide as to how you are going to proceed in the next quarter."*

#### 5.10.2.4 Increase staffing

**ACC02** said:

> *"They should also look at the staffing levels for technical staff because those staff that are actually on the ground to see the patients are not enough for the patients. We go around the hospital; they are not adequate we have a huge gap of over 50% gap. The posts are there but they are not fulfilled. But you look at the staff, there is no adequate staff."*

**IA01** said:

> *"And also, of the staffing levels would improve the situation in the hospital as well as the technical – the medical staff."*

#### 5.10.2.5 Extend consultations on funding allocations to staff

**EA01** said:

> *"At the local level, engagement of local staff when it comes to budgeting all departments should be involved not just in budgeting but including allocation. What I'm saying is they only involve staff in budgeting but when funding is here, they say the top management allocate funding. So, when it comes to budgeting as well as funding, involve all departments. You know that will help to improve performance."*

#### 5.10.2.6 Enhance use of ICT

**EA01** said:

> *"The other is better use of ICT, IFMIS, as we are saying ICT can help produce these reports more quickly so that the councillors and internal auditors can scrutinize them so that they can help improve their performance.*

#### 5.10.2.7 Enhance expenditure control

**EA01** said that hospitals need to minimise expenditure on non-core lines like administration:

> *"The other thing is these hospitals should try to reduce expenditures on administration. They are spending more on administration like that. They must aim at saving or indeed cutting on administration rather than on life saving activities."*

#### 5.10.2.8 Improve and clarify the fund allocation formula for district hospitals

**DHSS02** said:

> *"I think the other way would be to see how they do the allocations for the funds to say do they really reflect the population that we have? Does that really put into consideration the distance in referral facilities for example the district has the furthest health centre a distance at about 200kms and another one the furthest health centre maybe 50km… others maybe have 200kms to the central hospital … that also affect how much they get and with other environmental issues for example geographical issues for example the district has got a lot of catchment areas, would that determine how much they are funded? If it has quite a lot of facilities accessible or there is no facility would that affect how much money they would get in a financial year. I would really like to see if those are factored in. even to say if the district does have a district hospital and one that doesn't have a district hospital does that affect how much money they get for funding those are some of the issues that I would to see them quite clearly."*

**FA01** said:

> **"***So NLGFC has got a task now to say ok for the 40 billion allocated to health sector how much should Nsanje get, how much should Chikwawa get, how much should Likoma get, should their fundings [sic] be even? If they are supposed to be different what should the factors that should differentiate the funding levels so there is what we call an intergovernmental fiscal transfer formula, some of the factors that are considered in this*

*and this is approved by Cabinet by the way, this formula. The formula that we are currently using was approved 2003 way back but there is an effort to revise."*

#### 5.10.2.9 Improve transparency to the public

**CSO01** opines that there is need to improve on transparency for the public in the sector and said that:

> *"In terms of transparency I think a lot of more needs to be done to make sure that even the citizenry is involved they know how much was budgeted, they understand the budget cut by the central government such that when these facilities fail to provide the required services, they should be able to appreciate."*

#### 5.10.2.10 Enhance on procurement activities

**CSO01** stated that there is need to enhance on procurement:

> *"Reforms that we are talking about now also go down to the local councils, the district health facilities, look at their procurement processes and see what could be changed."*

In summary, this theme has presented results on findings on possible improvement strategies for the enhancement of public expenditure management. The analysis has revealed that the funding situation could be improved through enhancing revenue generation muscle of councils, introducing paying sections in the public hospitals, lobbying the government to increase funding and introducing national health insurance policy. Furthermore, on public expenditure management strategies, the analysis has presented the following suggestions for improvement: improvement on the funds allocation formula for government funding; enhanced capacity of oversight functions; recruitment of adequate staff; enhanced cost cutting in non-priority areas: use of ICT in production of reports; consult on budget and funds allocation; increased funding; improved budget flexibility; full devolvement of Councils; improved quality and availability of financial information to monitor public spending; foster constructive dialogue with the civil society; and strengthened the performance management system.

### 5.10.3 Implications for the quantitative phase

The findings from this theme forms part of the questionnaire. The variables obtained from this theme guided the framework design. The focus of this theme and consequently the questionnaire is: what should be done to enhance public expenditure management? This theme addresses research objective 4: Explore ways of enhancing efficiency in utilisation of financial resources in

the public healthcare delivery sector in and research objective 1: Determine the financing situation in the public healthcare delivery sector in Malawi.

### 5.11 Chapter summary

Chapter 5 presented the findings and results of the qualitative analysis. This chapter presented that insight into the public expenditure management environment in the public district hospitals in Malawi. Five themes emerged from the approach used for qualitative analysis is thematic and the thematic networks. The themes are: Theme 1: Funding situation; Theme 2: Status of public expenditure management in the public health service delivery sector; Theme 3: Vital functions in expenditure management; Theme 4: Management and personnel factors; and Theme 5: Strategies towards achieving improvements. The variables that emerged from the qualitative analysis were selected and used for questionnaire development for the quantitative phase of the study.

# CHAPTER 6: QUANTITATIVE DATA ANALYSIS AND DISCUSSION OF FINDINGS

## 6.1 Introduction

This study deployed exploratory sequential design mixed method research approach. Chapter 5 presented the qualitative results in which five themes were identified. The qualitative data that was collected and analysed in Chapter 5 was used to develop the questionnaire whose data is analysed and discussed in this chapter. Thus, the two research designs are connected as the qualitative results feed into quantitative data instrument design. Chapter 6 presents the quantitative results of this study having done factor analysis of the quantitative data.

Chapter 6 presents findings from primary data that was collected through self-administered questionnaires that were designed to address research problems that were being analysed. Data was collected from officials in randomly selected district hospitals in Malawi. Four hundred questionnaires were issued to respondents and 328 completed questionnaires were collected providing a response rate of 82%. The data was analysed using SPSS software. This chapter is segmented into three sections: descriptive statistics of demographic data, factor analysis and descriptive statistics of the study's core variables.

The data on demographics of the respondents is presented in form of descriptive statistics as frequency tables of the demographics. The section that follows deals with factor analysis for items that were used to measure factors that affect expenditure management in the public healthcare delivery sector in Malawi. The study used principal component analysis to validate and establish reliability of the instrument having conducted the following tests: Cronbach's alpha reliability coefficient for internal consistency; and Bartlett's test of Sphericity and Kaiser-Meyer-Olkin test (KMO) for the measurement of sampling adequacy. Finally, descriptive results from the study were assessed and discussed on the adoption of a framework result for improving expenditure management in the public health sector in Malawi. Percentages may not add to 100% due to rounding errors. Figure 5.1 presents a flow diagram of the processes followed in the analysis of the quantitative.

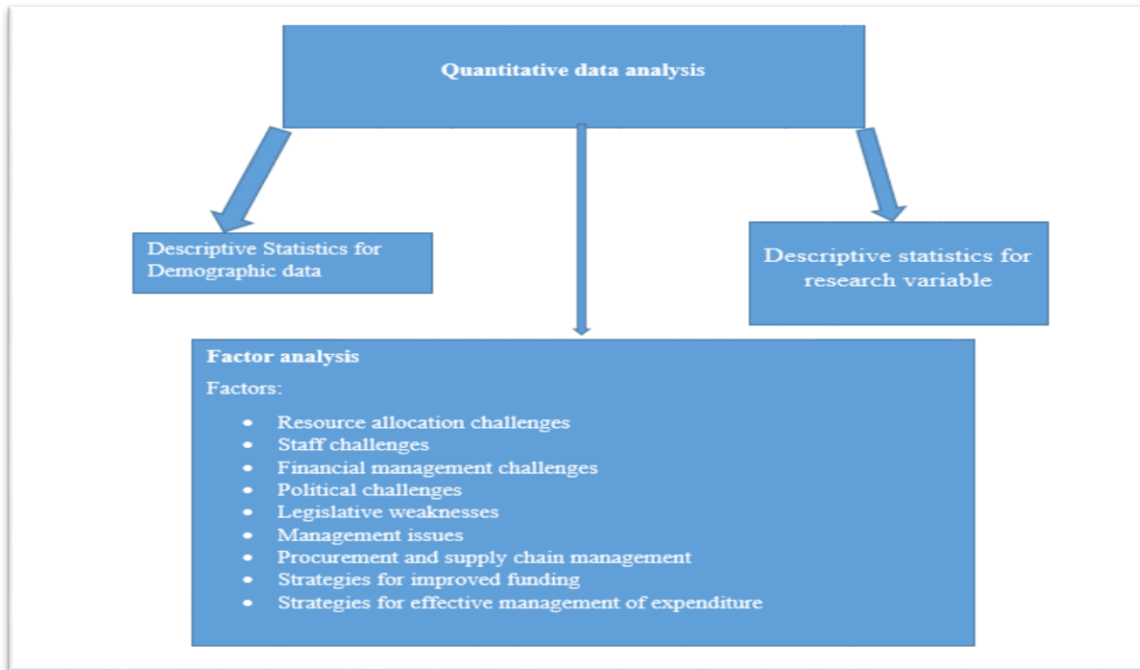



**Figure 6.1: Quantitative data analysis flow diagram**

**Source:** Own source

### 6.2 Respondents' demographics – descriptive statistics

Data on respondents' demographics was analysed and presented using frequency tables. Table 6.1 presents a summary of the demographic data for the respondents in form of summary percentages.

#### 6.2.1 Demographic profile of study respondents

This section presents demographic attributes of the respondents who were part of this study. Szabo *et al.* (2020:2) explain that an appreciation of the demographics enhances planning and managing of the work force. For this study, understanding the demographics of the respondents helps assess the suitability of the respondents in providing appropriate responses for the questions being addressed by the study topic. The respondents' demographic data presented in Table 6.1 comprises of districts where the participants are based, participants' gender, age, designation, highest qualification attained and number of years in service in their positions. A total number of 328 respondents were part of the study from different districts which were randomly determined by cluster sampling.

**Table 6. 1: Respondents demographic profile**

| District | | | Designation | |
|---|---|---|---|---|
| Balaka | 9.8% | | District Commissioner | 1.2% |
| Mchinji | 3.7% | | Director of Health and Social Services | 0.3% |
| Machinga | 6.7% | | Director of Finance | 1.2% |
| Chikwawa | 13.7% | | Director of Administration | 1.2% |
| Mwanza | 11.9% | | Director of Planning & Development | 1.2% |
| Phalombe | 4.0% | | Director of Public Works | 1.5% |
| Dedza | 4.3% | | District Medical Officer | 3.0% |
| Neno | 6.4% | | District Nursing Officer | 3.4% |
| Rumphi | 7.9% | | Health Promotion Officer | 2.7% |
| Kasungu | 7.6% | | Human Resource Management Officer | 4.0% |
| Nsanje | 7.6% | | District Environmental Health Officer | 4.3% |
| Salima | 8.2% | | Hospital Administrator | 4.0% |
| Lilongwe | 3.4% | | Procurement Officer | 2.4% |
| Thyolo | 4.9% | | Hospital Accountant | 2.1% |
| | | | Internal Auditor | 1.5% |
| | | | Program Coordinator | 65.9% |
| **Gender** | | | **Age group** | |
| Female | 34.5% | | 18 – 25 Years | 4.3% |
| Male | 65.5% | | 26 – 35 Years | 36.3% |
| | | | 36 – 45 Years | 33.5% |
| **Highest qualification** | | | 46 – 55 Years | 22.6% |
| Malawi School Certificate of Education or Equivalent | 2.1% | | 55 Years + | 3.4% |
| Professional Certificate & Diploma | 37.8% | | **Years in service** | |
| Bachelor's degree | 47.9% | | Less than 2 years | 9.8% |
| Honours degree | 3.4% | | 2– 5 years | 17.7% |
| Master's degree | 8.5% | | 6 –10 years | 22.6% |
| Doctoral degree | 0.3% | | 11–15 years | 23.2% |
| | | | Greater than 16 years | 26.8% |

**Source:** Survey data

### 6.2.2 Districts where respondents are based

The distribution of respondents by the district where they were based was measured using frequencies (see Table 6.1). The results indicate that respondents were stationed in the following districts: Balaka (9.8%); Mchinji (3.7%); Machinga (6.7%); Chikwawa (13.7%); Mwanza (11.9%); Phalombe (4%); Dedza (4.3%); Neno (6.4%); Rumphi (7.9%); Kasungu (7.6); Nsanje (7.6%); Salima (8.25); Lilongwe (3.4%); and Thyolo (4.9%). The findings indicate that the majority of respondents were from Chikwawa followed by Mwanza; while the least number of respondents were from Lilongwe. The structure of personnel at the Councils and the District Health Management Teams is the same in all the districts; however, the numbers of Programme

Coordinators at each hospital is different. The variations in response rates at district level was attributed to the level of cooperation each district presented at the time of data collection.

### 6.2.3 Gender of study respondents

Gender distribution of the study respondents was analysed as frequencies and have been presented in Table 6.1. The findings reveal that males that responded to the questionnaires amounted to 65.5%; whilst females were 34.5%, thus, relatively 31% higher males are in employment in the sector than women. This pattern of proportion of males and females in the health sector agrees with Szabo *et al.* (2020:5) where Nepal is reported to have far less females in the health sector than males. Thus, it is inferred from this study that there is male dominancy in public healthcare sector employment is compared to female, despite that the population of Malawi has a higher population of women than men, 52% and 48% respectively (Malawi Government, 2020b:3). Furthermore a higher employment rate among male than female professionals, conforms to the 2018 national census (Malawi Government, 2020a:12). In addition, the healthcare sector is predominantly science oriented. It has been observed that women particularly in Malawi, are yet to fully engage into science related fields. The majority of the research respondents are health personnel at various levels of management and about 90% respondents are health practitioners and managers at different levels in the hospitals. In support of these findings, studies reveal that despite the increasing number of females in the health sector, less females occupy management and leadership positions (International Labour Organisation, 2017:24; Le Boedec *et al.*, 2021:2). This probably explains the lower representation of females in the study.

### 6.2.4 Age group of the respondents

Table 6.1 shows the distribution of age groups of study respondents as measured by frequencies in form of percentages. The results indicate that the age group was spread as follows: 18 – 25 years (4.3%); 26 – 35 years (36.3%); 36 – 45 years (33.5%); 46 – 55 years (22.6%); and 55 years + (3.4%). From the findings, it can be interpreted that most of the respondents were in the age group 26 to 35 years, followed by 36 to 45 years and the minority age group was 55 years and above category. The findings of this study imply that the majority of employees in the healthcare sector in Malawi are between 26 to 45 years, thus, representing approximately 69.8% of the respondents. This conforms to the fact that Malawi is said to have a youthful population. With reference to health sector, it is said that the sector is emerging to be the biggest employer of the youth with a rising employment rates (World Health Organisation, 2019:9). Thus, it is concluded

that the study was dominated by respondents between 26-45 years which is an age range of most productive and experienced individuals.

### 6.2.5 Designation of the respondents

The study respondents were classified as Council Officials, District Health Management Team members and Programme Coordinators. Table 6.1 presents the distribution of respondents by designation and was measured using frequencies in form of percentages.

The findings showed participation to the study as follows: District Commissioners (1.2%); Directors of Health and Social Services (0.3%); Directors of Finance (1.2%); Directors of Administration (1.2%); Human Resource Management Officers (4%); Hospital Administrators (4%); Directors of Planning and Development (1.2%); Directors of Public Works (1.5%); District Medical Officers (3%); District Nursing Officers (3.4%); Health Promotion Officers (2.7%); District Environmental Health Officers (4.3%); Procurement Officers (2.4%); Hospital Accountants (2.1%); Internal Auditors (1.5%); and Programme Coordinators (65.9%).

Summarising the respondents in terms of their classifications above it translates into: Council officials (10.2%), District Health Management Team members (23.9%) and Programme Coordinators (65.9%). This compares well in terms of standard sample representation at 15%, 23% and 66% respectively. The results show that most of the respondents were Programme Coordinators (65.9%) followed by followed by District Environmental Health Officers (4.3%). The group that least participated in the study was that of Directors of Health and Social Services (0.3%). The findings of the study confirm that organisations have a greater number of lower-level managers for programme implementation. Furthermore, the findings show that public sector management structures aim at enhancing effectiveness and efficiency in management by establishing diverse positions that support the administration of the public hospitals. Accordingly, it is implied that non-finance personnel have roles in the management of finances. This is supported by Naranjee *et al.* (2019a:1) who extend the responsibility for financial management to the technical health personnel. These respondents hold positions that make decisions relating to healthcare delivery activities and consequently financial resource utilisation.

### 6.2.5 Years the respondents have been in service

Table 6.1 shows the distribution of study respondents in terms of number of years they have worked in the institution as was measured using frequencies that were presented as percentages.

The results showed that respondents have worked less than 2 years (9.8%); 2-5 years (17.7%); 6 - 10 years (22.6%); 11-15 years (23.2%); and greater than 16 years (26.8%). The results show that the majority of the study respondents have served the public health sector over 16 years, followed by service of between 11 to 15 years; whilst the least years of service was less than 2 years of service. The distribution of years of service show that most employees have served the health sector for longer than 6 years, have experience in the work they do, and that the public health sector manages to retain employees. These results of the study suggest that the public sector in general and public health sector in particular, has experienced and stable personnel.

### 6.2.6 Highest qualification of the respondents

Table 6.1 shows the distribution of respondents by highest qualification as was measured using frequencies. The results indicate that the highest qualification for respondents was distributed as follows: Malawi School Certificate of Education or Equivalent (2.1%); Professional Certificate & Diploma (37.8%); Bachelor's Degree (47.9%); Honours' Degree (3.4%); Masters' Degree (8.5%) and Doctoral Degree (0.3%). The findings indicate that most of the respondents were holders of a Bachelor's degrees, followed by holders of a Professional Certificates and Diplomas and the minority were the holders of a Doctoral Degree. It can be inferred from the findings that the bulk of the managers for the public healthcare service delivery sector at the levels of DHMT and Programme Coordinators hold Bachelors' degrees. This is not surprising, as the study targeted individuals in management or administrative positions.

## 6.3 Principal component analysis

The method of factor analysis that was used in this study is the principal component analysis. According to Abdi and Williams (2010:433), the principal component analysis is a 'multivariate technique that analyses data in which observations are described by several inter-correlated quantitative dependent variables.' In addition, principal component analysis is a data reduction analysis technique that reduces a large volume of variable into smaller components (Vogt *et al.*, 2014:337). The overall aim of undertaking principal component analysis is to get a sizeable number of combinations of correlated parameters that explain the differences in the data set of new unrelated parameters (Einasto *et al.*, 2011:3). The goals of principal component analysis as outlined by Abdi and Williams (2010:434) are to:

- Extract most important information from the data table
- Compress data set
- Abridge the description of the data set
- Assess structure of the observations and variables.

### 6.3.1 Factor analysis

Factor analysis is one of the techniques used in multivariate statistical analysis that allows for the reduction of variables; a commonly used one is principal components analysis (Watson & Thompson, 2005:330). Factor analysis establishes relationships between variables (Vogt *et al.*, 2014:334). Before subjecting data to factor analysis, the data set has to satisfy minimum requirements for sampling adequacy, which is measured by the Kaiser-Meyer-Olkin Test (KMO) and Bartlett's Test (Ozfidan & Burlbaw, 2017:6661).

#### 6.3.1.1 Kaiser-Meyer-Olkin measure of sampling adequacy

The Kaiser-Meyer-Olkin is a measure of sampling adequacy, which varies between 0 and 1. When a KMO value is 0, it indicates that there is dispersal in the pattern of correlations, and this shows that the factor analysis would be inappropriate. The closer the value is to 1, the more concentrated the data is. The Bartlett's Test of Sphericity is said to be a neutral standard that reduces the risk of construing factor analysis results to chance (Tobias & Carlson, 1969:375). The study used the Kaiser's rule, which allows a given factor to explain at least the equivalent of one variable's variance. In this study, KMO statistical test measured sampling adequacy for each variable. The KMO values obtained in this study are shown in Table 6.2. Having KMO values for individual components ranging from 0.566 to 0.879 and the corresponding Bartlett's test reading which was statistically significant at $p \leq 0.000$, indicated that both tests are satisfactory and met the minimum threshold for factor analysis. The KMO values were close to 1, and this shows that the correlations close and that the factor analysis factors presented by the factors were dependable.

**Table 6. 2: KMO values**

| Item | KMO value |
|---|---|
| Resource allocation challenges | 0.566 |
| Staff challenges | 0.717 |
| Financial management challenges | 0.879 |
| Political challenges | 0.733 |
| Legislative weaknesses | 0.832 |
| Management issues | 0.831 |
| Procurement and supply chain management | 0.831 |
| Strategies for improved funding | 0.627 |
| Strategies for effective management of expenditure | 0.871 |

**Source**: Survey data

### 6.3.1.2 Commonalities

A commonality is a fraction of the variance that is accounted for by the factors of the variable. A value of zero indicates that the factor does not explain any variation of the variable; whilst a value of 1 means that all the variations of a variable are all explained by the factor. In this study, the commonalities in Table 6.3 are all above 0 meaning that the factors account for some proportion of the variables.

**Table 6. 3: Commonalities**

| | Initial | Extraction |
|---|---|---|
| Inadequate financial resources | 1.00 | 0.664 |
| Late funding from government | 1.00 | 0.629 |
| Budget planning and preparation suffer from burdensome requirements arising from underfunding | 1.00 | 0.298 |
| Corrupt employees | 1.00 | 0.556 |
| Lack of staff integrity | 1.00 | 0.547 |
| Staff incompetence | 1.00 | 0.513 |
| Delays in disciplining staff | 1.00 | 0.472 |
| Excessively complicated administrative procedures | 1.00 | 0.284 |
| Poor control of expenditures | 1.00 | 0.639 |
| Weak financial management system | 1.00 | 0.703 |
| Lack of compliance to set procedures | 1.00 | 0.581 |
| Weaknesses in financial reporting | 1.00 | 0.694 |
| Inadequate flow of information | 1.00 | 0.531 |
| Weak capacity in external and internal audit functions | 1.00 | 0.430 |
| Directives from central government to the hospitals to undertake unplanned activities | 1.00 | 0.433 |
| Lack of political will | 1.00 | 0.600 |
| Partial decentralisation of Councils | 1.00 | 0.588 |
| Hospitals are managed at both the Council and Ministry resulting in dual management | 1.00 | 0.630 |
| Lack of compliance to legislative provisions | 1.000 | 0.488 |
| Legislative provisions for penalties are not deterrent enough | 1.000 | 0.507 |
| Legal provisions governing have inconsistencies | 1.000 | 0.623 |
| Legal provisions governing have loopholes | 1.000 | 0.700 |
| Legal framework is neither clear nor comprehensive | 1.000 | 0.421 |
| There is weak monitoring of compliance of legal provisions | 1.000 | 0.537 |
| There is weak enforcement of legal provisions | 1.000 | 0.522 |
| There is lack of fiscal discipline by the management | 1.000 | 0.536 |
| Management is not accountable to expenditure of public funds | 1.000 | 0.747 |
| There is lack of monitoring of finances | 1.000 | 0.755 |
| Management does not consult on resource allocations | 1.000 | 0.725 |
| There is no autonomy over finances | 1.000 | 0.522 |
| Compromised procurement function | 1.000 | 0.532 |
| Funding challenges affect compliance with procurement plans | 1.000 | 0.307 |
| Poor procurement planning and budgeting | 1.000 | 0.577 |
| Lack of effective supervision and monitoring | 1.000 | 0.616 |
| Poor stock management | 1.000 | 0.583 |
| Increasing prices constrain budget resources | 1.000 | 0.410 |

| Compromised procurement function | 1.000 | 0.532 |
|---|---|---|
| Introducing fee paying sections in the hospitals | 1.000 | 0.525 |
| Lobbying for increased budgetary allocation | 1.000 | 0.526 |
| Enhance revenue generating capacity of hospitals | 1.000 | 0.639 |
| Improve the formula used in allocating government funding to hospitals | 1.000 | 0.477 |
| Enhance capacity of oversight functions | 1.000 | 0.515 |
| Provide training to staff | 1.000 | 0.478 |
| Consult on budget and funds allocation | 1.000 | 0.553 |
| Improve quality and availability of financial information to monitor public spending | 1.000 | 0.564 |
| Foster constructive dialogue with the civil society | 1.000 | 0.592 |
| Strengthen the performance management system | 1.000 | 0.450 |

**Source:** Survey data

#### 6.3.1.3 Total variances explained

The nine cases showed that the associated Bartlett's Test of Sphericity was statistically significant at $p \leq .000$. The principal component analysis method was used to extract factors from the data which describes the best underlying relationships or correlations among variables. The total percentage variance explained was as follows:

Resource allocation challenges explain 53.05% of the variance in the data. Staff challenges explain 52.19% of the variance in the data. Financial management challenges explain 55.18% of the variance in the data. Political challenges explain 56.27% of the variance in the data. Legislative weaknesses explain 54.27% of the variances in the data. Management issues explain 65.72% of the variances in the data. Procurement and supply chain management issues explain 50.41% of the variances in the data. Strategies for improved funding explain for 56.33% of the variances in the data. Strategies for effective management of expenditure explain 51.84% of the variances in the data.

#### 6.3.1.4 Cronbach's Alpha - measure of internal consistency

The validity of the data collection instrument was tested using the Cronbach's Alpha. Cronbach's (1951) Alpha coefficient is a commonly used measure of quality indicators in the social sciences (Bonett & Wright, 2015:3; Sijtsma, 2009:107). According to (Bonett & Wright, 2015:3; Field, 2013:709), Cronbach's Alpha is a measure of a data collection instrument's internal consistency and is more appropriate when measuring multiple test items. Cronbach's Alpha measures range from 0 to 1 and the closer the measure is to one, the more valid the instrument is (Vogt *et al.*, 2014:35). It has been argued that there is no universally acceptable minimum value for the Cronbach's Alpha value and that an acceptable reliability value is dependent on its application as such it is recommended that emphasis should be placed on the population's reliability value

(Bonett & Wright, 2015:4). In addition, Field (2013:709) states that the guideline value for acceptability of Cronbach is 0.7, but indicates that a Cronbach alpha value of 0.5 can be used. However, it is advised that interpretation should be cautiously handled in the latter case.

Following on these arguments, as all Cronbach's Alpha values are close to 1, the questionnaire is deemed to be reliable, the lowest Cronbach's Alpha value being 0.545 and the highest 0.867. The instrument reliability results show the reliability levels as measured by Cronbach's Alpha. Table 6.5 presents the initial and Cronbach's Alpha based on standardized items. The findings of this study were measured by Cronbach's Alpha, and revealed that the identified factors had acceptable levels of reliability as there were close to 1. This indicates that there was consistency in the 5 - point Likert scales that were used in the questionnaire.

**Table 6. 4: Cronbach Alpha reliability analysis**

| No. | Item | **Cronbach Alpha** | **Cronbach's Alpha Based on Standardized Items** |
|---|---|---|---|
| 1 | Resource allocation challenges | 0.499 | 0.545 |
| 2 | Staff challenges | 0.693 | 0.694 |
| 3 | Financial management challenges | 0.846 | 0.840 |
| 4 | Political challenges | 0.738 | 0.739 |
| 5 | Legislative weaknesses | 0.858 | 0.858 |
| 6 | Management issues | 0.869 | 0.867 |
| 7 | Procurement and supply chain management issues | 0.801 | 0.799 |
| 8 | Strategies for improved funding | 0.611 | 0.583 |
| 9 | Strategies for effective management of expenditure | 0.844 | 0.845 |

**Source:** Survey data

### 6.3.1.5 Component matrix

Table 6.6 presents a component matrix for all the factors that were analysed in the study. The component matrix shows the correlation of each variable item with its component. The component matrix in Table 6.5 shows that all of the extracted statements have a component loading of above 0.5, meaning that the correlation is high.

**Table 6. 5: Component matrix**

| Variable | Component |
|---|---|
| | **Resource allocation challenges** |
| Inadequate financial resources | 0.815 |
| Late funding from government | 0.793 |
| Budget planning and preparation suffer from burdensome requirements arising from underfunding | 0.546 |
| | **Staff challenges** |
| Corrupt employees | 0.746 |
| Lack of staff integrity | 0.739 |
| Staff incompetence | 0.716 |
| Delays in disciplining staff | 0.687 |
| | **Financial management challenges** |
| Weak financial management system | 0.838 |
| Weaknesses in financial reporting | 0.833 |
| Poor control of expenditures | 0.799 |
| Lack of compliance to set procedures | 0.762 |
| Inadequate flow of information | 0.729 |
| Weak capacity in external and internal audit functions | 0.656 |
| Excessively complicated administrative procedures | 0.533 |
| | **Political challenges** |
| Hospitals are managed at both the Council and Ministry resulting in dual management | 0.794 |
| Lack of political will | 0.774 |
| Partial decentralisation of Councils | 0.767 |
| Directives from central government to the hospitals to undertake unplanned activities | 0.658 |
| | **Legislative weaknesses** |
| Legal provisions governing have loopholes | 0.837 |
| Legal provisions governing have inconsistencies | 0.790 |
| There is weak monitoring of compliance of legal provisions | 0.733 |
| There is weak enforcement of legal provisions | 0.722 |
| Legislative provisions for penalties are not deterrent enough | 0.712 |
| Lack of compliance to legislative provisions | 0.699 |
| Legal framework is neither clear nor comprehensive | 0.649 |
| | **Management issues** |
| There is lack of monitoring of finances | 0.869 |
| Management is not accountable to expenditure of public funds | 0.864 |

| | |
|---|---|
| Management does not consult on resource allocations | 0.851 |
| There is lack of fiscal discipline by the management | 0.732 |
| There is no autonomy over finances | 0.723 |
| | **Procurement and supply chain challenges** |
| Lack of effective supervision and monitoring | 0.785 |
| Poor stock management | 0.764 |
| Poor procurement planning and budgeting | 0.760 |
| Compromised procurement function | 0.729 |
| Increasing prices constrain budget resources | 0.640 |
| Funding challenges affect compliance to procurement plans | 0.554 |
| | **Strategies for improved funding in the public district hospitals** |
| Enhance revenue generating capacity of hospitals | 0.799 |
| Lobbying for increased budgetary allocation | 0.725 |
| Introducing fee paying sections in the hospitals | 0.725 |
| | **Strategies for effective management of public expenditure** |
| Foster constructive dialogue with the civil society | 0.769 |
| Improve quality and availability of financial information to monitor public spending | 0.751 |
| Consult on budget and funds allocation | 0.744 |
| Enhance capacity of oversight functions | 0.717 |
| Provide training to staff | 0.691 |
| Improve the formula used in allocating government funding to hospitals | 0.690 |
| Strengthen the performance management system | 0.671 |

**Source:** Survey data

#### 6.3.1.6 Questionnaire questions and the Likert scale

All the questions in the questionnaire except for the demographic data questions, comprised five-point Likert scale questions. The Likert scale is also called a summated rating scale, because the responses from each item are summed to obtain the respondent's score on the scale (Vaskea *et al.*, 2017:163). Therein, respondents were requested to agree or disagree with each statement. According to (Saunders *et al.*, 2009:378; Vaskea *et al.*, 2017:163), the Likert scaling approach commences with a number pool of items that are identified to be of interest for the study; and respondents show the extent of agreement or disagreement. In the Likert scale in the questionnaire used for this study, 1 represented strongly disagree; 2 represented disagree; 3 represented neutral meaning the respondent neither agreed nor disagreed to a position; 4 represented agree and 5 strongly agree. The determination of constructs and their statistical significance were based on the agreement or disagreement of the listed variables.

Table 6.2 presents the mean and standard deviation values of expenditure management in public health service delivery sector in Malawi. The highest mean value was 4.3709 with a standard deviation score of 0.71649 from the strategies for improved funding variable. The second highest mean values were 4.3669 with standard deviation scores of 0.67065 from the resource allocation challenges variable. The least mean value was obtained from the management issues variable and was 3.2421 with a standard deviation score of 1.09982.

**Table 6. 6: Descriptive Statistics for expenditure management for public health delivery sector in Malawi**

| Variable | N | Mean/Standard deviation |
|---|---|---|
| Resource allocation challenges | 328 | 4.3669 ± 0.67065 |
| Staff challenges | 328 | 3.4787 ± 0.88519 |
| Financial management challenges | 328 | 3.7221 ± 0.85112 |
| Political challenges | 328 | 3.9063 ± 0.90074 |
| Legislative weaknesses | 328 | 3.5823 ± 0.79571 |
| Management issues | 328 | 3.2421 ± 1.09982 |
| Procurement and supply chain issues | 328 | 3.8587 ± 0.79341 |
| Strategies for improved funding | 328 | 4.3709 ± 0.71649 |
| Strategies for effective management of public expenditure | 328 | 4.3249 ± 0.57812 |

**Source:** Survey data

### 6.3.2 Factor analysis of individual factors

#### 6.3.2.1 Resource allocation challenges

**Table 6. 7: Likert scale: Resource allocation challenges**

| To what extent do you agree or disagree that the following resource allocation challenges influence public expenditure management in the public district hospitals? On a scale ranging from Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2 to Strongly Disagree = 1. *(Please put a "circle" on a number representing your preferred answer. If you make a mistake, put an "X" across the circle and choose another answer).* |
|---|

A factor analysis was carried out on resource allocation challenges that influence expenditure management in public district hospitals and require an adoption of public expenditure management framework in the public healthcare delivery sector in Malawi. The challenges consist

of inadequate financial resources, late funding from government, misallocation of resources and budget planning and preparation suffer from burdensome requirements arising from underfunding. A mean of 4.3669 and a standard deviation of 0.67065 were obtained from the resource allocation challenges variables. The mean has an inclination towards the higher end of the Likert scale above 4 in Table 6.7. This infers that district hospitals experience resource allocation challenges which affect management of public expenditure. This explains that the flow of funding to the district hospitals is impaired. As such, hospital management struggle to provide health service as expected affecting the morale of both patients and employees and consequently, service delivery.

These findings are supported by Akortsu and Abor (2011:126) who articulate that hospitals should be well financed so that the task for healthcare service delivery is achieved. Therefore, there is need for hospitals to be prioritised in resource allocation. For instance, deliberate actions of increasing funding to the hospitals. This means that financial allocation challenges faced by the health sector could be addressed then the health sector could improve on services delivery.

#### 6.3.2.2 Staff challenges

**Table 6. 8: Likert scale: Staff challenges**

| To what extent do you agree or disagree that the following staff challenges influence public expenditure management in the public district hospitals?<br>On a scale ranging from Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2 to Strongly Disagree = 1. *(Please put a "circle" on a number representing your preferred answer. If you make a mistake, put an "X" across the circle and choose another answer).* |
|---|

A factor analysis was carried out on staffing challenges that influence public expenditure management in the public district hospitals in Malawi. The staff challenges comprise staff shortages that compromises processing of transactions and reporting, staff shortages cause irregular deployment of personnel, staff incompetence, lack of performance appraisal for staff, delays in disciplining staff, corrupt employees, lack of staff morale, a lack of integrity and poor rapport with colleagues and superiors. A mean of 3.4787 and a low standard deviation of 0.88519 were confirmed through the factor staff challenges. This mean indicates an inclination towards a higher end of the Likert scale above 3 in Table 6.8. This implies that there are staff challenges that influence public expenditure management in the public healthcare sector.

In support of these findings, Souliotis *et al.* (2016:160) explain that weaknesses in the health systems like those relating to budgeting contribute to challenges portrayed by staff. Consequently, these factors should be addressed and incorporated in the public expenditure management framework. This, therefore, entails that public healthcare service delivery sector in Malawi should address the staff challenges in order to have staff that makes effective and efficient expenditure management decisions which would lead to improved service delivery in the health sector.

#### 6.3.2.3 Financial management challenges

**Table 6. 9: Likert scale: Financial management challenges**

| To what extent do you agree or disagree that the following financial management challenges affect management of public expenditure in the public district hospitals? On a scale ranging from Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2 to Strongly Disagree = 1. *(Please put a "circle" on a number representing your preferred answer. If you make a mistake, put an "X" across the circle and choose another answer).* |
|---|

Factor analysis was carried out on financial management challenges as an issue that affect management of public expenditure in the public district hospitals. In this section, the respondents were asked about their views on financial management challenges that were experienced by the district hospitals which had influences on public expenditure management. The set of statements under this section relating to financial management challenges that were analysed were: excessively complicated administrative procedures, poor control of expenditures, weak financial management system, lack of compliance to set procedures, weaknesses in financial reporting, inadequate flow of information and weak capacity in external and internal audit functions. A high mean of 3.7221 and a low standard deviation of 0.85112 were confirmed through the factor, financial management challenges. This mean indicates an inclination which is almost towards the high end of the Likert scale of above 3. in Table 6.9. and this infers that the public district hospitals face challenges related to financial management. Therefore, having access to finances alone may not on its own lead to improved financial goals and therefore, high quality service delivery.

In support of the findings, Huzaila-Majid and Singaravelloo (2017:260) explain that poor financial management systems, poor policies and external and internal factors deter effective management of finances. It is then held that if the public healthcare service delivery sector is to improve management of its financial resources, there is need to strengthen its financial

management systems, enforce compliance of financial procedures and strengthen the internal and external oversight functions.

#### 6.3.2.4 Political challenges

**Table 6. 10: Likert scale: Political challenges**

| To what extent do you agree or disagree that the following political challenges influence management of public expenditure in the public district hospitals? On a scale ranging from Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2 to Strongly Disagree = 1. *(Please put a "circle" on a number representing your preferred answer. If you make a mistake, put an "X" across the circle and choose another answer).* |
|---|

A factor analysis was carried out on the political issues that influence management of expenditure in the public district hospitals. In this section, respondents were asked their views on political issues that were experienced by the district hospitals which had influences on public expenditure management. The set of questions under this section relating to political challenges that affect public expenditure management in the heath sector were directives from central government to the hospitals to undertake unplanned activities; lack of political will; partial decentralisation of Councils and that hospitals are managed at both the Council and Ministry resulting in dual management. A moderate mean of 3.9063 and a standard deviation of 0.90074 were obtained through the political challenges factor. This mean reflects a tendency which is almost towards the higher end of the Likert scale of above 3. in Table 6.10. This implies that the district hospitals experience political challenges that affect management of expenditure.

According to Allen and Tommasi (2001:22), accomplishments in improving financial management in a budget system is dependent on political commitment. It is thus, imperative for the government to improve the political environment for the betterment of public expenditure management in the district hospitals.

#### 6.3.2.5 Legislative weaknesses

**Table 6. 11: Likert scales: Legislative weaknesses**

| To what extent do you agree or disagree that the following legislative weaknesses affect management of public expenditure in the public district hospitals? On a scale ranging from Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2 to Strongly Disagree = 1. *(Please put a "circle" on a number representing your preferred answer. If you make a mistake, put an "X" across the circle and choose another answer).* |
|---|

A factor analysis was carried out on legislative challenges that affect public expenditure management in the public healthcare delivery sector in Malawi. The challenges that the district hospitals face include: lack of compliance to legislative provisions, legislative provisions for penalties are not deterrent enough, legal provisions governing have inconsistencies; legal provisions governing have loopholes, legal framework is neither clear nor comprehensive, there is weak monitoring of compliance of legal provisions and there is weak enforcement of legal provisions. A mean of 4.3958 and a low standard deviation of 0.57238 were confirmed through the factor legislative weaknesses. This mean shows there is an inclination towards a higher end of the Likert scale above 4 in Table 6.11. Therefore, the public healthcare delivery sector experiences legislative weakness. This shows that the health sector experiences various challenges related with the legal provisions governing public expenditure management. The implementation of the legal instruments governing management of public finance, achievement of financial objectives and, consequently, public sector goals is thus compromised. This implies that the implementation of legislative provisions should be enhanced in order to achieve the intent on its conceptualisation should be achieved. This relates to both the public finance management and procurement and disposal legal instruments. These findings entail that the public sector in general does not fully benefit from the legal instruments that it develops and as a result management of public finances is compromised.

These results concur with studies conducted by Tsheletsane and Fourie (2014:43) where they lament the increasing trends in poor financial management notwithstanding that there are legal instruments aimed at governing effective financial management.

#### 6.3.2.6 Procurement and supply chain management challenges

**Table 6. 12: Likert scales: Procurement and supply chain management challenges**

| To what extent do you agree or disagree that the following procurement and supply chain challenges influence public expenditure management in the public district hospitals? On a scale ranging from Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2 to Strongly Disagree = 1. *(Please put a "circle" on a number representing your preferred answer. If you make a mistake, put an "X" across the circle and choose another answer).* |
|---|

Factor analysis was carried out on procurement and supply chain management challenges that influence public expenditure management in Malawi. The set of questions under this section relating to procurement and supply chain management challenges are compromised procurement

function; funding challenges affect compliance to procurement plans; centralisation of some procurements; poor procurement planning and budgeting; lack of effective supervision and monitoring; poor stock management; increasing prices constrain budget resources and strict procurement regulations. A mean of 3.8587 and a standard deviation of 0.79341 were confirmed through the factor procurement and supply chain management challenges. This mean reflects an inclination towards a higher end of the Likert scale of above 3 in Table 6.12. This implies that there are several procurement and supply chain management challenges that affect management of expenditure in the public healthcare delivery sector of Malawi.

This is the case despite the fact that procurement in Malawi is regulated, and according to Boe and Kvalvik (2015), regulating procurement allows to make efficient use of public finances. For public expenditure management to be effective, these supportive functions have to be flawless. Ajibolade and Oboh (2017:234) conclude that the Nigerian government has experienced less achievements through the budget system due to noncompliance to specifications in the budget and flouting of procurement procedures.

#### 6.3.2.7 Management issues

**Table 6. 13: Likert scales: Management issues**

| To what extent do you agree or disagree that the following management issues contribute to public expenditure management in the public district hospitals? On a scale ranging from Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2 to Strongly Disagree = 1. *(Please put a "circle" on a number representing your preferred answer. If you make a mistake, put an "X" across the circle and choose another answer).* |
| --- |

Factor analysis was carried out on management issues that affect public expenditure management in the public district hospitals in Malawi. In this section, the respondents were asked their views on management issues that were experienced by the district hospitals which had influences on public expenditure management. The set of statements under this section relating to management issues that were looked at are lack of fiscal discipline by the management; management is not accountable to expenditure of public funds; there is lack of monitoring of finances; management does not consult on resource allocations; and there is no autonomy over finances. A mean of 3.2421 and a standard deviation of 1.09982 were obtained through the factors on management issues. This mean reflects an inclination towards a higher end of the Likert scale of above 3 in Table 6.13.

In support, Obiwuru *et al.* (2011:102) uphold the thinking that leadership/management has potential to influence organisational performance. In addition, Nguyen *et al.* (2021:1863) found that management commitment is essential to financial management. Furthermore, Coovadia *et al.* (2009:817) establish that management challenges and leadership failures have contributed to poor health outcomes.

**6.3.2.8 Strategies for improved funding in the public district hospitals**
**Table 6. 14: Likert scales: Strategies for improved funding**

| The following are recommendations for improvement of public expenditure management in the public district hospitals. To what extent would you agree or disagree with each of the following recommendations on a scale ranging from Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2 to Strongly Disagree = 1. *(Please put a "circle" on a number representing your preferred answer. If you make a mistake, put an "X" across the circle and choose another answer).* |
|---|

A factor analysis was carried out on strategies for improved funding in the district hospitals in Malawi. The strategies for improved funding include introducing fee paying sections in the hospitals; lobbying for increased budgetary allocation; and enhancing revenue generating capacity of hospitals. A mean of 4.3709 and a low standard deviation of 0.71649 were confirmed through the factor strategies for improved funding. This mean indicates an inclination towards a higher end of the Likert scale of above 4 in Table 6.14.

Chu *et al.* (2019:33) confirm that for health systems to be strong there is need for it to be financed sustainably including the strengthening of domestic funding. This implies that these strategies can improve funding in the public healthcare sector and that affect could enhance the availability of finances and, therefore, the management of expenditure.

**6.3.2.9 Strategies for effective management of public expenditure**
**Table 6. 15: Likert scales: Strategies for effective management of public expenditure**

| The following are recommendations for improvement of public expenditure management in the public district hospitals. To what extent would you agree or disagree with each of the following recommendations on a scale ranging from Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2 to Strongly Disagree = 1. (Please put a "circle" on a number representing your preferred answer. If you make a mistake, put an "X" across the circle and choose another answer). |
|---|

A factor analysis was carried out on strategies for effective management of public expenditure and aimed at enhanced public expenditure management in the public health sector in Malawi. The strategies that were identified to improve public expenditure in the district hospitals include improve the formula used in allocating government funding to hospitals; enhance capacity of oversight functions; provide training to staff; enhance cost cutting in non-priority areas; enhance use of ICT in production of reports; consult on budget and funds allocation; increase funding for hospitals; hospitals should be able to easily move funds from one budget item to the other due to the nature of their operations; full devolvement from central government to District Councils; improve quality and availability of financial information to monitor public spending; foster constructive dialogue with the civil society; and strengthen the performance management system. A mean of 4.3249 and a low standard deviation of 0.57812 were confirmed through the factor strategies for effective management of public expenditure. This mean indicates an inclination towards a higher end of the Likert scale above 4 in Table 6.15.

Regarding the implementation of strategies aimed at enhancing public expenditure management, Allen and Tommasi (2001:25) note that public expenditure management is country-specific, and such strategies should be developed having evaluated the country's public expenditure management environment. This implies that the respondents feel that implementation of the enlisted strategies would enhance public expenditure management in the healthcare sector. This shows that there are diverse opportunities for enhancement of public expenditure management.

### 6.4 Descriptive statistics for research variables

The following sections discuss the responses to the questions in the questionnaire and are discussed based on the descriptive statistics generated. Apart from the quantitative data analysis, the discussions also incorporated qualitative data results and findings from literature.

#### 6.4.1 The funding situation in the public health delivery sector in Malawi

This section presents an analysis of the descriptive statistics of the funding situation in Malawi. Specifically, the analysis covers sources of funding for the public district hospitals and the challenges that public district hospitals experience in relation to the funding sources. There are two sub-sections in the section: sources of funding for the public district hospitals; and the challenges that funding sources presents to the district hospitals.

##### 6.4.1.1 Funding sources

This sub-section presents findings on the sources of funding in the public health delivery sector in Malawi. The sources of funding that were looked at are: government, donor funding/funding

from implementation partners, Council and patients' contribution and respondents were asked to state their confirmation as to whether they agree or not that the stated was indeed a source of funding for their hospital. Public healthcare delivery sectors experience multiple sources of funding as evidenced by (Akortsu & Abor, 2011:128). For instance, Abor and Abor (2020:565) state that the health sector in Ghana is financed by the government, donors, the national health insurance scheme, and patients' contributions. This is because they need to supplement the traditional funding source, the government funding which is usually not adequate.

#### 6.4.1.1.1 Government funding

The study reveals that public district hospitals in Malawi are funded by the government. Figure 6.2 shows that a large percentage of 84.7% of the respondents agreed (26.8% agree; 57.9% strongly agree) that the public district hospitals are funded by the government. The qualitative results also identified government as a certain source of funding the public healthcare sector.

These findings are supported by (Rao, 2018:113; Yefriza, 2015:148) who hold that the government has responsibility over funding in the public healthcare sector. This means that governments have a duty towards its citizens to provide access to healthcare. Despite being a sure source of funding, the government does only fund about a third of the hospital budget. This is confirmed by the qualitative study results and Micah *et al.* (2019:1) who explain that government funding towards healthcare in the Sub Saharan African is basically a third of the total budget for the healthcare sector. The need for multiple sources of funding, therefore, is imperative to supplement the funding.

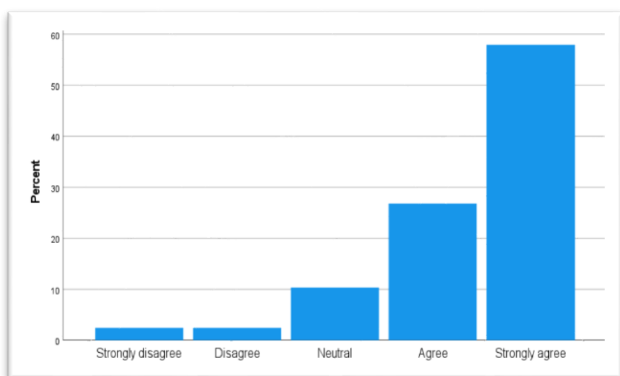



**Figure 6.2: Government funding**

**Source:** Survey data

#### 6.4.1.1.2 Donor funding/ funding from implementing partners

Public district hospitals also get their funding from donors or implementing partners. As depicted in Figure 6.3, respondents pointed out that the public district hospitals are funded by donors or implementing partners. The results confirm that district hospitals are funded by donors or implementing partners as decided by 70.1% of respondents (43% strongly agree; 27.15 agree).

Borghi *et al.* (2018:60) confirm that district hospitals in Malawi are funded by donors. The low-income generation capacity of most governments, especially in developing countries necessitates integrated funding sources. In most countries, donors have been funding various activities including health. In support of the findings, Akortsu and Abor (2011:128) confirm that the public health sector in Ghana is as well dependent on donor funding.

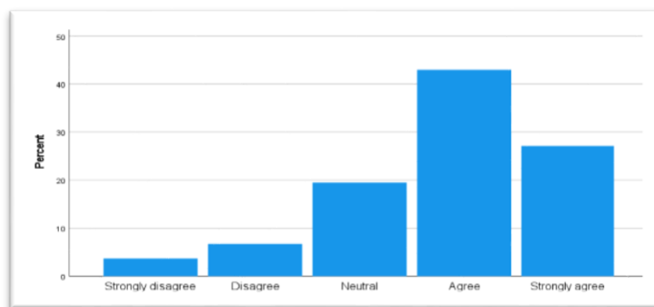



**Figure 6.3: Funding from donors and implementing partners**

**Source:** Survey data

#### 6.4.1.1.3 Council funding

Figure 6.4 indicates the position of respondents on hospitals being funded by Council. The results show that majority of respondents 42.7% disagree (25.9% strongly disagree; 16.8% disagree that district hospitals are funded by Councils. On the other hand, 37.5% of the respondents agree (22.0 agree; 15.5% strongly agree) and 19.8% were not decided as to whether district hospitals are funded by Councils. These findings agree with the qualitative results wherein participants indicated that policy provides that Councils should also fund the sectors under them, which includes the health sector. However, Councils are challenged on income earning capacity as such they fail to extend financing to the district hospitals. However, there is mixed practice in the funding aspect from Councils which probably explains the close scores for respondents agreeing and those that are disagreeing on Council as a source of funding. In some cases, the District Commissioner, who is the Controlling Officer for the Councils may decide to fund the hospitals. This point of view emerged from the qualitative data as well that for hospitals to be funded by the

Councils own generated income was dependent on the attitude of the Councils' Controlling Officer, the District Commissioner. On the other hand, there are also those officers who opine that Councils fund hospitals. They may hold this position as practically all the management and disbursement of funds is done at the Council offices and that health sector funding is co-managed with Council.

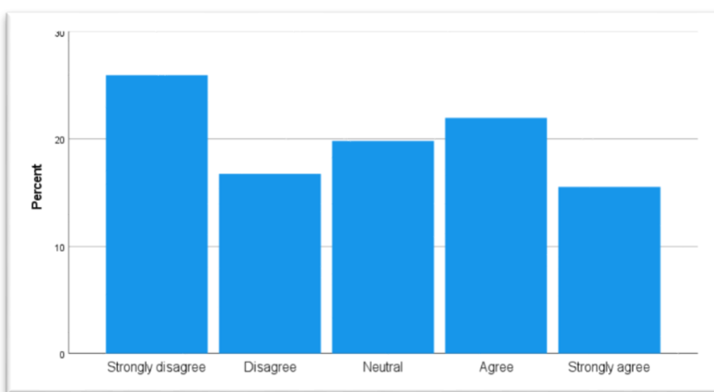



**Figure 6. 4: Funding from Councils**

**Source:** Survey data

#### 6.4.1.1.4 Funding from patients' contributions

Figure 6.5 presents findings in terms of respondents' position of patients' contribution as a source of funding to the hospitals. As can be deduced from the graph, the majority, 77.5%, (65.9% strongly disagree; 11.6% disagree) of the respondents indicate that hospitals are not funded by financial contributions from patients. Whilst only 12.5% viewed patients' contributions as sources of funding (6.1% agreed; 6.4% strongly agreed and 10.1% were non-committal on patients' contribution being a source of funding for the hospitals. This is the case as currently, access to healthcare in the public district hospitals in Malawi is non-contributory. Thus, the patients get healthcare at 'technically' no cost to them.

These findings concur with those of Akortsu and Abor (2011:128), where patients' contributions for healthcare services were not found to be part of the sources of funding in Ghana. Regardless, a few public district hospitals are introducing or contemplating to introduce paying sections in the facilities. Consideration of patients' contribution as a source of funding is supported by results of this study as presented in section 6.4.9.1, where 78.4% of participants are of the view that district hospitals should introduce private sections in the district hospitals as one way of generating own income.

The respondents were then asked to state their extent of agreement or disagreement with the listed challenges relating to funding in the district hospitals.

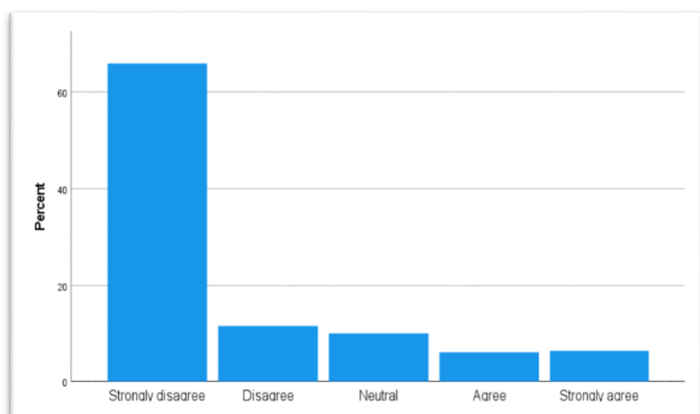



**Figure 6. 5: Funding from patients' contribution**

**Source:** Survey data

#### 6.4.1.2 Challenges/limitations faced with the funding sources

This section presents study results on the challenges that district hospitals face with the current sources of funding. The challenges that were explored are late government funding, declining donor funding, inadequate government funding, donor funding is provided with specific instructions for its use and weak income generation capacity of Councils.

##### 6.4.1.2.1 Inadequate financial resources

Overall, the respondents agreed that public district hospitals receive inadequate finances for healthcare delivery. Inadequate funding is an issue of concern as 90.9% of the respondents as shown in Figure 6.6, agree that it is one of the resource allocation challenges.

In support of these findings, a number of studies have mentioned that the public healthcare sector is insufficiently funded (Akortsu & Abor, 2011:129; Grigoli & Kapsoli, 2018:384; Kiross *et al.*, 2020:5; Piatti-Fünfkirchen *et al.*, 2020:ix). Thus, insufficient funding is a resource allocation issue that affect expenditure management. Public health facilities need sufficient resources in order for them to meet the ever-increasing demand for healthcare. In addition, inadequate resources affect staff morale (Chimwaza *et al.*, 2014:9).

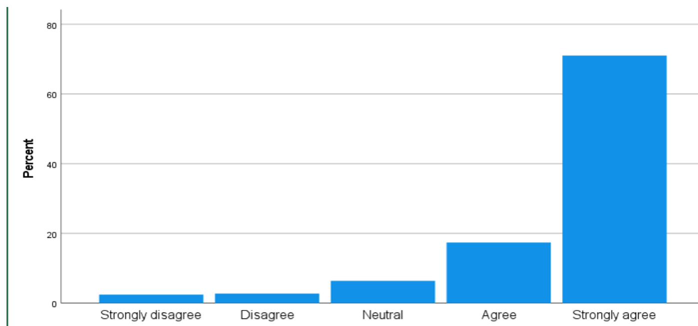



**Figure 6. 6: Inadequate funding**

**Source:** Survey data

**6.4.1.2.2 Late government funding**

In Figure 6.7, study results indicate that hospitals receive government funding late. This is supported by a majority (86.65%: 31.4 agree; 55.2 strongly agree) of the respondents who are in agreement with the statement that government funding is received late by the hospitals.

These findings are supported by results from the qualitative study in chapter 5 and studies by (Akortsu & Abor, 2011:128; Frumence *et al.*, 2013:20983; Piatti-Fünfkirchen *et al.*, 2020:v) who point out that public health facilities receive funding late which affect discharge of operations.

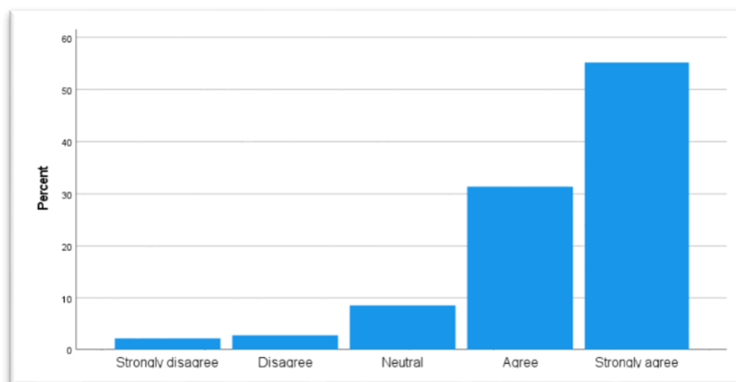



**Figure 6. 7: Late government funding**

**Source:** Survey data

**6.4.1.2.3 Declining donor funding**

The results of the study reveal that district hospitals are experiencing declining donor funding. Figure 6.8 shows that the majority of the respondents (70.7%) (34.1% agree; 36.6 strongly agree) are in agreement that donor funding to the hospitals is declining. These findings are supported by the qualitative study results presented in chapter 5. In support of the findings, Gotsadze *et al.*

(2019:258) note that there is declining donor funding in the health sector. As an example of declining donor funding, Shretta *et al.* (2017:258) found out that donor funding for malaria has been declining from 2010 and continue to do so.

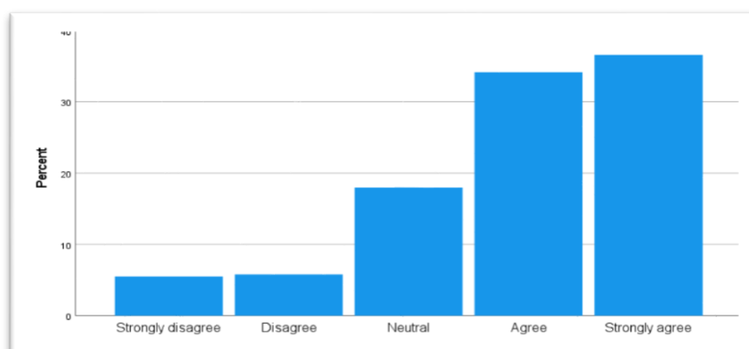



**Figure 6. 8: Declining donor funding**

**Source:** Survey data

#### 6.4.1.2.3 Inadequate government funding

The results of the study as presented by Figure 6.9 indicate that district hospitals receive inadequate funding from the government. A large proportion of the respondents (88.4%) were in agreement (17.4% agree; 71.0 strongly agree) that inadequate funding in district hospitals is a challenge.

These findings are supported by the findings of (Ashiabi *et al.*, 2016:1386; Boachie *et al.*, 2018:62; Frumence *et al.*, 2013:20983; Grigoli & Kapsoli, 2018:384; Piatti-Fünfkirchen *et al.*, 2020:ix) where they confirm that public healthcare facilities are underfunded thereby crippling their operations. Thus, the one third that the government provides to the hospitals barely covers health operations. This may explain the need for multiple sources of funding for district hospitals.

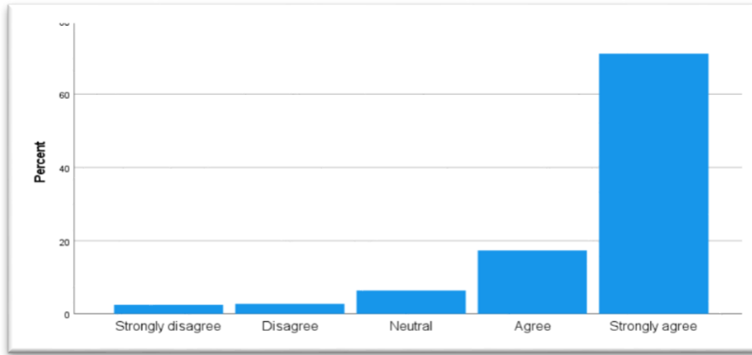



**Figure 6. 1: Inadequate government funding**

**Source:** Survey data

#### 6.4.1.2.4 Donor funding is provided with specific instructions for its use

The results of this study reveal that district hospitals face challenges with donor funding, especially when the donors stipulate the use for the resources they provide to the health facilities. Figure 6.10 indicates that the majority of the respondents (82.9%) were in agreement (29.3% agree; 53.7% strongly) that the funding they get from donors comes with conditions for its use. This entails that such funding can only address the areas of preference that donors have and not any other needs of the hospital. This means that such funding is restricted for the hospitals.

These findings are supported by Cashin *et al.* (2017:27) as they point out that health funding from donors usually comes along with prescriptions for its application. However, Abor and Abor (2020:268) are of the view that donor funding should be targeted but emphasise the need for coordination so that duplications in resource allocation for the same areas could be avoided.

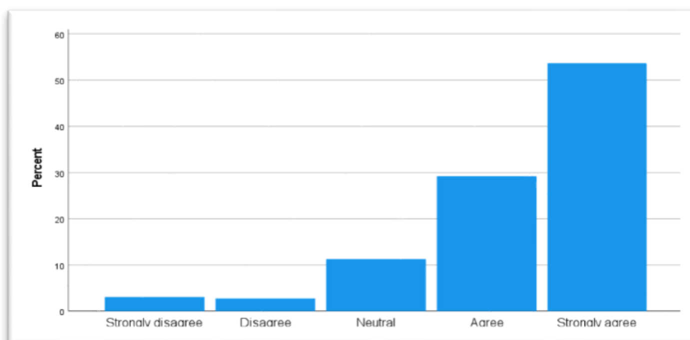



**Figure 6. 2: Earmarked donor funding**

**Source:** Survey data

#### 6.4.1.2.5 Weak income generation capacity of Councils

Table 6.11 presents the degree of agreement or disagreement to the statement that Councils have a weak generation capacity as such fails to extend funding to the district hospitals. The study findings suggest that Councils have a weak capacity to generate income and, therefore, fail to extend funding to the hospitals. This was the position of 76.5% respondents (18.9% agreed; 57.6% strongly agreed).

These results concur with the qualitative findings presented in Chapter 5, wherein participants felt that despite that the health sector at district level are under the umbrella of Councils, the Councils have a weak revenue earning capacity and hence, fail to extend funding to the hospitals. In further support of the findings, Frumence *et al.* (2013:20987) found that district councils in Tanzania could not ably support the health sector as they had inadequate finances which was as a result of lack of sources from where they could generate revenue.

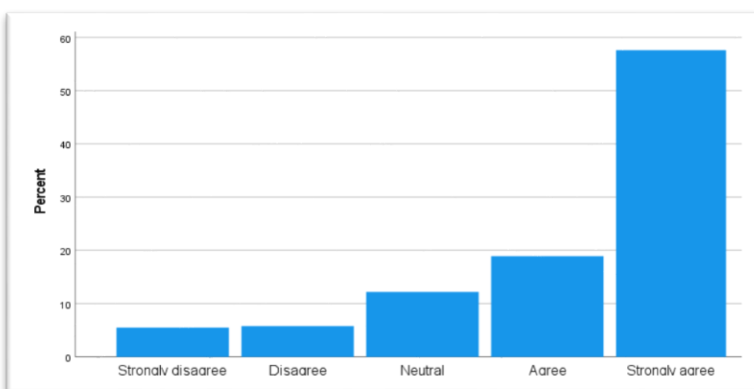



**Figure 6. 3: Weak income generation capacity of Councils**

**Source:** Survey data

### 6.4.2 Resource allocation challenges

#### 6.4.2.1 Inadequate financial resources

Overall, the respondents agreed that public district hospitals receive inadequate finances for healthcare delivery. Despite the fact that public hospitals have multiple sources of funding, mainly donors and the government, hospitals are cash strapped. Inadequate funding is an issue of concern as 90.9% of the respondents as shown in Table 6.16, agree that it is one of the resource allocation challenges. In support of these findings, a number of studies have mentioned that the public healthcare sector is insufficiently funded (Grigoli & Kapsoli, 2018:384; Kiross *et al.*, 2020; Piatti-Fünfkirchen *et al.*, 2020:ix). Thus, insufficient funding is a resource allocation issue that

affect expenditure management. Public health facilities need sufficient resources in order for the to meet the ever-increasing demand for healthcare.

**Table 6. 16: Inadequate financial resources**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 7 | 2.1 |
| Disagree | 4 | 1.2 |
| Neutral | 19 | 5.8 |
| Agree | 81 | 24.7 |
| Strongly agree | 217 | 66.2 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.2.2. Late government funding

Overall, the respondents were of the position that late provision of funding by the government is a challenge that public hospitals face. As presented in Table 6.17, respondents (85.7%) agreed that funding to the hospitals is usually late. Late funding for the public healthcare sector has been echoed by (Akortsu & Abor, 2011:128; Piatti-Fünfkirchen *et al.*, 2020:v).

**Table 6. 17: Late government funding**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 10 | 3.0 |
| Disagree | 11 | 3.4 |
| Neutral | 26 | 7.9 |
| Agree | 98 | 29.9 |
| Strongly agree | 183 | 55.8 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.2.3 Misallocation of resources

For the most part the respondents felt that the misallocation of resources influences management of expenditure in the public district hospitals. As portrayed by Table 6.18, respondents (58.8%) were of the view that public expenditure management is affected by the misallocation of resources that take place in the district hospitals whilst 23.2% chose to neither agree nor disagree.

The findings are supported by various researchers. For instance, Ajibolade and Oboh (2017:224) point out that the budget has been used to mismanage resources in Nigeria. To strengthen this thinking, Capuno *et al.* (2018:94) hold that effective processes in budgeting is a recipe for healthy spending. This entails that the budget, is an expenditure management tool, and if properly produced and managed can assist in achieving effective allocation of resources.

**Table 6. 18: Misallocation of resources**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 30 | 9.1 |
| Disagree | 29 | 8.8 |
| Neutral | 76 | 23.2 |
| Agree | 87 | 26.5 |
| Strongly agree | 106 | 32.3 |
| Total | 328 | 100.0 |

**Source:** Survey data

**6.4.2.4 Budget planning and preparation suffer from burdensome requirements arising from underfunding**

The results of the study suggest that budget planning and preparation suffer from cumbersome requirements that arise from underfunding and consequently affect management of public expenditure in the sector. As deduced from Table 6.19, respondents (80.2%) are in agreement that chronic underfunding in the sector affect planning and preparations of budgets.

The qualitative results in chapter 5 confirm this state of affairs, since with so much need for finance yet less being made available, budgeting planning and preparation become arbitrary. This practice impacts on management of resources since the allocated figures are not in sync with the resource needs on the ground. These results are supported by Le Gargasson *et al.* (2014:1040) where they state that the persistent underfunding in the sector leads to lack of motivation in budget preparation and implementation. The consequence of this is that budget management becomes challenged and thus gives rise to ineffective expenditure management.

**Table 6. 19: Budget planning and preparation**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 6 | 1.8 |
| Disagree | 15 | 4.6 |
| Neutral | 44 | 13.4 |
| Agree | 84 | 25.6 |
| Strongly agree | 179 | 54.6 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.3 Staff challenges

#### 6.4.3.1 Staff shortages compromise processing of transactions and reporting

The findings suggest that district hospitals in Malawi experience staff shortages that lead to compromise in processing of transactions and reporting. This was the position of 65.2% of the respondents to the study as presented in Table 6.20. Processing of financial transactions demands compliance to set procedures like segregation of duties which may not be achieved if the appropriate number of staff is not made available.

These findings are supported by related studies in the area, for instance, Myende *et al.* (2018:2) explain that staff shortages have resulted in disregard of laid down financial management procedures where roles overlap on personnel and hence disregarding internal controls.

**Table 6. 20: Staff shortages compromise processing of transactions and reporting**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 16 | 4.9 |
| Disagree | 34 | 10.4 |
| Neutral | 64 | 19.5 |
| Agree | 107 | 32.6 |
| Strongly agree | 107 | 32.6 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.3.2 Staff shortages cause irregular deployment of personnel

The results reveal that the health sector is challenged by lack of adequate staff as such this encourages irregular deployment of staff. As presented in Table 6.21, respondents (67.7%) affirmed to the statement that the hospitals face staff shortages, and this causes the hospitals to deploy personnel irregularly.

The qualitative results presented in Chapter 5 demonstrated that the health sector faces staff shortages and these impact on expenditure management. The effect of these on expenditure management arises as the shortages have to be managed by recruiting short term and emergency staff whose cost is usually unbudgeted for. In support, Chimwaza *et al.* (2014:20) found out that due to staff shortages, personnel work extra hours and expect compensation, which strains the hospitals' cash flows.

**Table 6. 21: Staff shortages cause irregular deployment of personnel**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 19 | 5.8 |
| Disagree | 30 | 9.1 |
| Neutral | 57 | 17.4 |
| Agree | 108 | 32.9 |
| Strongly agree | 114 | 34.8 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.3.3 Staff incompetence

The results of the study suggest that respondents were divided on the view of staff incompetence versus public expenditure management. This is the case as overall figures presented in Table 6.22 were spread where 39.1% of respondents agreed that the district hospitals had staff who were incompetent and their incompetence affected public expenditure management, 36.2% disagree that staff in the district hospitals were incompetent and 24.75% of the respondents were neutral in expressing their views.

However, in related studies, a study by Frumence *et al.* (2013:20983) found that Tanzania was facing challenges in its finance management due to lack of competent staff.

**Table 6. 22: Staff incompetence**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 49 | 14.9 |
| Disagree | 70 | 21.3 |
| Neutral | 81 | 24.7 |
| Agree | 74 | 22.6 |
| Strongly agree | 54 | 16.5 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.3.4 Lack of performance appraisal

The results suggest the district hospitals are not effective in undertaking performance appraisals of its personnel. Table 6.23 indicates that 67.7% of the respondents were of the view that lack of performance appraisals for staff affect expenditure management in the district hospitals.

In support of the findings, Dieleman *et al.* (2006:2) found that Mali had ineffective staff appraisals and this was seen to affect motivation and performance.

**Table 6. 23: Lack of performance appraisal**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 10 | 3.0 |
| Disagree | 22 | 6.7 |
| Neutral | 64 | 19.5 |
| Agree | 92 | 28.0 |
| Strongly agree | 140 | 42.7 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.3.5 Delays in disciplining staff

The results suggest that respondents were of the view that district hospitals experience delays in disciplining staff in the district hospitals and, consequently, affect expenditure management. the figures presented in Table 6.24 indicate that respondents (53.6%) agree that there are delays in disciplining staff and this impacts on expenditure management whilst 28% are neutral. These results confirm to the qualitative study results obtained in Chapter 5, where participants alluded to the fact that an important factor affecting public expenditure management is that the public sector takes long to bring to book staff who have contravened provisions of the Public Financial

Management and the Public Procurement and Disposal Acts. In support of these findings, Allen and Tommasi (2001:26) stress that as a way of strengthening public expenditure management, perpetrators should be punished as soon as the perpetrations take place.

**Table 6. 24: Delays in disciplining staff**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 26 | 7.9 |
| Disagree | 34 | 10.4 |
| Neutral | 92 | 28.0 |
| Agree | 92 | 28.0 |
| Strongly agree | 84 | 25.6 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.3.6 Corrupt employees

The results suggest that employees in the district hospitals are corrupt, and this has an effect on management of public expenditure. Overall, as depicted in Table 6.25, respondents (58.2%) hold that employees in the district hospitals are corrupt. In support of the findings, Souliotis *et al.* (2016:160) explain that due to limitations in resources and low morale amongst staff, corruption creeps in and affects expenditure management negatively. It has been found that as hospitals are provided with inadequate resources, corruption becomes rampart. In addition, Allen and Tommasi (2001:26) state that corruption is a major source of inefficiencies in public expenditure management.

**Table 6. 25: Corrupt employees**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 26 | 7.9 |
| Disagree | 38 | 11.6 |
| Neutral | 73 | 22.3 |
| Agree | 82 | 25.0 |
| Strongly agree | 109 | 33.2 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.3.7 Lack of staff morale

The results reveal that there is lack of staff morale in the public district hospitals. Table 6.26 shows that 79% of the respondents are of the view that staff lack morale which affect expenditure management. In support of these findings, (Capuno *et al.*, 2018:3; Souliotis *et al.*, 2016:160) explain that limitations in resources and low morale amongst staff, could encourage corruption among the employees and, consequently, negatively affecting expenditure management. Furthermore, poor motivation contributes to low service delivery especially in low income countries (Songstad *et al.*, 2012:33). In addition, inadequate resources affect staff morale (Chimwaza *et al.*, 2014:9).

**Table 6. 26: Lack of staff morale**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 10 | 3.0 |
| Disagree | 16 | 4.9 |
| Neutral | 43 | 13.1 |
| Agree | 104 | 31.7 |
| Strongly agree | 155 | 47.3 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.3.8 Lack of staff integrity

The figures in Table 6.27 highlight that 60.7% of respondents were in agreement that staff in the public district hospitals lack integrity, which affect management of public expenditure. This finding coupled with lack of staff morale can only render the management of expenditure inefficient and ineffective. In support of this finding, Johari *et al.* (2021:1217) explain that lack of integrity amongst staff causes poor governance, lack of compliance to procedures, fraud and, consequently, poor financial management.

**Table 6. 27: Lack of staff integrity**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 16 | 4.9 |
| Disagree | 31 | 9.5 |
| Neutral | 82 | 25.0 |
| Agree | 105 | 32.0 |
| Strongly agree | 94 | 28.7 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.3.9 Poor rapport with colleagues and superiors

The results on poor rapport with colleagues and superiors as influencing expenditure management presents mixed positions; none of the positions is decisive on its own. No category of respondent as shown in Table 6.28 is above 50% to decide majority position. This result, therefore, can be interpreted that there is no poor rapport amongst staff and, therefore, this may not be an issue.

**Table 6. 28: Poor rapport with colleagues and superiors**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 36 | 11.0 |
| Disagree | 61 | 18.6 |
| Neutral | 101 | 30.8 |
| Agree | 88 | 26.8 |
| Strongly agree | 42 | 12.8 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.4 Financial management challenges

#### 6.4.4.1 Excessively complicated administrative procedures

The study results as depicted in Table 6.29 suggest that the district hospitals are bureaucratic in processing transactions. This is a position of 57.6% of respondents who expressed that the hospitals administrative procedures are excessively complicated. This is most likely the case as a way of enhancing controls in public sector management in general. According to Frumence *et al.* (2014:11), Tanzania as well as Botswana experience bureaucratic procedures in funds processing.

**Table 6. 29: Excessively complicated administrative procedures**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 25 | 7.6 |
| Disagree | 36 | 11.0 |
| Neutral | 78 | 23.8 |
| Agree | 110 | 33.5 |
| Strongly agree | 79 | 24.1 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.4.2 Poor control of expenditures

The figures in Table 6.30 highlight that 65% of the respondents pointed out that there is poor control of expenditures in the district hospitals. This is surprising, as section 6.5.3.1 discusses the rigid and administratively cumbersome processing procedures in the sector which are aimed at enhancing controls but in contrast, the hospitals have been rated highly in poorly controlling expenditures. The findings are supported by Rangongo *et al.* (2016:1) in their studies.

**Table 6. 30: Poor control of expenditures**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 12 | 3.7 |
| Disagree | 39 | 11.9 |
| Neutral | 59 | 18.0 |
| Agree | 111 | 33.8 |
| Strongly agree | 107 | 32.6 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.4.3 Weak financial management system

The overall figures highlight that although public financial management in the public sector is highly regulated, the financial management system is weak. This is the position as Table 6.31 indicates that 60.8% of the respondents agreed that the financial management system is weak. According to Ball (2020:660), weak public financial management systems lead to poor financial management decisions.

**Table 6. 31: Weak financial management system**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 20 | 6.1 |
| Disagree | 40 | 12.2 |
| Neutral | 69 | 21.0 |
| Agree | 92 | 28.0 |
| Strongly agree | 107 | 32.6 |
| Total | 328 | 100.0 |

**Source:** Survey data

**6.4.4.4 Lack of compliance with set procedures**

The figures highlight that district hospitals do not wholly comply with set procedures. Table 6.32 shows that 57.9% of the respondents were of the position that there is a lack of compliance with set procedures, which has an effect on the management of expenditure. A study by Ibrahim *et al.* (2017:370) support these findings.

**Table 6. 32: Lack of compliance with set procedures**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 25 | 7.6 |
| Disagree | 38 | 11.6 |
| Neutral | 75 | 22.9 |
| Agree | 102 | 31.1 |
| Strongly agree | 88 | 26.8 |
| Total | 328 | 100.0 |

**Source:** Survey data

**6.4.4.5 Weaknesses in financial reporting**

The study results suggest that the financial reporting system in the district hospitals is weak. This is evidenced by 57% of the respondents in Table 6.33 who affirmed that there are weaknesses in the financial reporting in the district hospitals. This concurs with the findings in section 6.4.4.6 where respondents felt that there was inadequate flow if financial information. In support, Fofie (2016:296) argues for effective financial reporting in the course of managing public finances.

**Table 6. 33: Weaknesses in financial reporting**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 19 | 5.8 |
| Disagree | 35 | 10.7 |
| Neutral | 87 | 26.5 |
| Agree | 92 | 28.0 |
| Strongly agree | 95 | 29.0 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.4.6 Inadequate flow of information

The results indicate that the district hospitals are challenged with inadequate flow of information. This is the position of 67.7% of respondents as presented in Table 6.34 who indicated that the flow of financial information in the district hospitals is inadequate. As observed in section 6.4.4.5, the stated poor financial reporting agrees with this observation for insufficient flow of information. In support, Redmayne and Vašiček (2021:85) stress that financial reporting is crucial for financial monitoring and management and that financial reporting affirms quality in the public sector and is vital for performance improvements (Tran *et al.*, 2021:106806).

**Table 6. 34: Inadequate flow of information**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 16 | 4.9 |
| Disagree | 27 | 8.2 |
| Neutral | 63 | 19.2 |
| Agree | 123 | 37.5 |
| Strongly agree | 99 | 30.2 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.4.7 Weak capacity in external and internal audit functions

The findings in the study suggest that the external and internal audit functions in the district hospitals are very weak. Table 6.35 shows that 72.2% of the respondents affirm that there is weak capacity of the external and internal audit functions. This agrees with the qualitative findings where participants pointed out that the internal and external audit functions are short staffed to an extent some districts do not completely have internal auditors. Further, the qualitative results indicate that due to the shortages, external auditors are outsourced but lamented that audit

emphasis differ which may not be ideal for public sector auditing. These results are supported by (Mahyoro & Kasoga, 2021:1009; Ștefănescu & Trincu-Drăgușin, 2020:778).

**Table 6. 35: Weak capacity in external and internal audit functions**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 11 | 3.4 |
| Disagree | 16 | 4.9 |
| Neutral | 64 | 19.5 |
| Agree | 109 | 33.2 |
| Strongly agree | 128 | 39.0 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.5 Political challenges

#### 6.4.5.1 Directives from central government to the hospitals

The results suggest that district hospitals suffer from directives emanating from the central government to the hospitals where hospitals are made to undertake activities not in their plans. Such directives impact on expenditure management as expenses have to be incurred outside set plans. Table 6.36 shows that 70.1% of responds attested to the challenge that central government directives occur where the hospitals are directed to undertake activities that they never planned. These results agree with the findings of the qualitative study discussed in Chapter 5, where participants lamented that government directives affect management of public expenditure. These findings are supported by Frumence *et al.* (2013:20992) on government interference.

**Table 6. 36: Directives from central government to the hospitals to undertake unplanned activities**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 23 | 7.0 |
| Disagree | 27 | 8.2 |
| Neutral | 48 | 14.6 |
| Agree | 90 | 27.4 |
| Strongly agree | 140 | 42.7 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.5.2 Lack of political will

The results indicate that there is no political will from the government to enhance health sector status. This is the case as Table 6.37 shows that to 68.3% of respondents agree that there is no political aimed at uplifting the situation in the district hospitals. In support, studies by (Gambo *et al.*, 2019:11; Yefriza, 2015:148 ) confirm that the health sector is challenged by lack of political will which affect management of public expenditure. This means that if there was political will, budgetary allocations to the sector would have reasonably improved, oversight functions could have been strengthened and staff shortages among other shortfalls could have been addressed.

**Table 6. 37: Lack of political will**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 23 | 7.0 |
| Disagree | 24 | 7.3 |
| Neutral | 57 | 17.4 |
| Agree | 98 | 29.9 |
| Strongly agree | 126 | 38.4 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.5.3 Partial decentralisation of Councils

The results indicate that the partial decentralisation of the Councils has an effect on public expenditure management in the healthcare sector. Table 6.38 shows that 69.2% of the respondents were of the view that the Councils are not fully decentralised, and this has a bearing on the management of expenditure in the sectors under the Council in general and specifically for the health sector. In support of these findings, studies by (Gambo *et al.*, 2019:11; Yefriza, 2015:148 ) confirm that the health sector is challenged by disintegrated public sector management structures which affect management of expenditure; and in this case the disintegration is not even full. This is the case of dual management as discussed under section 6.4.5.4.

**Table 6. 38: Partial decentralisation of Councils**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 13 | 4.0 |
| Disagree | 28 | 8.5 |
| Neutral | 60 | 18.3 |
| Agree | 97 | 29.6 |
| Strongly agree | 130 | 39.6 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.5.4 Hospitals are managed by both the Council and Ministry resulting in dual management

The results demonstrate that hospitals are managed by both Councils and the government, and this affects management of expenditure. Table 6.39 shows that 71% of the respondents felt that the dual management of hospitals by both the Council and the Ministry affects public expenditure management in the hospitals. As pointed out in section 6.4.5.3 the Councils do not have full control over the hospitals. In support of these findings, a study in Indonesia found that sector management is more directed by the central government (Heywood & Harahap, 2009:17).

**Table 6. 39: Dual hospital management**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 25 | 7.6 |
| Disagree | 20 | 6.1 |
| Neutral | 50 | 15.2 |
| Agree | 87 | 26.5 |
| Strongly agree | 146 | 44.5 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.6 Legislative weaknesses

#### 6.4.6.1 Lack of compliance with legislative provisions

The results suggest that there is a lack of compliance with legislative provision in the district hospitals. Table 6.40 shows 56.4% of the respondents to the study agreed that there is a lack of compliance with legislative provisions in the district hospitals, and that this situation has an effect on public expenditure management. In support of these findings, a study by Kontogeorga (2017:153) found that Greece experiences weak legal enforcement and monitoring, unclear and

ambiguous provisions of public financial management which leads to non-compliance. This entails that if the factors that lead to non-compliance are addressed, the public sector generally and the health sector would improve in terms of compliance.

**Table 6. 40: Lack of compliance to legislative provisions**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 13 | 4.0 |
| Disagree | 36 | 11.0 |
| Neutral | 94 | 28.7 |
| Agree | 128 | 39.0 |
| Strongly agree | 57 | 17.4 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.6.2 Legislative provisions for penalties are not deterrent enough

Table 6.41 shows that respondents slightly above half (50.9%) were of the view that the legislative provision for penalties is not a sufficient deterrent to ensure that employees are keen to achieve effective and efficient public expenditure management. 33.5% are undecided as to whether the penalties in place are deterrent enough or not. The results agree with the qualitative findings where participants pointed out that disciplinary actions that are meted out to offenders for financial crimes are not preventive enough. Thus, the position is that the legislative provisions are not strong enough to prevent potential offenders from committing crimes related to financial management, as such public expenditure management continues to suffer. Having established in section 6.4.3.8 that staff on the sector lack integrity, the penalties should have been strong enough at least to act as punitive measures for dishonest staff.

**Table 6. 41: Legislative provisions for penalties are not deterrent**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 14 | 4.3 |
| Disagree | 37 | 11.3 |
| Neutral | 110 | 33.5 |
| Agree | 100 | 30.5 |
| Strongly agree | 67 | 20.4 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.6.3 Legal provisions have inconsistencies

This question asked on whether respondents agree or not with the statement that legal provisions that govern management of finances have inconsistencies. Respondents were divided on this question. As can be deduced from Table 6.42, only 17%.1% disagreed; 35.4% were indifferent to; and 47.6% agreed with the statement legal provisions have inconsistencies which affect management of public expenditure in the hospitals. Regardless, findings of a study by Kontogeorga (2017:153) found that financial regulations in Greece experiences were unclear and ambiguous and this contributed to non-compliance.

**Table 6. 42: Legal provisions have inconsistencies**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 16 | 4.9 |
| Disagree | 40 | 12.2 |
| Neutral | 116 | 35.4 |
| Agree | 97 | 29.6 |
| Strongly agree | 59 | 18.0 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.6.4 Legal provisions have loopholes

The results indicate that legal provisions of the laws relating to financial management in Malawi have loopholes, and this affects management of public expenditure in the district hospitals. Table 6.43 shows that 59.5% of respondents concurred that there are legal provisions in the legal provisions governing financial management. In support of this finding, Kontogeorga (2017:153) states that the legal provisions governing public financial management in Greece is not clear and is ambiguous .

**Table 6. 43: Legal provisions have loopholes**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 16 | 4.9 |
| Disagree | 37 | 11.3 |
| Neutral | 80 | 24.4 |
| Agree | 118 | 36.0 |
| Strongly agree | 77 | 23.5 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.6.5 Legal framework is neither clear nor comprehensive

The study results indicate that respondents are divided as to whether the legal framework governing public financial management if clear as well as comprehensive. Table 6.44 shows that only 19.5% disagreed, 47% and 33.5% are indifferent to the statement that the legal framework is neither clear not comprehensive as such this affects management of expenditure management. Nevertheless, a study by Kontogeorga (2017:153) found that the financial legal framework in Greece is both unclear and ambiguous provisions of public financial management which leads to non-compliance.

**Table 6. 44: Legal framework is neither clear not comprehensive**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 24 | 7.3 |
| Disagree | 40 | 12.2 |
| Neutral | 110 | 33.5 |
| Agree | 96 | 29.3 |
| Strongly agree | 58 | 17.7 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.6.6 There is weak monitoring of compliance of legal provisions

The study findings suggest that monitoring of compliance to legal provisions is weak. As shown in Table 6.45, respondents (66.2%) agree that there is weak monitoring of compliance of legal provisions which affect management of public expenditure in the district hospitals. Kontogeorga (2017:153) point out that non-compliance to legal provisions is as a result of poor legal enforcement and monitoring, unclear and ambiguous provisions of public financial management.

**Table 6. 45: Weak monitoring of compliance of legal provisions**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 11 | 3.4 |
| Disagree | 28 | 8.5 |
| Neutral | 72 | 22.0 |
| Agree | 122 | 37.2 |
| Strongly agree | 95 | 29.0 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.6.7 There is weak enforcement of legal provisions

The findings suggest that there is weak enforcement of legal provisions in the district hospitals. Table 6.46 shows that 64.4% of the respondents to the study agreed that weak enforcement of legal provisions in the district hospitals affect management of public expenditure. In support of the findings, a study by Kontogeorga (2017:153) found that, among other issues, Greece experiences experience weak enforcement and monitoring of public financial management legal provisions which leads to non-compliance of the same.

**Table 6. 46: Weak enforcement of legal provisions**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 17 | 5.2 |
| Disagree | 24 | 7.3 |
| Neutral | 75 | 22.9 |
| Agree | 110 | 33.5 |
| Strongly agree | 102 | 31.1 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.7 Management challenges

#### 6.4.7.1 There is lack of fiscal discipline by management

For the most part, respondents felt that there is lack of fiscal discipline by management which affects public expenditure management. Table 6.47 shows that about half of the respondents (50.9%) were of the view that there is lack of fiscal discipline by management. This entails that management of public expenditure is compromised if the controllers lack discipline in managing finances. Obiwuru *et al.* (2011:101) explain that management's approach to resource management can influence employees' attitudes on how to use resources effectively and efficiently.

**Table 6. 47: Lack of fiscal discipline by management**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 33 | 10.1 |
| Disagree | 53 | 16.2 |
| Neutral | 75 | 22.9 |
| Agree | 100 | 30.5 |
| Strongly agree | 67 | 20.4 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.7.2 Management is not accountable to expenditure of public funds

Respondents were divided as regards the statement that management are not accountable for finances that they are entrusted with. Table 6.48 shows that no category of agree or disagree attained a majority of answers. The table shows that 44.9% agreed and 38.7% disagreed, whilst 16% were neutral to the fact that management is not accountable. However, in Indonesia, a study by Heywood and Harahap (2009:5) shows that as there is central government control, the district hospitals are held less accountable for performance. In addition, Boe and Kvalvik (2015:872), explain that to ensure effectiveness in resource utilisation, individuals should be made accountable for such resources.

**Table 6. 48: Management not accountable**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 57 | 17.4 |
| Disagree | 70 | 21.3 |
| Neutral | 54 | 16.5 |
| Agree | 75 | 22.9 |
| Strongly agree | 72 | 22.0 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.7.3 There is lack of monitoring of finances

The results of the study suggest that there is lack of monitoring of finances in the district hospitals that affect management of expenditure. Overall, as shown in Table 6.49, respondents (50.9%) felt that monitoring of finances is lacking in the district hospitals. In support of the findings, a study by Herbert (2007:256) established that there were poor budget monitoring and non-compliance with public financial management legal provisions and regulations. Similar observations were made by Frumence *et al.* (2013:20989). This observation complements section 6.4.4.5 where it

was found that reporting of finances is a challenge in the sector as without proper reporting, monitoring becomes difficult.

**Table 6. 49: Lack of monitoring of finances**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 53 | 16.2 |
| Disagree | 55 | 16.8 |
| Neutral | 53 | 16.2 |
| Agree | 101 | 30.8 |
| Strongly agree | 66 | 20.1 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.7.4 Management does not consult on resource allocations

For a large part, the respondents were divided on the statement that management does not consult on resource allocation. Table 6.50 shows that 38.1% disagreed; 48.8% agreed and 13.1% were neutral about management not consulting on resource allocations.

**Table 6. 50: Management does not consult**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 58 | 17.7 |
| Disagree | 67 | 20.4 |
| Neutral | 43 | 13.1 |
| Agree | 79 | 24.1 |
| Strongly agree | 81 | 24.7 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.7.5 There is no autonomy over finances

The findings indicate that respondents were divided on the issue of lack of autonomy over finances in the district hospitals. Table 6.51 shows that there is no majority position as 25.9% disagreed; 48.5% agreed and 25.6% were neutral to the statement that there is no autonomy over finances in the public district hospitals. However, in Indonesia, the position is clear as studies found out that despite the anticipated benefits of decentralisation, there is little discretion over finances in the district hospitals (Heywood & Harahap, 2009:5).

**Table 6. 51: Lack of autonomy over finances**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 34 | 10.4 |
| Disagree | 51 | 15.5 |
| Neutral | 84 | 25.6 |
| Agree | 82 | 25.0 |
| Strongly agree | 77 | 23.5 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.8 Procurement and supply chain management challenges

#### 6.4.8.1 Compromised procurement function

The findings from this study indicate that procurement functions in the district hospitals are compromised thereby, affecting management of public expenditure. Table 6.52 shows that 61.9% of the respondents felt that the procurement function is compromised. Botlhale (2017:293) found that weak capacity of the procurement personnel compromises the procurement function and is thus, a challenge for effective expenditure management.

**Table 6. 52: Compromised procurement function**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 21 | 6.4 |
| Disagree | 34 | 10.4 |
| Neutral | 70 | 21.3 |
| Agree | 100 | 30.5 |
| Strongly agree | 103 | 31.4 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.8.2 Funding challenges affect compliance to procurement plans

Most respondents were of the view that challenges that are experienced in funding affect the extent of compliance to procurement plans, thereby, affecting management of expenditure in the district hospitals. Table 6.53 indicates that the majority of the respondents (80.5%) felt that funding challenges that the district hospitals face affect compliance with procurement plans. The findings revealed that funding is usually insufficient in the public district hospitals, and therefore plans are difficult to follow through. These findings are supported by Botlhale (2017:293) who established that Botswana faces low adherence to procurement plans, and this can be explained by the funding challenges that governments, including in Malawi, face.

**Table 6. 53: Funding challenges affect compliance to procurement plans**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 14 | 4.3 |
| Disagree | 19 | 5.8 |
| Neutral | 31 | 9.5 |
| Agree | 127 | 38.7 |
| Strongly agree | 137 | 41.8 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.8.3 Centralisation of some procurements

The results indicate that some procurements are centralised in the district hospitals. As shown in Table 6.54, respondents (72.5%) agreed that some procurements are centralised. This entails that management have less control over such procurement decisions. A case in point is the procurement of drugs. Despite the fact that central operations have their own benefits, district hospitals face challenges with such central decisions as to how much and where to procure. Sections 6.4.5.3 and 6.4.5.4 discussed the results on the effect of dual management of hospitals and partial decentralisation of Councils; directives on central procurements are some of the effects. This has an effect on expenditure as managers tend to lack control over a certain portion of their funding.

**Table 6. 54: Centralisation of some procurements**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 14 | 4.3 |
| Disagree | 14 | 4.3 |
| Neutral | 62 | 18.9 |
| Agree | 129 | 39.3 |
| Strongly agree | 109 | 33.2 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.8.4 Poor procurement planning and budgeting

The results indicate that there is poor procurement planning and budgeting that affect management of expenditure in the district hospitals. Table 6.55 shows that 56.4% of the respondents agreed that procurement planning and budgeting are poor in the district hospitals.

The qualitative results in Chapter 5 confirms that district hospitals fail to adhere to procurement plans citing funding challenges as the contributor. These findings are supported by Botlhale (2017:293) who established that Botswana experiences low adherence to procurement plans.

**Table 6. 55: Poor procurement planning and budgeting**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 17 | 5.2 |
| Disagree | 51 | 15.5 |
| Neutral | 75 | 22.9 |
| Agree | 84 | 25.6 |
| Strongly agree | 101 | 30.8 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.8.5 Lack of effective supervision and monitoring

The respondents felt for the most part that there is a lack of effective supervision and monitoring that affect expenditure management in the district hospital. Table 6.56 indicates that 65.5% of the respondents were in agreement that procurement and supply chain management lack effective supervision and monitoring, and that this has an effect on the management of expenditures. In support of these findings, a study by Botlhale (2017:293) found that Botswana is challenged with poor supervision and enforcements in the procurement function.

**Table 6. 56: Lack effective supervision and monitoring**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 13 | 4.0 |
| Disagree | 34 | 10.4 |
| Neutral | 66 | 20.1 |
| Agree | 112 | 34.1 |
| Strongly agree | 103 | 31.4 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.8.6 Poor stock management

The results indicate that there is poor stock management in the district hospitals. As shown in Table 6.57, overall 60.6% of the respondents agree that poor stock management in the district

hospitals affect public expenditure management. Carlson *et al.* (2015:16) attribute poor stock management to budget management challenges.

**Table 6. 57: Poor stock management**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 19 | 5.8 |
| Disagree | 44 | 13.4 |
| Neutral | 66 | 20.1 |
| Agree | 111 | 33.8 |
| Strongly agree | 88 | 26.8 |
| Total | 328 | 100.0 |

**Source:** Survey data

**6.4.8.7 Increasing prices constrain budget resources**

Most respondents felt that there the continued increasing prices constrain budget resources and this has an effect on the management of public expenditure. As shown in Table 6.58, 86.6% of the respondents concurred that price increases impact management of expenditure. These results agree with the qualitative results, where participants were of the view that amongst the challenges they encounter in managing procurements and supply chain management are the rising prices of goods and services. With the discussed inadequate provision of financial resources, adherence to procurement plans and set budgets could be hard to attain.

**Table 6. 58: Increasing prices constrain budget resources**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 10 | 3.0 |
| Disagree | 5 | 1.5 |
| Neutral | 29 | 8.8 |
| Agree | 101 | 30.8 |
| Strongly agree | 183 | 55.8 |
| Total | 328 | 100.0 |

**Source:** Survey data

**6.4.8.8 Strict procurement regulations**

Most respondents were of the view that the procurement regulations are strict and that this impacts on procurement activities and consequently, on management of expenditure. As depicted

in Table 6.59, 57.6% of the respondents are in agreement that the district hospitals practice strict procurement regulations.

**Table 6. 59: Strict procurement regulations**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 25 | 7.6 |
| Disagree | 34 | 10.4 |
| Neutral | 80 | 24.4 |
| Agree | 89 | 27.1 |
| Strongly agree | 100 | 30.5 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.9 Strategies for improved funding

#### 6.4.9.1 Introducing fee paying sections in the hospitals

Many participants felt that introducing fee paying sections in the hospitals would boost income for operations in the hospitals. Table 6.60 shows that respondents 78.3% were in agreement of the proposal to privatise some sections within the hospital in order to generate additional funding for the hospitals. This proposal is in line with studies by Abor and Abor (2020:566) where it is stated that Ghana's healthcare sector is funded by 1% of out-of-pocket funds. In addition, a study by Akortsu and Abor (2011:139) recommended that governments should permit hospitals to charge fees to patients.

**Table 6. 60: Introducing fee paying section in the hospitals**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 23 | 7.0 |
| Disagree | 21 | 6.4 |
| Neutral | 27 | 8.2 |
| Agree | 69 | 21.0 |
| Strongly agree | 188 | 57.3 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.9.2 Lobbying for increased budgetary allocation

Many participants felt that the government should be lobbied for additional funding allocation to the health sector. Table 6.61 shows that an overwhelming 93.6% of the respondents agreed that lobbying for additional resources would improve the funding situation in the district hospitals.

These results concur with the quantitative results presented in Chapter 5 where participants were of the view that government could be lobbied for increased funding allocations to the health sector. In support of the findings, Twea (2016:2) is of the view that lobbying government for additional resources would be beneficial only if the financial resources were better managed.

**Table 6. 61: Lobbying for increased budgetary allocation**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 4 | 1.2 |
| Disagree | 4 | 1.2 |
| Neutral | 13 | 4.0 |
| Agree | 71 | 21.6 |
| Strongly agree | 236 | 72.0 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.9.3 Enhance revenue generating capacity of hospitals/Councils

The findings suggest that there is a need to enhance the revenue generation capacity of the hospitals for additional financial resources. As shown in Table 6.62, respondents (86.9%) agreed that hospitals should increase their capacity to generate revenue so that they can extend the same to the health sector which are under them. Abor and Abor (2020:268) explain that it is the responsibility of the hospital leadership and management to identify additional sources of revenue for the hospitals. This could extend to the Councils who are the controllers of the health sectors where they can lead in being active in revenue generation for the hospitals as such they can increase the funding base.

**Table 6. 62: Enhance revenue generation capacity of Councils**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 5 | 1.5 |
| Disagree | 10 | 3.0 |
| Neutral | 28 | 8.5 |
| Agree | 110 | 33.5 |
| Strongly agree | 175 | 53.4 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.9.4 Charging additional taxes on alcohol and cigarettes and committing the funds generated to public health service delivery

For the most part, respondents felt that funding for the hospitals can be increased by charging additional taxes on alcohol and cigarettes and committing the funds generated to public health service delivery. Table 6.63 shows that 54% of the respondents agreed with the point that the government should charge additional taxes on alcohol and cigarettes and commit the funds for health cares service delivery. In support of the proposal to increase health funding through taxes, Chu *et al.* (2019:39) note that there is a move by countries to levy taxes on some commodities like sugar, alchol and cigarettes in order to enhance revenue for the health budget.

**Table 6. 63: Charging additional taxes**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 41 | 12.5 |
| Disagree | 36 | 11.0 |
| Neutral | 74 | 22.6 |
| Agree | 74 | 22.6 |
| Strongly agree | 103 | 31.4 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.9.5 Introducing national health insurance schemes

Most participants felt that the government should introduce national health insurance schemes as one way of widening the revenue base for the district hospitals. Table 6.64 shows that 71.1% of the respondents agreed that the introduction of national health insurance schemes would enhance access to additional funding for the district hospitals. Confirming that national health insurance schemes are a potential source of income, Abor and Abor (2020:565) mention national health insurance schemes as additional funding source for the hospitals since it contributes 3% of health financing. Thus, there is potential for the hospitals to generate extra income, if the government introduced national health insurance schemes.

**Table 6. 64: Introducing national insurance health schemes**

| | Frequency | Percent |
|---|---|---|
| trongly disagree | 10 | 3.0 |
| isagree | 20 | 6.1 |
| leutral | 65 | 19.8 |
| gree | 99 | 30.2 |
| trongly agree | 134 | 40.9 |
| otal | 328 | 100.0 |

**Source:** Survey data

#### 6.4.9.6 Entering into public private partnerships

The results of the study reveal that public private partnerships can enhance revenue base for the district hospitals. Overall, Table 6.65 shows that respondents (68.9%) felt that entering into public private partnerships would assist in widening the revenue base or the health sector. In support of this proposal, Kostyak *et al.* (2017:120), state that public private partnerships have enhanced revenue availability for the health sectors in some countries.

**Table 6. 65: Entering into public private partnerships**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 13 | 4.0 |
| Disagree | 19 | 5.8 |
| Neutral | 70 | 21.3 |
| Agree | 112 | 34.1 |
| Strongly agree | 114 | 34.8 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.10 Public expenditure improvement strategies

#### 6.4.10.1 Improve the formula used in allocating government funding to hospitals

The results of the study indicate that there is need to improve the formula used to allocate resources in the public healthcare service delivery sector in Malawi. Table 6.66 shows that most respondents (89.9%) were of the view that the formula used in sharing government funding to the hospitals should be improved. This means that the current funding sharing formula is lacking and has to be improved. These results agree with the results from the qualitative study where participants lamented that the current formula for sharing finances at district level is weak and needs to be improved. A number of studies concur with the findings in this study that the resource

allocation formula for the health sector should be improved (Islam *et al.*, 2018:66; Maharaj *et al.*, 2018:190).

**Table 6. 66: Improve formula used in allocating government funding to hospitals**

| | Frequency | Percent |
|---|---|---|
| ;trongly disagree | 1 | 0.3 |
| )isagree | 5 | 1.5 |
| ‌Jeutral | 27 | 8.2 |
| ‌\gree | 108 | 32.9 |
| ;trongly agree | 187 | 57.0 |
| ‌'otal | 328 | 100.0 |

**Source:** Survey data

### 6.4.10.2 Enhance capacity of oversight functions

The results of the study suggest that there is a need to enhance the capacity of the oversight functions in order to improve on public expenditure management. Table 6.66 indicates that 82% of the respondents concurred with this strategy and it is believed this option can contribute to the enhancement of expenditure management in the health sector. The qualitative results presented in Chapter 5 also found that the oversight functions of internal and external auditing are weak and inadequate.

**Table 6. 67: Enhance capacity of oversight functions**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 1 | 0.3 |
| Disagree | 10 | 3.0 |
| Neutral | 48 | 14.6 |
| Agree | 152 | 46.3 |
| Strongly agree | 117 | 35.7 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.10.3 Provide training to staff

The results suggest that providing training to staff would enhance public expenditure management in the health sector. Table 6.67 shows that 86.6% of the respondents were of the view that staff should be trained to enhance their capacity in expenditure management. This is recommended despite the fact that the results in section 6.4.3.3 were not conclusive because respondents had divided views as to the statement that staff are incompetent and therefore affected management

of expenditure. In support of this strategy, (Chimwaza *et al.*, 2014:17; Rangongo *et al.*, 2016:8) recommend providing training as one way of enhancing financial management.

**Table 6. 68: Provide training to staff**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 5 | 1.5 |
| Disagree | 10 | 3.0 |
| Neutral | 29 | 8.8 |
| Agree | 116 | 35.4 |
| Strongly agree | 168 | 51.2 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.10.4 Enhance cost cutting in non-priority areas

The results of the study indicate that there is need to enhance cost cutting in non-priority areas in the district hospitals. This is the position of 83.9% of respondents as depicted in Table 6.68. It follows that if there was cost cutting in non-priority areas, management of public expenditure would be enhanced. These findings concur with findings and recommendations by (Mbuya-Brown & Sapuwa, 2015; Twea *et al.*, 2020:2) .

**Table 6. 69: Enhance cost cutting in non-priority areas**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 2 | 0.6 |
| Disagree | 9 | 2.7 |
| Neutral | 42 | 12.8 |
| Agree | 137 | 41.8 |
| Strongly agree | 138 | 42.1 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.10.5 Enhance use of ICT in production of reports

Most respondents felt that there must be enhancement in the use of ICT in production of reports. Tabe 6.69 shows that majority of respondents (85.7%) agreed that ICT use should be enhanced in the district hospitals. The qualitative results in Chapter 5 revealed that participants bemoaned poor use of ICT in production of reports and some attributed this to non availability of ICT equipment.

**Table 6. 70: Enhance use of ICT in production of reports**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 5 | 1.5 |
| Disagree | 10 | 3.0 |
| Neutral | 32 | 9.8 |
| Agree | 114 | 34.8 |
| Strongly agree | 167 | 50.9 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.10.6 Consult on budget and funds allocation

The majority of respondents felt that there must be consultations on budget and funds allocations in order to enhance management of expenditure by all players. As depicted from Table 6.70, respondents (89.9%) were in agreement with the statement 'consult on budget and funds allocation' being a strategy for the enhancement of public expenditure management.

**Table 6. 71: Consult on budget and funds allocation**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 3 | 0.9 |
| Disagree | 6 | 1.8 |
| Neutral | 24 | 7.3 |
| Agree | 112 | 34.1 |
| Strongly agree | 183 | 55.8 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.10.7 Increase funding for hospitals

Almost all respondents felt that funding for hospitals should be increased and that this would enhance management of public expenditure. As shown in Table 6.71, respondents (95.4%) were of the view that the hospitals needed increased funding. In support of these findings, Kiross *et al.* (2020:5) advocate for increased government funding for the healthcare service delivery sector.

**Table 6. 72: Increase funding for hospitals**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 1 | 0.3 |
| Disagree | 6 | 1.8 |
| Neutral | 8 | 2.4 |
| Agree | 57 | 17.4 |
| Strongly agree | 256 | 78.0 |
| Total | 328 | 100.0 |

**Source:** Survey data

**6.4.10.8 Hospitals should be able to easily move funds from one budget item to the other due to the nature of their operations**

Most of the respondents felt that hospitals must be able to easily funds from one budget item to another due to the nature of their operations. Table 6.72, respondents (71.1%) agreed with the statement that hospitals should be allowed to move funds across budget lines due to the uncertain nature of its operations. Di Francesco and Alford (2016:232) confirm that budget flexibility allows organisations to achieve their goals effectively.

**Table 6. 73: Hospitals should be able to move funds**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 26 | 7.9 |
| Disagree | 29 | 8.8 |
| Neutral | 40 | 12.2 |
| Agree | 99 | 30.2 |
| Strongly agree | 134 | 40.9 |
| Total | 328 | 100.0 |

**Source:** Survey data

**6.4.10.9 Full devolvement from Central government to District Councils**

The results of the study indicate that full devolvement of district Councils would enhance expenditure management at district hospital level. As shown in Table 6.73, most respondents (73.2%) agreed that full authority should be transferred to Councils for effective expenditure management in the district hospitals. In the same vein, Frumence *et al.* (2013:20983) recommend that central governments should stick to established principles on decentralisation and let the Councils have greater autonomy.

**Table 6. 74: Full devolvement of authority from central government to District Councils**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 12 | 3.7 |
| Disagree | 17 | 5.2 |
| Neutral | 59 | 18.0 |
| Agree | 95 | 29.0 |
| Strongly agree | 145 | 44.2 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.10.10 Improve quality and availability of financial information to monitor public spending

Overall, the respondents (89.9%) as presented in Table 6.74, felt that availability and quality of information should be improved as this will enhance monitoring of public spending. This shows that the financial information in the hospitals need to be produced and be meaningful to the users. Thus, the monitoring aspect is crucial but can only be achieved if the information to be monitored is available and in useful form. In agreement with the study, Redmayne and Vašiček (2021:85), argue that public sector management accounting information is used to monitor, shows transparency and accountability in the public sector as such, the information produced should be such that it is useful and informative to the users.

**Table 6. 75: Improve quality and availability of financial information to monitor public spending**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 2 | 0.6 |
| Disagree | 5 | 1.5 |
| Neutral | 26 | 7.9 |
| Agree | 125 | 38.1 |
| Strongly agree | 170 | 51.8 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.4.10.11 Foster constructive dialogue with the civil society

The results reflect that dialogue should be fostered with the civil society as a strategy towards enhancing expenditure management. Table 6.75 shows that most respondents (77.4%) felt that the Government and Councils should foster constructive dialogue with the Civil Society

Organisations as a strategy for enhancement of public expenditure management. This is the case since the civil society serves as an oversight community that enforces the achievement of public goals in a country. According to Mbuya-Brown and Sapuwa (2015:5), Civil Society Organisations have monitoring and reporting roles on public expenditures and therefore, serve as oversight functions in public sector management.

**Table 6. 76: Foster constructive dialogue with civil society**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 6 | 1.8 |
| Disagree | 8 | 2.4 |
| Neutral | 60 | 18.3 |
| Agree | 124 | 37.8 |
| Strongly agree | 130 | 39.6 |
| Total | 328 | 100.0 |

**Source:** Survey data

#### 6.4.10.12 Strengthen the performance management system

The results of the study show that public expenditure management can be enhanced if the performance management system is strengthened. Table 6.76 indicates respondents (91.5%) were in agreement to the suggestion that a strengthened performance management system enhances expenditure management. Dieleman *et al.* (2006:2) explain that improved performance management strategies influence staff motivation and, hence, motivated staff contribute to effective financial management.

**Table 6. 77: Strengthen the performance management system**

| | Frequency | Percent |
|---|---|---|
| Strongly disagree | 4 | 1.2 |
| Disagree | 4 | 1.2 |
| Neutral | 20 | 6.1 |
| Agree | 113 | 34.5 |
| Strongly agree | 187 | 57.0 |
| Total | 328 | 100.0 |

**Source:** Survey data

### 6.5 Chapter summary

In this chapter, the aim was to provide an empirical analysis and findings of the quantitative data gathered from the study. Thus, statistical analysis of quantitative data was reported in this chapter. As such the focus of this chapter was the analysis, interpretation and discussion of the primary data that was collected in the study. The data was collected from a sample of 328 respondents. These were officials from Councils, District Health Management Teams and Programme Coordinators. The quantitative data was analysed using the SPSS. The chapter presented descriptive statistics and factor analysis of the major variables in relation to public expenditure management in the healthcare service delivery sector in Malawi, specifically district hospitals. The next chapter looks at the framework for public expenditure management in the public health service delivery sector in Malawi drawing from the analysed data collected from the participants.

# CHAPTER 7: A FRAMEWORK FOR PUBLIC EXPENDITURE MANAGEMENT FOR THE PUBLIC HEALTHCARE DELIVERY SECTOR IN MALAWI

## 7.1 Introduction

Chapters 5 and 6 of this study presented and interpreted the findings from the qualitative study and results of the quantitative study. This chapter focuses on the framework for expenditure management which is deemed suitable for the public healthcare services delivery sector in Malawi. The framework designed for expenditure management for the public healthcare delivery sector in Malawi is informed by contributions from the results of interviews and questionnaires during the study. The interviews were conducted with public expenditure management role-players in the public health service delivery sector in the district hospitals. Interviewees included individuals from Council officials, hospital management, financial analyst (National Local Government Finance Committee), internal and external audit functions and civil society organisations. The questionnaires were administered to Council officials, District Health Management Teams, and Programme Coordinators. The Government, Council and hospital management should champion the implementation of the framework. The strategies on improved hospital funding and public expenditure management should be incorporated in the public health service delivery sector as they could contribute towards improved availability of funding and enhance expenditure management in the public district hospitals in Malawi.

## 7.2 A review of public expenditure management framework

According to Allen and Tommasi (2001:19), public expenditure management relates to the efficient and effective allocation of resources. This means that how financial resources are utilised within an entity, determines the quality of management of public expenditure. In addition, Premchand (1993:41) explains that fundamental to expenditure management is being economic, effective and efficient in resource mobilisation, allocation and utilisation. On top of that, an instrument for public expenditure management should be specific to the environment it relates to, since the significance and efficacy of institutional arrangements and expenditure management are country specific (Allen & Tommasi, 2001:26). To this end, Allen and Tommasi (2001:25) explain that it is necessary that when efforts are being made to enhance the public expenditure management of a country, the country's institutional framework must be analysed.

Premchand (1993:28) stresses the importance of controls on expenditure management and presents what he calls the expenditure management cycle presented in Figure 7.1. In the cycle, the author looks at the various management levels as levels of control for public sector organisation and classifies control as external (players outside the organisation) and internal

controls (as relating to the organisational structure of the organisation) and is responsive to decisions. The framework for the current study is designed along the expenditure management cycle where the emphasis is on strengthening control factors along all the processes of the expenditure cycle. Herein, the influencers of the control environment of the expenditure management and the control environment itself, is at the centre of the framework.

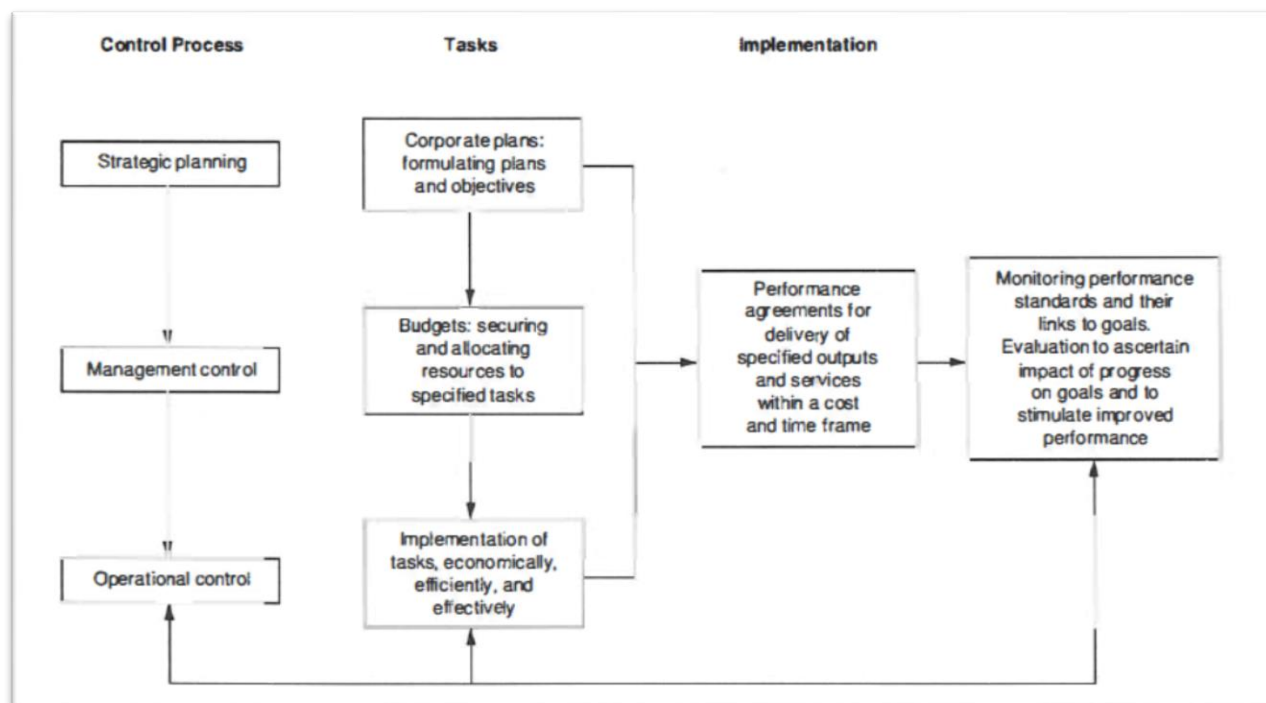



**Figure 7. 1: Expenditure management cycle**

**Source:** Premchand (1993:30)

The results of both the qualitative and quantitative studies informed design of the framework for public expenditure management for the public healthcare sector in Malawi so that it addressed the specific problems of the sector. According to Schiavo-Campo (2018:92), revenue generation and utilisation of financial resources for the public sector are political decisions. As such, the structure of the framework for this study places the Government as the most important role-player who must champion the adoption and implementation of the framework.

The background of the public district hospitals in Malawi is one of chronic financial constraints, poor service delivery and low personnel morale. This may be worsened by ineffective and inefficient management of expenditure in the public district hospitals. Most importantly, deficient public expenditure management in the public healthcare sector has impacted negatively on

healthcare service delivery. Public expenditure management in the public sector should be focused towards achievement of financial goals which encompass 'aggregate fiscal discipline, allocative and operational efficiency (Campos, 2001:1; Premchand, 1993:22). Expenditure management is a system where each component to the system complements and contributes to the master system and that no segment of the system is independent of the other (Premchand, 1993:6). Thus, it is the system approach to expenditure management that is advocated herein, where the sum of the whole is more than that of the individual parts.

The study revealed challenges that affect management of public expenditure, thereby, impacting service delivery in the hospitals. Therefore, a framework for public expenditure management developed in this study is aimed at addressing challenges related to funding, planning, utilisation and monitoring of finances in the healthcare sector. The contribution of this study is that it will improve expenditure management in the public health sector and so, provide better quality healthcare delivery system. This is because, every nation desires a high quality healthcare system that yields a healthy nation which in turn breeds economic growth (Alhassan *et al.*, 2020:1).

The results of the study are aligned to underlying management theories that form its theoretical background. The agency theory forms the foundation of this study since the study is principally about management of entrusted resources. Further to that, the results are explained by the positions of management theories that constitute the study's theoretical framework. The position is that for effective management of public resources, managers should be accountable, efficient, stewards. These values are embedded in the management principles that were deliberated and discussed as forming the theoretical framework of this study.

### 7.3 The framework: A fusion of qualitative and quantitative results

The study identified a number of issues in expenditure management which are addressed through the framework. These challenges, weaknesses and shortcomings are summarised as follows: inadequate and late government funding resulting from lean government coffers; declining and earmarked donor funding and weak revenue generation capacity of Councils; low staff capacity and morale coupled with lack of integrity, shortages, corruption, poor performance appraisals and delayed and weak staff disciplinary procedures; budget preparation and implementation, budget inflexibilities, poor control procedures; bureaucracies, weak reporting and financial management systems, poor governance and expenditure controls; government interference, dual management, poor monitoring and supervisory functions, lack of accountability; weak oversight functions characterised by inadequate personnel and lacking capacity in the external and internal audit functions and lack of capacity of the audit committees; weak legislative function with weak

enforcements and penalties; poor procurement function with low procurement plans compliance levels, selected centralised procurements and increasing prices.

In order to challenge and address this myriad of constraints into effective and efficient public expenditure management, a framework to address them was designed as shown in Figure 7.2 The responses that informed the framework design were obtained from the data gathered from participants from the qualitative and quantitative study phases. These include the need for political will from government, strengthened regulatory framework, full devolvement of Councils, management accountability, enhanced monitoring and supervisory mechanisms, enhanced revenue generation capacity of Councils, privatised public hospital sections, introduction of national health insurance schemes, government lobbies, increased funding, enriched financial management and procurement supply chain management systems, boost budget management flexibility, improved on spending efficiencies, enhanced supervisory functions, creative a conducive environment for civil society organisations.

The framework depicted in Figure 7.2 purports to provide strategies meant to improve public expenditure management in the public healthcare delivery sector in Malawi. The framework has a purpose, identified players, and the tasks to be performed by these players. It provides guidance to multiple public expenditure management role players on their possible contributions to the framework. The goal of the framework is to address the expenditure management deficiencies in the public healthcare service delivery sector in Malawi, thereby enhancing public expenditure management in the sector.

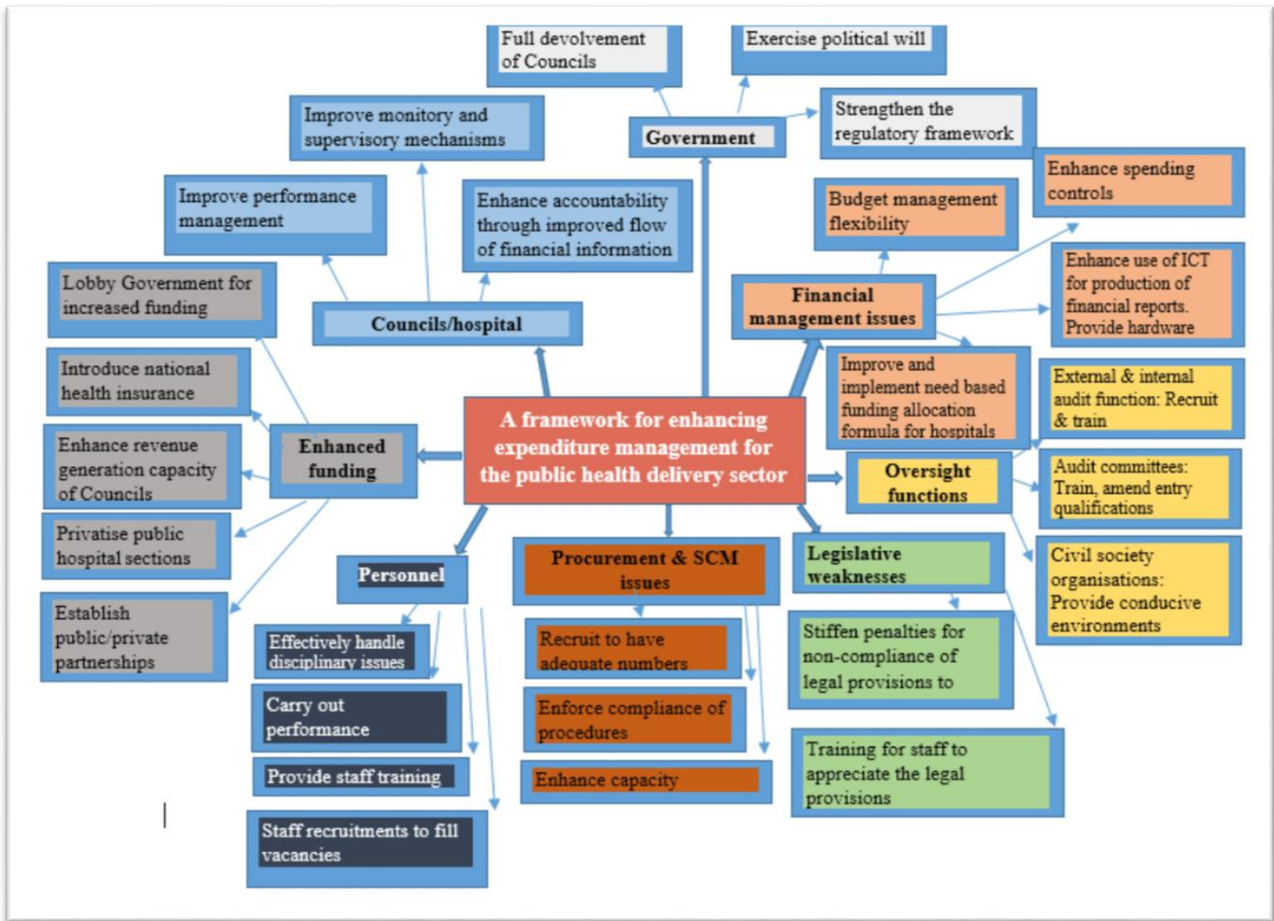



**Figure 7. 2: A framework for expenditure management in public healthcare service delivery sector in Malawi**

**Source:** Own Source

### 7.3.1 The government

The starting point for the public expenditure management framework in Figure 7.2 is the government, since it is responsible for strategy and policy formulation and direction. This is the case as Allen and Tommasi (2001:22) state that the success of reformations in public finance management system is dependent on commitment by the government.

#### 7.3.1.2 Challenges relating to the government

Both the qualitative and quantitative results indicate that expenditure management in the sector is challenged by the government's lack of political will, not releasing powers to the local governments following decentralisation and thus, making directives at central level resulting into dual management. This state of affairs handicaps management in discharging managerial responsibilities as Coovadia *et al.* (2009:817) explain that challenges faced by management and leadership failures led to poor health performance. The current situation could result in a managerial crisis as management cannot plan and implement activities for their own goal attainment effectively.

#### 7.3.1.2 Solutions for government challenges from the framework

The government is the game changer in the quest for public expenditure management in the public sector in general and the health sector. As such, it is believed that their positive response to suggestions for improvements would go a long way in having reforms and change achieved. Therefore, the government should exercise the necessary political will and set the tone at the top with a view to enhanced public expenditure management.

Data collected from the study revealed that participants were of the view that the government need to exercise political will and support public expenditure management enhancement efforts. It is concluded that in order to achieve enhanced public expenditure management, government's political will is crucial in safeguarding and the strengthening the regulatory and legislative framework and the associated policies that affect public finance management. This includes the full devolvement of Councils. Thus, the framework stipulates that the government should have and exercise political will and make pronouncements and decisions that are crucial for public expenditure management, fully devolve the Councils and grant them authority and strengthen the regulatory and legislative environment.

### 7.3.2 The Council and hospital management

The framework recognises the role in the decentralised setup that the Council and hospital management has on enhancing public expenditure management in the district hospitals since they are implementers of strategy and policy. This is the case as Obiwuru *et al.* (2011:102) are of the view that the type of leaders an organisation has, influence the performance of an organisation. In addition, management commitment is vital to shape the play field in financial management (Nguyen *et al.*, 2021:1863). Thus, senior management in the Councils and hospitals

need to be committed in spearheading public expenditure management reforms at the institutional level.

#### 7.3.2.1 Problems relating to Councils and hospital management

The high mean from the quantitative data analysis indicates that there are management challenges faced by the sector in terms of lack of fiscal discipline, accountability, monitoring of finances, consultations finances and autonomy over finances. This may mean that there are management lapses in expenditure management resulting in finance leakages, for instance. According to Coovadia *et al.* (2009:818), to achieve organisational goals in this case health goals require good leadership and stewardship. Thus, stewards would maintain financial discipline, be accountable and undertake effective management functions to protect finances.

#### 7.3.2.2 Solutions for Council/hospital management from the framework

Effective management and leadership are believed to contribute significantly towards efficient and effective financial management. Therefore, managers should be bent on managing hospitals comprehensively, including finances. The focus for management should be on accountability through financial reporting, maintenance of financial discipline, consulting and continuously monitoring the finances. The qualitative and quantitative sections of this study concur on the role of managers in management of finances. The framework offers the following solutions: enhancing accountability through improved flow of financial information, improving performance management, and monitoring and supervisory functions.

### 7.3.3 Improved funding

The framework for public expenditure management pins the responsibility for district hospital funding on the Government, the Councils and the hospital management. For health systems to operate, there is need for sustainable and adequate financing including the strengthening of domestic funding (Chu *et al.*, 2019:33). Accordingly, there is need for the identification of additional sources of funding for the health sector instead of the traditional government and donor funding. For example, Ghana’s health system is financed by government, donors, contributions from the national health insurance scheme and individual payments (Abor & Abor, 2020:565).

#### 7.3.3.1 Problems relating to health sector funding

The quantitative and qualitative analyses show that there are funding challenges for the health sector in Malawi. This may mean that the public hospitals may not efficiently and effectively deliver healthcare. According to Frumence *et al.* (2013:5), inadequate financial resources for the hospitals are due to lack of reliable sources of extra funding for the hospitals. The sector is challenged with inadequate funding, reliance on donor funding and late government funding. The effect is that the sector will continue to deliver poor services due to lack of essential resources to support healthcare delivery.

#### 7.3.3.2 Solutions for health funding from the framework

In light of the chronic funding that the hospitals face, the framework advocates for integrated efforts for income generation for the district hospitals so that one funding source complements the other. Hung and Hager (2019:5) promote diversified revenue sources for the health sector to ensure financial resource availability as there is flexibility in having diversified resource base and provides a cushion and complement access to resource in situations where one source fails. The framework recommends strategies for increased funding sources; these include lobbying the government for increase funding allocation to the health sector; the hospital management should consider introducing private sections in the hospitals for income generation purposes; and introduce national health insurance schemes and establish public private partnerships. The framework also provides that Councils and hospitals should be capacitated in revenue generation in order to be able to generate more and extend support to the sectors under them including the health sector.

### 7.3.4 Financial management

Councils and hospital management should recognise that the financial management function is a vital function. This is the case as Huzaila-Majid and Singaravelloo (2017:260) explain that poor financial management systems negatively affect management of finances. Therefore, a well-functioning financial management system ensures that finances are efficiently and effectively managed.

#### 7.3.4.1 Problems relating to financial management

Both the qualitative and quantitative studies have affirmed that the sector faces financial challenges specifically budget management. For instance, poor governance as highlighted by a participant (EA01) '*So generally there is poor governance. There is no respect for management of these health funds.'* Additionally, there is poor control of expenditures EA01 is reported saying

'*Number one is the lack of control of expenditures which I have said'.* The sector is also said to have a weak financial management system, weak resource sharing formula among the districts and poor financial reporting. These defects affect management of finances which consequently, lead to financial wastages and inefficacies and hence, disturb service delivery.

#### 7.3.4.2 Solutions for financial management from the framework

Efficient and effective financial management is believed to contribute to organisational goal achievement. Therefore, management should continue to ensure that the finances for the hospitals are managed properly. The framework provides for strategies for improved financial management in the sector. The framework recommends that there should be enhanced financial reporting in order to be able to monitor and keep track of financial flows through harnessing the use of ICT having provided the necessary ICT platform. Furthermore, the framework recommends enhanced spending efficiency through effective budget management. The framework also stipulates that budget management for the sector should be made more flexible and that financial management systems are strengthened.

### 7.3.5 Personnel

Personnel constitute an important organisational resource. As such, to make the best from such a resource, an organisation should train and develop, bring out the best behaviour and effectively and efficiently recruit its workforce in order to increase the "potential, reliability and employability" of its employees (Chopra, 2017:89).

#### 7.3.5.1 Problems relating to personnel

The high mean from the quantitative analysis show that there are personnel challenges that the sector faces that affect public expenditure management. This may mean that personnel may not be giving in their best in the sector, and this could affect service delivery adversely. According to Chopra (2017:92), if human resources were to contribute effectively to the processes within the organisation and the available technologies, they need competencies and skills. The personnel in the sector are incompetent, lack integrity, are in short supply and are not effectively disciplined.

#### 7.3.5.2 Solutions for personnel shortfalls

Personnel have a role in the enhancement of public expenditure management as staff are the ones who carry put programme activities. Management should ensure that the level of staff capabilities, their integrity and adequacy is acceptable. How an organisation manages performance management, staff disciplinary issues and staff training and recruitment shapes the

calibre of staff and the quality of the output they produce. This being the case, the framework suggests that there should be effective performance evaluations and disciplinary measures for staff, recruitment of staff to fill in the vacancies. Staff should have their performance assessed to gauge how they are doing and how they can be assisted to improve. In addition, adequacy of staff is important. For instance, in the financial management section where for certain controls to be implemented there is need for segregation of duties, this cannot take place with inadequate staffing. Furthermore, inadequate staff in the healthcare service delivery section entails that the existing ones are overworked, and casual staff are engaged to fill in the gaps. This cause a drain on the cash flows, thus impacting on expenditure.

#### 7.3.6 Oversight functions

If oversight functions are effective and efficient in discharging their duties in public finance management, it will mean that there would be enhanced accountancy and transparency of utilisation of resources. According to Ștefănescu and Trincu-Drăgușin (2020:778), public sector auditing helps to improve the economic, effective and efficient utilisation of resources, which is dependent on auditors' experiences. Similar sentiments are held for internal audits (Mahyoro & Kasoga, 2021:999).

##### 7.3.6.1 Problems relating to oversight functions

The qualitative and quantitative analysis indicate that the internal and external audits are short-staffed and lack the competencies to undertake audits comprehensively and effectively in the sector. According to Ocheni and Agba (2018:156), audits are an important activity in public expenditure management that contributes to attainment of transparency, performance measurement and evaluation. As it is, the health sector is deprived of such a contribution since it lacks the competencies and it has inadequate staff.

##### 7.3.6.2 Solutions for oversight functions from the framework

Government, Council and hospital management should ensure that external and internal audit functions are effectively constituted and perform as required. There is need to equip these functions so that they have adequate personnel and are competent to undertake their tasks especially audits related to public sector management. External audits promote credibility of financial reports and internal audit serve as an internal control function for the whole organisation. Civil Society Organisations play advocacy role on behalf of the public and their indulgence in public sector management enhances accountability and transparency. In that regard, the framework recommends for the recruitment and training of the external and internal audit arms of

the government and local government. It further provides for provision of training in order to build capacity for the audit committees as well as amending entry qualifications into such committees. The framework also recommends for a conducive environment for civil society organisations.

### 7.3.7 Procurement and supply chain management

The procurement and supply chain management is a crucial function because it is here where finances are spent. Ideally, the regulation of the procurement and supply chain management function is meant to ensure efficient, economic and effective use of the public financial resources (Boe & Kvalvik, 2015:873). However, the present study reveals many challenges that affect efficient and effective procurement and the management of the health sector supplies.

#### 7.3.7.1 Problems relating to procurement and supply chain management

The high mean from the quantitative analysis indicates that the function is facing challenges. Similar experiences are observed in Botswana, where it was established that public procurement and supply chain management is challenged with poor adherence to procurement plans, unauthorized procurements, insufficient supervision and non-submission of activity expenditure reports (Botlhale, 2017:294). Such challenges may mean that funds could be lost along the way due to inefficiencies, thereby affecting delivery of services.

#### 7.3.7.2 Solutions for procurement and supply chain management from the framework

The framework provides for strategies meant to improve procurement and supply chain activities. There is need to recruit personnel to fill in the staff vacancies in the function. The framework offers the following solutions: recruit adequate personnel for the function, enhance personnel capacity by training and enforcing compliance to set regulations.

### 7.3.8 Legislative weaknesses

Legislation and regulatory framework are developed and instituted to govern public financial management so that it is effective and efficient. However, Tsheletsane and Fourie (2014:43) explain that despite the availability of such frameworks, public finances continue to be mismanaged. In addition, Ibrahim *et al.* (2017:370) observe that to have a legal and regulatory framework does not a guarantee compliance and hence, effective financial governance. It means that the legislative and regulatory structures have to be supported.

#### 7.3.8.1 Problems relating to legislative weaknesses

The high mean from the quantitative analysis shows that the legislative and regulatory frameworks are weak. This may mean that the legislation and regulatory environment is not effective enough to ensure proper governance of public finances. The study reveals that the legislative and regulatory framework relating to public finances in Malawi experiences shortfalls. For instance, there is lack compliance to provisions, the legislative provisions for penalties are not deterrent enough, legal provisions governing have inconsistencies, legal provisions governing have loopholes legal framework is neither clear nor comprehensive there is weak monitoring of compliance of legal provisions and there is weak enforcement of legal provisions. The effect is that the purported governance function of the regulatory framework may not be served.

#### 7.3.8.2 Solutions for legislative weaknesses from the framework

Regulations and legislation are believed to direct the actions and practices of those being governed. If such rules and laws have weaknesses, mismanagement occurs. Therefore, the framers of the law should continue to improve them to reflect the gaps they have and the expectations on the ground. Both the qualitative and quantitative analyses contributed much on the shortfalls as the study participants pointed out the areas for improvements. The framework offers the following solutions: train staff to appreciate the legal provisions that relate to them for instance the public finance management and public procurement laws and the implications for non-compliance. Secondly, the penalties for non-compliance and default should be stiffened in order to deter potential offenders.

### 7.3.9 Enhanced public expenditure management in the public health service delivery sector

Implementing the suggestions made in sections 7.3.1 to 7.3.8 above relating to the framework entails that the public expenditure management deficiencies would be improved. This means that the framework for public expenditure management when acceptable and implemented would lead to service delivery improvements in the public health sector in the district hospitals in Malawi.

## 7.5 Chapter summary

This chapter presented the framework for improving expenditure management for the public healthcare services delivery sector. The qualitative and quantitative phases study identified weaknesses and challenges that the expenditure management environment in the public healthcare services delivery sector and the associated strategies for their enhancement. These were summarised and informed the production of the framework. The framework identifies the

role players and areas of improvements as suggested by the study respondents. The framework puts responsibility for adoption and its implementation on the Government, Councils and hospital management. The framework proposes improvement strategies to address challenges and shortfalls relating to the government, Councils and hospital management, financial management, oversight functions, funding, legislation procurement and supply chain management and personnel. It is felt that implementation of the recommendations would improve expenditure management as well as the funding levels. Improved expenditure management could contribute to improved service delivery in the sector. A healthy nation contributes towards economic growth, and that is what every government aims for. The next chapter provides conclusions and recommendations emanating from this study.

# CHAPTER 8: KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

## 8.1 Introduction

This last chapter, Chapter 8, follows on from the discussions and interpretation of results from the previous chapters. The chapter makes conclusions in relation to the main research objective of this study. On the onset, the chapter provides a recap of the problem statement, research questions and objectives of the study. This chapter makes conclusions from the qualitative and quantitative results of the study and identifies the major contributions to the body of knowledge through the development of a framework for public expenditure management for the public healthcare service delivery sector. Furthermore, the chapter makes contribution for future research, outlines limitations of the study, and offers recommendations for future work.

## 8.2 Research problem – revisited

The public healthcare delivery sector in Malawi faces challenges in financial management deficiencies relating to inadequate funding; waste and leakages; and budget formulation and implementation. Sub-Saharan African countries experience highest levels of inefficiencies compared to other regions of the world (Grigoli & Kapsoli, 2018:397; Makuta & O'Hare, 2015:933). In Malawi, the public health sector is said to be less efficient in resource use when delivering public health services (International Monetary Fund, 2018; World Bank, 2017:2).

Specifically, Government spending in the health sector is inadequate to satisfy health needs (Mbuya-Brown & Sapuwa, 2015:1; UNICEF, 2019:16). As such, the sector relies on donor funding and is subjected to its effects (World Bank, 2013:19). Constrained funding in the public health sector, leads to shortages of hospital drugs, equipment and low staff motivation resulting in provision of poor quality services (Mussa & Masanjala, 2015:13,15); in addition, there are challenges of low staff morale which breeds absenteeism, corrupt practices and low performance (International Monetary Fund, 2018:7). Unfortunately, it is the poor who are significantly affected as they are the ones who mostly seek public health services (Mbuya-Brown & Sapuwa, 2015:4; Mchenga *et al.*, 2017:30; Mussa & Masanjala, 2015:6; O'Hare & Curtis, 2014:133) thereby, compounding the disease burden in Malawi (World Bank, 2013:107).

Additional challenges are that, at district level, planning and funding are uncoordinated, financial planning and supervision is weak (O'Neil *et al.*, 2014:29); planning is disintegrated, and budgeting and monitoring and evaluation systems are at high risk of failure (Ministry of Health, 2017a:57); delayed financial disbursements; financial leakages and unsatisfactory reporting on finances and accountability (UNICEF, 2019:14). As a result, the mismanagement and pilferage of resources

in the health sector contribute to poor service delivery (Abiiro *et al.*, 2014:5; Ministry of Health, 2017a:56); the shortfalls in public financial management and embezzlement of public finances (Mussa & Masanjala, 2015:16); the leakages and the high risk that allocated funds may not be used for their intended purposes (UNICEF, 2019:8) all disturb the quality of service delivery. This means that finances may not be utilised for their intended purpose. Hence, the need for improvements on spending efficiencies of health expenditure by strengthened financial reporting and accountability (UNICEF, 2019:1). Thus, enhanced spending efficiency improves resource availability set activities.

In view of the above arguments, the study evaluated the public financial management environment in the public healthcare sector in Malawi and subsequently, developed a framework that could enhance expenditure management.

### 8.3 Research questions and objectives - revisited

This study aimed at analysing the expenditure management environment in the public healthcare service delivery sector in Malawi with a view of developing a framework for the enhancement of expenditure management. Public financial management in Malawi is regulated and there have been initiatives for improvements; however, it still faces deficiencies. Public financial management and public expenditure management have been researched globally, but Malawi lacks specific and comprehensive studies on public expenditure management and more especially in the public health service delivery sector.

The study's research questions were formulated from the problem statement that was summarised in section 8.2. Table 8.1 provides an outline of the study's research questions which are matched with the specific research objectives.

**Table 8. 1: Research questions matched with research objectives**

| Aim: To develop a framework for enhancing public expenditure management in the public healthcare delivery sector in Malawi | |
|---|---|
| **Research question** | **Research objective** |
| **RQ1.** What is the funding situation for the public health sector in Malawi? | **Obj1.** Determine the funding situation for the public health sector in Malawi. |
| **RQ2.** What factors deter role players in public health delivery sector in Malawi to achieve optimum public expenditure management? | **Obj2.** Ascertain factors that influence optimisation of public expenditure management in the public health sector in Malawi. |
| **RQ3.** To what extent can budgetary systems in public health delivery be utilised in the effective management of expenditure? | **Obj3.** Establish the extent to which budgetary systems are utilised in the effective management of expenditure. |
| **RQ4.** How can efficiency in utilisation of financial resources in public health sector in Malawi be enhanced? | **Obj4.** Explore ways of enhancing efficiency in utilisation of financial resources in the public health sector in Malawi. |
| **RQ5.** What is the proposed framework to enhance public expenditure management in the public healthcare service delivery sector in Malawi? | **Obj5.** Design a framework for improving expenditure management in the public healthcare sector in Malawi. |

**Source:** Own source

Table 8.2 indicates how the study's research questions have been answered and consequently, articulates achievement of research objectives.

**Table 8. 2: Research questions answered and objectives addressed**

| Quantitative | Qualitative | Objective | Research Question | Answers |
|---|---|---|---|---|
| **Section 2:** Funding sources and funding constraints | **Theme 1:** Funding in the public healthcare service in Malawi | **Obj1.** Determine the financing situation for the public health sector in Malawi. | **RQ1.** What is the funding situation for the public health sector in Malawi? | Public health sector is currently funded by the government and donors. However, government funding is late and inadequate; donor funding is declining, uncertain and earmarked restricting usage. |
| **Section 4:** Strategies to improve constraints/challenges in funding | **Theme 2:** Status of public expenditure management | **Obj3.** Establish the extent to which budgetary systems are | **RQ3.** To what extent can budgetary systems in public health | Budgetary systems can be used for effective management of expenditure by improving budgeting |

| | | | | |
|---|---|---|---|---|
| and public expenditure management | | utilised in the effective management of expenditure | delivery be utilised in the effective management of expenditure? | and budget management, fully utilising the strengths in the budget system and addressing the challenges that the public expenditure environment faces. |
| **Section 3:** Factors that influence public expenditure management: Resource allocation, financial management, political, management, personnel and procurement and supply chain management weaknesses | **Theme 3:** Vital functions in public expenditure management | **Obj2.** Ascertain factors that influence optimisation of public expenditure management in the public health sector in Malawi | **RQ2.** What factors deter role-players in public health delivery sector in Malawi to achieve optimum public expenditure management? | Optimisation of public expenditure management is deterred by deficiencies in legislation and supply chain management. |
| | **Theme 4:** Management and personnel functions | **Obj2.** Ascertain factors that influence optimisation of public expenditure management in the public health sector in Malawi | **RQ2.** What factors deter role-players in public health delivery sector in Malawi to achieve optimum public expenditure management? | Optimisation of public expenditure management is prevented by managerial and human resource defects in managing public expenditure. |
| **Section 4:** Strategies to improve constraints/challenges in funding and public expenditure management | **Theme 5:** Improvement strategies | **Obj1.** Determine the financing situation for the public health sector in Malawi.<br><br>**Obj4.** Explore ways of enhancing efficiency in utilisation of financial resources in the public health sector in Malawi. | **RQ1.** What is the funding situation for the public health sector in Malawi?<br><br>**RQ4.** How can efficiency in utilisation of financial resources in public health sector in Malawi be enhanced? | In order to improve public expenditure, the funding status needs to be improved as well. There is need to diversify domestic revenues to supplement government and donor funding of which each has limitations. In addition, a number of strategies addressing the challenges identified in the study need to be implemented to enhance resource utilisation. |

**Source:** Own source

### 8.4 Conclusions from the qualitative results

This section presents a summary of the results drawn from the qualitative study phase. Interviews were held with participants from diverse roles and professions, and these revealed that there were a number of challenges that affect public expenditure management in the public healthcare

service sector in Malawi. The following is a summary of the challenges experienced by the public healthcare delivery sector in Malawi based on the qualitative results:

The study found that the public healthcare delivery sector in Malawi depends largely on the government and donors for funding. The study concludes that most public healthcare sector in developing countries rely on multiple sources of funding. According to Piatti-Funfkirchen and Schneider (2018:336), the public healthcare service delivery sector is funded by multiple sources. The study found that the funding sources present challenges to the district hospitals thereby, affecting service delivery. Such challenges include inadequate funding, late provision of funding, earmarked donor funding and dwindling donor funding which tend to disrupt service delivery. This implies that if funding is inadequate and is also late, planned operational activities cannot take place leading to poor service delivery. Furthermore, the study concludes that donor funding is declining. Declining donor funding implies that total in the long run disrupt service delivery as donor funding form the bulk of public health sector funding. In addition, the study concludes that donor funding is earmarked which means the hospitals can only utilise the same to the extent of donor prescriptions. Thus, unless there is coordinated planning and budgeting between the healthcare sector and the donors, restricted funding can lead to funding duplications or indeed deficits in planned activities.

The study found that in terms of budget and budget management, budget allocations are restricted to ceilings that the Treasury announces; there are rigid budget reviews and weak formulae for the allocation of resources to health facilities. It is concluded that there is no link between resource requirements and funds made available, and that the disbursed finances cannot support current hospital operations. The study found that, regardless of the uncertain nature of healthcare service delivery, there is rigidity in undertaking budget reviews. The study concludes that rigid budget reviews could lead to the health facilities being unresponsive. The study demonstrated that how financial resources are shared amongst the healthcare facilities is not equitable. The study, therefore, concludes that unequitable distribution of health resources could lead to variation of health outcomes across the country. If these issues were addressed, budget management would be enhanced and therefore, public expenditure management would be effective and efficient, and this would ultimately improve service delivery.

The study established that the public healthcare service delivery sector has limitations on staffing in terms competencies, staff shortages and integrity. In addition, it was found that staff engaged in oversight functions in both external and internal audits are not adequate. This implies that the districts are deprived of benefits from the internal audit functions and in cases of external audits,

which are usually outsourced to general audit providers, the type of audits they undertake does not match the requirements of public sector audits. The study concluded that addressing staff shortfalls could enhance management of public expenditure in the health facilities and enhance service delivery.

It was noted that district hospitals are under decentralised institutional arrangements. However, it was found that hospital management is under the influence of the central government, and that the decentralisation is only partial. Furthermore, it was found that there is dual management in the management of district hospitals, thus, by Councils and the Central Government. The study concluded that such type of control lead to bureaucracy in planning and implementing activities for healthcare service delivery. Finally, the study concluded that it is important to give more autonomy to the Councils in order to enhance hospital performance.

It was demonstrated that there is a lack of compliance to procedures and legislation. Legislative provisions in procurement and public financial management in the healthcare delivery sector are not complied with. The study concluded that it is important that such legislation is complied with by enforcing compliance through among other options effective disciplinary procedures, since the principle behind such legislation was to safeguard public resources and essentially improving resources utilisation.

### 8.5 Conclusions from quantitative findings

The study analysed public expenditure management environment in the public healthcare service delivery sector in Malawi. Based on the quantitative results from the study, it is concluded that the healthcare sector environment in Malawi faces expenditure management deficiencies in its systems and functions which affect public expenditure management and accordingly, service delivery. According to Allen and Tommasi (2001:32), improving public expenditure management requires consideration of the institutional and organisational aspects since it is the regulatory aspects that guide organisational and individual behaviour. These challenges should be addressed by adopting the strategies identified by the study in order to achieve efficiency and effectiveness in financial resource use. The argument is that solutions to challenges faced with public expenditure management require tailor made strategies that address a unique environment. This is in line with (Allen & Tommasi, 2001; Yefriza, 2015:26) who maintain that the application of public expenditure management should be specific to the country being analysed. Against this background, this study sought to investigate the issues that affect public management expenditure in the public health service delivery sector in Malawi and identified strategies that can

enhance management of expenditure and consequently, thereby positively impacting service delivery.

The respondents to the study were Council officials, District Health Management Teams and Programme Coordinators. These are managerial and administrative positions at varying levels. The study findings revealed that there are more male managers than females in the public healthcare sector in Malawi, specifically the district hospitals. This study concluded that more men occupy the senior positions in the Council, hospital management teams and serving as Programme Coordinators in Malawi. In support of these findings, statistics show that there are more males in employment than females in Malawi (Malawi Government, 2020a:12), despite that there are more females than males in Malawi, (Malawi Government, 2020b:3). In support of these findings, it has been observed that regardless of the high numbers of females in the health sector, fewer females occupy management and leadership positions (International Labour Organisation, 2017:24; Le Boedec *et al.*, 2021:2). This study concluded that there is male dominancy in the workplace in Malawi, especially at the managerial level, despite the fact that much effort has been made towards the promotion of the girl child in attaining education and consequently participating in various professions.

The study findings revealed that the youth dominate the workforce in the public healthcare service delivery sector in Malawi. The study concluded that more young people are in employment in the health sector. The findings confirm that Malawi has a youthful population and that is why more of the youth are represented in the workplace.

Also, the findings revealed that the highest qualifications held by the bulk of hospital managers are Bachelor’s degrees. The study concluded that most health sector personnel at managerial level hold a first degree. Despite that many health personnel in the health sector are technicians holding certificates and diplomas, those with managerial level and formed part of this study respondents are degree holders. Furthermore, the study concluded that very few individuals hold doctoral degrees in the Councils and hospital. Mostly, such high post graduate degree holders are found at universities and research institutions.

Studies have been undertaken in Malawi relating to management of finances. The focus on the major studies has been on governance and local service delivery and efficiency in relation to decentralisation and health financing. In contrast to the mentioned studies, this empirical study examines the expenditure management environment in the health sector by identifying the challenges that the sector faces and suggests strategies for the deficiencies with the aim of

enhancing management of public expenditure. The study concludes that the sector faces various challenges from its different functions/systems and different levels of operations, for example, central government, Council, hospital management, and staff. The study results indicate that there is need to address the various challenges as a system so that efficiency and effectiveness in financial resource management could be comprehensively be achieved. The study concludes that the default source of funding for the health sector is the government; however, it has its challenges including lean resource pocket which leads to inadequate funding to the hospitals as well as delays in making funding remittances. In addition, the study concludes that the healthcare sector is reliant on donor funding and it does not generally generate its own funding. The study findings also reveal that Councils are unable to finance the health sector, despite that hospitals are under Councils. Furthermore, the study concludes that there are a number of functions and systems that are deficient and contribute to poor expenditure management. This implies that the challenges related to management of public expenditure are due to funding inadequacies and organisational and functional deficiencies across the organisational setup. The study concludes that public expenditure management depends on the effectiveness of the various systems/functions which are country specific though the basic principles are similar across nations (Allen & Tommasi, 2001:26).

Efficient and effective organisational functions/systems are believed to improve public expenditure management. However, inefficient and ineffective public expenditure management will lead to poor service delivery. The functions and systems that were evaluated in this study include resource allocation, personnel, management, financial management systems, legislation, procurement and supply chain management and politics which contribute towards inefficient and ineffective public expenditure management.

The descriptive statistics on funding situation in the public healthcare delivery sector in Malawi indicate that the public healthcare service delivery sector in Malawi faces a number of challenges that affect expenditure management and consequently, affect healthcare delivery services adversely. The study examined the sources of funding for the public district hospitals in Malawi and the challenges associated with the sources of funding. The findings indicate the public district hospitals are funded by the government and donors. The results show that the public healthcare sector experiences delayed government funded, is inadequately funded, donor funding is already earmarked to donors' preferred activities and that donor funding is declining. The study, therefore, concludes that the public district hospitals in Malawi are characterised by funding challenges which impact service delivery. Funding challenges affect service delivery in the healthcare

facilities and this implies that if adequate funding was timely provided, service delivery would improve.

Based on factor analysis, the study concludes that public health service delivery sector faces challenges with inadequate finances, delayed funding, budget planning and preparation, corrupt employees, lack of staff integrity and incompetence, delayed staff disciplining, bureaucracy, poor control of expenditures, weak financial management systems and financial reporting, compliance, flow of information, external and internal audit functions, dual management, political will, partial decentralisation of Councils, central government directives, legal provisions, monitoring and supervision, enforcement of legal provisions, fiscal discipline, accountability, autonomy over finances, compromised procurement function, stock management and increasing prices. For improved public expenditure management, the government, Councils and hospital management should spearhead to address the mentioned challenges in order to attain efficiency and effectiveness in financial resource utilisation.

The findings revealed that resource allocation challenges that the health sector face include inadequate financial resources, late government funding and budget planning and preparation. This entails that the sector experiences several resource allocation challenges that affect public expenditure management in the district hospitals. This implies that for the healthcare service delivery sector to enhance on expenditure management, there is need to improve the identified resource challenges. Therefore, the study notes that the public healthcare sector should improve on finance allocation challenges in order to achieve effective and efficient public expenditure management.

Based on the factor analysis, the study concludes that the public healthcare service delivery sector in Malawi face challenges related to personnel and they affect public expenditure management. These challenges are staff shortages, incompetence, performance appraisal, disciplinary delays, corrupt employees, staff morale, integrity and poor rapport with colleagues and superiors. The study, therefore, concludes that it is important for the public healthcare delivery sector to manage the staff challenges as they affect management of public expenditure.

Based on the factor analysis, the study concludes the public healthcare sector faces financial management challenges. These challenges are bureaucracy, poor control of expenditures, weak financial management system, lack of compliance to set procedures, financial reporting weaknesses, inadequate flow of information and weak capacity in external and internal audit functions. The study then, concludes that it is important that Councils and hospital management

in the district hospitals should strengthen financial management, enforce compliance to procedures among other strategies in order to enhance public expenditure management and consequently, improve effectiveness and efficiency in resource utilisation.

Drawing on from factor analysis, the study concludes that the political challenges in the public health service delivery sector in Malawi include central government directives, lack of political will, partial decentralisation of Councils and dual management. In addition, there is need for political will from the government on funds availability to the health sector. The study therefore concludes that it is important for the government have the political will to bring improvements in the sector.

Based on the factor analysis, the study concludes that the legislative weaknesses which are faced by the public health service delivery include: lack of compliance to legislative provisions, weak legislative provisions for penalties, inconsistent legal provisions, legal provisions with loopholes, unclear and incomprehensive, weak monitoring and enforcement on compliance. This implies that the government, Councils and hospital management should address the aforementioned weaknesses that affect public expenditure management, if the hospitals are to be efficient and effective in managing expenditure. In addition, the study concludes that the legal weaknesses which affect expenditure management, also affect service delivery in the hospitals.

Following the factor analysis, the study concludes that the public healthcare services delivery sector is faced with management challenges. The management challenges include a lack of fiscal discipline by the management, non-accountability by management, poor monitoring of finances, lack of consultations on finances and lac of autonomy over finances. The study concludes that it is vital that hospital management and Council address these challenges for effective and efficient management of expenditure and consequently, contribute to improved healthcare services delivery.

Based on factor analysis, the study concludes that the public healthcare service delivery sector faces procurement and supply chain management challenges that affect public expenditure management. The challenges include compromised procurement function, funding, procurement planning and budgeting, lack of effective supervision and monitoring, poor stock management and increasing prices. It is concluded that the procurement and supply chain management function challenges drain financial resources and, therefore, negatively affected management of resources and therefore service delivery. Therefore, the Council, government and hospital management need to address the individual challenges in order to improve the operations of the

function. The following section focuses on the major contributions to the body of knowledge based on the findings and results from this study.

### 8.6 Contributions of the study

This study is of interest to healthcare policymakers, hospital managers and consumers of healthcare services who envisage an improved healthcare delivery sector and are keen to see improved financial management in the sector. The framework developed from the study adds to existing literature on work undertaken on public financial management in the public healthcare sector in Malawi and beyond.

#### 8.6.1 The Institutional level (practitioners)

It is envisaged that the framework that was designed following the study is employed as a basis for the review of the current financial management practices in the public healthcare sector in Malawi and provide an improved public health sector financial management resource effectiveness and efficiency. Kioko *et al.* (2011:i120) contend that scholars in public management acknowledge that finances are central to public service delivery. Thus, it is general knowledge that finances have play a crucial role in facilitating service delivery. There is recognition on the need to improve public financial management systems to boost revenue generation as well as effect controls in expenditure management to achieve great efficiencies for public resource management (World Bank, 2017:8). Since expenditure needs proper management for it to ensure achievement of organisational goals, those in charge of public financial management should ensure that they apply proven and well researched strategies that should lead to proper financial management. Malawi had been exposed to public finance management reforms and has been adopting laws and regulations for improved accountability and management of public resources, but the gaps still remain, perhaps the implemented reforms were not appropriate for Malawi (World Bank, 2017:5). This infers that tailor made solutions would address specific challenges that Malawi faces in effective public finance management other than applying universal solutions.

Bridges and Woolcock (2017:1) find an abundance of interventions adopted due to their being the best practice somewhere and had been instrumental in bringing positive change there, but they fail to fix local Malawian problems. Furthermore, reforms designed and implemented for public financial management are meant enhance operational results (Bridges & Woolcock, 2017:6). Thus, local challenges call for local remedies and in this case Malawi. This study is, therefore, an attempt to bring in additional measures in the public financial management practices by developing a framework that responds to the public financial environment for Malawi.

### 8.6.2 The public

The public is another set of beneficiaries of improved expenditure management. It is hoped that if there is an improvement in financial resource management, quality in the public healthcare system will improve. Mussa and Masanjala (2015:16) bemoan the low quality health service delivery of Malawi's public health care system which stems from issues related to the management of funds. Thus, the poor quality healthcare service delivery in Malawi is associated with poor management of financial resources. Ngwakwe (2012:312) agrees with Mussa and Masanjala's sentiments as he laments poor service delivery in the healthcare sector due to issues related to the management of finances. Therefore, it is hoped that an improved financial management particularly expenditure management will improve on service delivery in the public healthcare system.

### 8.6.3 Policy level

In terms of contribution to policy formulation, it is hoped that the framework which is the product of this study will inform public sector financial management policy and regulations reviews. This is so as (Kothari, 2004:6) explains that research aids decisions of policy makers. Thus, the rigour associated with research produces proven strategies for policy improvements. Farag *et al.* (2013:49) assert that health spending has a positive impact on health outcomes and that there is a link on government spending on health and the effectiveness of the government; if only the government has the appropriate policies and establishments in place. This entails that improved policies and regulations would contribute to enhanced public finance management.

Thus, the outcome of this study is aimed to contribute to policy direction and changes. Globally, there is a move towards expansion of the Universal Health Coverage, amidst calls by the World Health Assembly (WHO) and the United Nations General Assembly (UNGA) for countries to 'urgently and significantly scale up efforts to accelerate the transition toward universal access to affordable and quality healthcare services' (Cashin *et al.* 2017:3). Therefore, governments need to review and incorporate into their policies working improvements for management of finances that should result in improved healthcare services and consequently health outcomes. This study makes a contribution towards the World Health Organisation's and the United Nations General Assembly's goals by analysing the public expenditure management setup in Malawi and with a view to enhancing expenditure management and consequently, achieving improved health outcomes for Malawi.

### 8.6.4 Research level

The study adds to scholarly debate on the concept of expenditure management in the public sector in order to contribute to improved health sector outcomes. Kioko *et al.* (2011:i120) hold that studies in public finance management yield new perspectives to scholars in financial decision making, control and related issues. Obviously, the outcomes from this study add to existing literature in studies related to the management of public resources.

The framework for improved public expenditure management furthers provide in-depth knowledge about the interrelationships of healthcare delivery and expenditure management**.** The framework developed from the results analysis becomes part of literature to be consulted. The data collection instruments for this study are available for scrutiny by researchers for further development.

### 8.6.5 Contribution to future research

This study produces a framework for enhancing public expenditure management in the public health sector. What is being provided now is a framework specifically on public expenditure management in the public healthcare sector. This framework, therefore, affords researchers, practitioners and policymakers with a base from which to assess public expenditure management in the public healthcare delivery sector and establishes a basis for related research. One study area emanating for this research could be to evaluate enhanced revenue generation capacities for local government to support healthcare service delivery. Secondly, future studies could compare public expenditure management at tertiary level, thus, the central hospitals and the district hospitals with a view to learning from the best practice of the two setups.

### 8.6.6 Contribution to new knowledge

The study produced a framework for enhanced public expenditure management in the public healthcare. New knowledge generated from the study cuts across the aspects of expenditure management in a decentralised public entity, a healthcare setup. Further studies can be made on the individual aspects identified as key influencers to effective and efficient expenditure management.

In addition, the study makes a contribution towards research methodology. Saunders *et al.* (2009:116) argues that research management and business studies require deep understanding of the phenomena in question, since they are complex in nature, thereby prescribing a qualitative approach to studies. However, due to complexities in business and management research, only obtaining a deep understanding of a phenomenon may not comprehensively answer a research

question. This study contributes to pragmatic approach to management and business research by mixing research methods where the individual research approaches enriches each other.

### 8.7 Limitations of the study

Studies always present limitations that affect the research process. This section presents limitations which were experienced during the period of the study which include:

i. The qualitative data was basically dependent on the participants' experience, perceptions and judgement on the subject matter, which could be subjective and restrictive in terms of the possibilities of generalisation of the results.
ii. Public expenditure management is quite a broad area and all aspects may not to be incorporated in this study as such, the specific issues to do with public expenditure management in Malawi may have to be part of future studies.

### 8.8 Recommendations for future work

The research was deemed complex and demanded thorough preparedness, patience and resilience and more importantly, excellent communication skills for its effective execution. Studies to do with financial management especially in the public sector are sensitive in that participating entities and participants themselves are considered political.

With the aforesaid in mind, caution was always exercised in order to motivate engagement and cooperation of the participants. Provided below is a list of issues that emerged from the study which contain suggestions put forward for future work:

i. Hospital management should look into modalities of effectively introducing fee paying sections in the hospitals in order to enhance revenue for the hospitals.
ii. The public and civil society are being mandated to lobby the government for increased budgetary allocation. Despite that the Government is usually stretched on resources, effective and efficient financial management in public sector management as a whole can free up finances which can be pumped into the health sector.
iii. In a bid to enhance revenue for healthcare service delivery there is need to enhance revenue generating capacity of hospitals. District health facilities are under local governments, but the local governments do not have adequate resources to extend and support the health facilities.
iv. As funding for healthcare service delivery is approved in a lump sum and reallocated to individual districts, it is vital that the government should improve and implement the

formula used for allocating government funding to hospitals so that funding is equitable amongst the districts.

v. The Government and Councils need to enhance the capacity of the personnel internal and external audit functions, which have been noted to be inadequate.
vi. Councils and hospital management should provide finance management trainings to staff, including finance and non-finance management staff.
vii. Councils and hospital management should enhance cost cutting in non-priority areas so that they are efficient and effective in finance resource utilisation in light of limited resources available in the health sector.
viii. Councils and hospital management should create an enabling environment so that personnel could access and be able to use information and computing technology in order to improve efficiency of financial reporting.
ix. Hospital management should make wider hospital consultations on budget and funds allocation so that allocations are comprehensive and also owned by the personnel and funding challenges appreciated.
x. Government should flex budget management protocols so that hospitals are able to easily move funds from one budget item to the other due to the nature of their operations.
xi. Government should expedite full devolvement from Central Government to District Councils so that the Councils are more effective and efficient in managing sectors including the health sector.
xii. Councils and hospital management should improve the quality and availability of financial information to allow effective monitoring of public spending
xiii. Government, Councils and hospital management should foster constructive dialogue with the civil society as these offer oversight functions on behalf of the public.
xiv. The Government and Councils should strengthen the performance management system.
xv. The Government should consider charging additional taxes on alcohol and cigarettes and committing the funds generated to public health service delivery for widening revenue base for the hospitals.
xvi. The government should consider introducing national health insurance schemes as this could be one way of enhancing revenue for the district hospitals.
xvii. The government and Councils could research on how public private partnerships could be fostered to the benefit of the Councils and the hospitals.

### 8.9 Implications for future study

This study explored public expenditure management in the public healthcare sector in Malawi. Based on the findings, there is need to look into the following areas in order to attain Malawi's goal of providing adequate and quality healthcare services needed by Malawians.

Future research could focus on the revenue generation models in Councils. Based on the fact public healthcare service delivery in Malawi is decentralised and that Councils at the moment cannot make substantial financial contribution to any of its sectors, studies must be conducted on the revenue of Councils to determine the revenue generation capabilities. Then, Councils can extend funding to the healthcare sector, among the other sectors it is responsible for.

Another recommendation for future research is a study into the possible restructuring of the budgetary approach for the public health sector in Malawi to determine a structure that best fits the peculiarity of the health sector in the Malawian context.

### 8.10 Chapter summary

This chapter made a recap on the research problem, research questions and research objectives. The research objectives were addressed including the major research objective. This chapter also presented a brief of the key findings from qualitative and quantitative results in Chapters from Chapter 5 and 6. The study analysed the challenges in the public healthcare service delivery sector that affect management of public expenditure. Having analysed the expenditure management environment, it was confirmed that efficient and effective public expenditure management for the public health service delivery sector could be enhanced by adopting the framework designed for the enhancement of public expenditure management in the health sector in Malawi. It is believed that the framework that was developed in this study can make a contribution towards expenditure management in the healthcare sector in Malawi, specifically the district hospitals. The public expenditure management framework could inform policymaking and practice in the hospital management. Lastly, usefulness of the framework depends on its acceptability by the government which is the policymaker, the Councils and hospital management as these in practice and implementers of policy.

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## ANNEXURE A: DATA COLLECTION TOOL - RESEARCH INTERVIEW GUIDE

**INTERVIEW GUIDE FOR AN ACADEMIC RESEARCH**

**RESEARCH TITLE: DEVELOPING A FRAMEWORK FOR EXPENDITURE MANAGEMENT IN THE MALAWIAN PUBLIC HEALTHCARE SECTOR**

Submitted in partial fulfilment of the requirements for the degree of Doctor of philosophy in Business Management at the Potchefstroom Campus of the North-West University

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**BACKGROUND**

*The public health sector's role in health service delivery is crucial in improving lives of the majority of the public who depend on public health services and consequently remain productive citizens who in turn effectively contribute to the economy of the country. Availability of finances and their management is said to have a crucial role on service delivery and achievement of health outcomes. Taking cognizance of this, the study purports to design a framework aimed at enhancing public expenditure management in the public health sector in Malawi.*

**INSTRUCTIONS**

The interview is an important research instrument for the study that I am undertaking. As such though you have to undertake voluntarily, kindly respond to each question thoroughly. Your name or any means of identification, will not appear anywhere in the research document for the sake of maintaining your anonymity. All your responses will be strictly confidential and will serve only this study and any publications that arise from the study, without having your identity revealed.

## SECTION A

**Personal details:**

Please share your personal details such as your designation, educational qualifications and the number of years you have been in service in your position.

## SECTION B

**B1 What are your views about the funding situation in the public district hospitals?**

a) What have been the trends in funding levels in the public district hospitals over the years?
b) What are(is) the major funding sources
c) What other sources supplement the major sources funding?
d) What innovations could be introduced to improve and widen funding?

**B2 How can the budget system be used to manage expenditure?**

a) How is the budget developed?
    - Who is involved in the determination of budgetary requirements?
    - What is the role of each of the players you have mentioned in the budgetary process?
    - How are the budgetary requirements determined?
b) How are funds allocated to hospitals? And how are allocations made to the hospital's departments?
c) How is the budget amended during the year in light of reality? How better would this be done?
d) How do the budgets relate with procurement plans?
e) Are there significant gaps between actual and budgeted annual expenditures over the years?
f) What is the relationship between of funding releases with budgetary provisions?

**B3 How do you perceive the efficiency in the utilisation of financial resources in the sector?**

a) Can you explain spending control measures applied in the hospital's sections/departments?
b) Are financial reports produced? How often are they produced? What actions are taken based on the financial report?
c) To what extent do the various providers of finance require the hospitals to account for the funds provided?
d) Are there external and internal audits on the use of finances? Who has access to the audit results, internally and externally? Are they discussed at management level? Are actions taken?

**B4 What factors influence optimization of management of public expenditure in the public district hospital?**

a) What do you consider to be the strengths that contribute to optimization of public expenditure management in the public district hospitals?
b) What challenges do the hospitals face in optimising management of expenditure?
c) What can be done to improve on these challenges?
d) What would you want improve in the hospital expenditure management environment?

***I sincerely thank you for your time and cooperation***

## ANNEXURE B: DATA COLLECTION TOOL – QUESTIONNAIRE

**RESEARCH QUESTIONNAIRE**

**BY**

**RABIYA HANIF**

**The questionnaire below is part of the Doctor of Philosophy in Economic and Management Sciences (PhD in Business Management) study that seeks to develop a framework for public expenditure management in the public health service delivery sector in Malawi.**

### A. INSTRUCTIONS:

1. I kindly request you to complete this questionnaire, it will not take you more than 30 minutes to complete.
2. Please do not write your name on this document.
3. By answering this questionnaire, you consent to take part in this study.

### B. BACKGROUND

The public health sector's role in health service delivery is crucial in improving lives of the majority of the public who depend on public health services and consequently remain productive citizens who in turn effectively contribute to the economy of the country. Availability of finances and their management is said to have a vital role on service delivery and achievement of health outcomes. Taking cognizance of this, the study purports to design a framework aimed at enhancing public expenditure management in the public health delivery sector in Malawi.

**Contact details:**

Rabiya Hanif (Mrs): rhanif@mubas.ac.mw mobile: 0997245399/0888843132 (Researcher)

or

Professor W Musvoto: Wedzerai.Musvoto@nwu.ac.za +27 762152255 (Supervisor)

**INSTRUCTIONS:** For each question below please put a tick in the appropriate box of your preferred answer. If your answer to a question is not in the options provided, write it in the space to the right of "Other *(Please specify)*". Please answer all questions.

## SECTION ONE

## BIOGRAPHICAL DATA

### 1.1 Name of the District you work in

| Balaka | | Mchinji | |
|---|---|---|---|
| Ntchisi | | Chikwawa | |
| Mwanza | | Phalombe | |
| Dedza | | Neno | |
| Rumphi | | Kasungu | |
| Nsanje | | Salima | |
| Lilongwe | | Ntcheu | |
| Thyolo | | Machinga | |
| Other *(Please specify)* ………………. | | | |

### 1.2. Gender

| Female | | Male | |
|---|---|---|---|

### 1.3 Age group

| 18 – 25 Years | | 26 – 35 Years | | 36 – 45 Years | |
|---|---|---|---|---|---|
| 46 – 55 Years | | 55 Years + | | | |

### 1.4 Designation

| District Commissioner | | Human Resource Management Officer | |
|---|---|---|---|
| Director of Health and Social Services | | District Environmental Health Officer | |
| Director of Finance | | Hospital Administrator | |
| Director of Administration | | Procurement Officer | |
| Director of Planning and Development | | Hospital Accountant | |
| Director of Public Works | | Internal Auditor | |

| District Medical Officer | | Program Coordinator | |
|---|---|---|---|
| District Nursing Officer | | Other:*(Please specify)* | |
| Health Promotion Officer | | | |

**1.5 Years in service**

| Less than 2 years | | 2– 5 years | | 6 –10 years | |
|---|---|---|---|---|---|
| 11–15 years | | Greater than 16 years | | | |

4

**1.6 Your highest qualification**

| Malawi School Certificate of Education or Equivalent | |
|---|---|
| Professional Certificate & Diploma | |
| Bachelor's degree | |
| Honours degree | |
| Master's degree | |
| Doctoral degree | |

## SECTION TWO

## THE FUNDING SITUATION IN THE PUBLIC HEALTH DELIVERY SECTOR IN MALAWI

| **To what extent do you agree or disagree with each of the following sources of funding for the public district hospitals. Indicate your response on a scale ranging from Strongly Disagree = 1, Disagree = 2, Neutral = 3, Agree = 4, Strongly Agree = 5. *(Please put a "circle" on a number representing your preferred answer and if you make a mistake, put an "X" across the circle and make another choice).*** | | | | | | |
|---|---|---|---|---|---|---|
| **The following sources of funding for the public district hospitals affect public expenditure management** | | | | | | |
| **2.1** | **The sources of funding for the public district hospitals** | | | | | |
| 2.1.1 | Government | 1 | 2 | 3 | 4 | 5 |
| 2.1.2 | Donors/implementation partners | 1 | 2 | 3 | 4 | 5 |
| 2.1.3 | Local Councils | 1 | 2 | 3 | 4 | 5 |
| 2.1.4 | Patients' contributions | 1 | 2 | 3 | 4 | 5 |
| **To what extent would you agree with each of the following challenges/limitations of funding sources in the public district hospitals. Indicate your responses on a scale ranging from Strongly Disagree = 1, Disagree = 2, Neutral = 3, Agree = 4, Strongly Agree = 5. *(Please put a "circle" on a number representing your preferred answer and if you make a mistake, put an "X" across the circle and make another choice).*** | | | | | | |
| **2.2** | **Challenges/limitations faced with the funding sources** | | | | | |
| 2.2.1 | Late government funding | 1 | 2 | 3 | 4 | 5 |
| 2.2.2 | Declining donor funding | 1 | 2 | 3 | 4 | 5 |
| 2.2.3 | Inadequate government funding | 1 | 2 | 3 | 4 | 5 |
| 2.2.4 | Donor funding is provided with specific instructions for its use | 1 | 2 | 3 | 4 | 5 |
| 2.2.5 | Weak income generation capacity of the Councils | 1 | 2 | 3 | 4 | 5 |

## SECTION THREE

## FACTORS THAT INFLUENCE PUBLIC EXPENDITURE MANAGEMENT IN THE PUBLIC HEALTH SERVICE DELIVERY SECTOR

**To what extent would you agree or disagree with each of the following statements on a scale ranging from Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2 to Strongly Disagree = 1.** ***(Please put a "circle" on a number representing your preferred answer. If you make a mistake, put an "X" across the circle and choose another answer)*****.**

| | | | | | | |
|---|---|---|---|---|---|---|
| **3.1** | **To what extent do you agree or disagree that the following resource allocation challenges influence public expenditure management in the public district hospitals?** | | | | | |
| 3.1.1 | Inadequate financial resources | 1 | 2 | 3 | 4 | 5 |
| 3.1.2 | Late funding from government | 1 | 2 | 3 | 4 | 5 |
| 3.1.3 | Misallocation of resources | 1 | 2 | 3 | 4 | 5 |
| 3.1.4 | Budget planning and preparation suffer from burdensome requirements arising from underfunding | 1 | 2 | 3 | 4 | 5 |
| **3.2** | **To what extent do you agree or disagree that the following staff challenges influence public expenditure management in the public district hospitals?** | | | | | |
| 3.2.1 | Staff shortages that compromises processing of transactions and reporting | 1 | 2 | 3 | 4 | 5 |
| 3.2.2 | Staff shortages causes irregular deployment of personnel | 1 | 2 | 3 | 4 | 5 |
| 3.2.3 | Staff incompetence | 1 | 2 | 3 | 4 | 5 |
| 3.2.4 | Lack of performance appraisal for staff | 1 | 2 | 3 | 4 | 5 |
| 3.2.5 | Delays in disciplining staff | 1 | 2 | 3 | 4 | 5 |
| 3.2.6 | Corrupt employees | 1 | 2 | 3 | 4 | 5 |
| 3.2.7 | Lack of staff morale | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 3.2.8 | Lack of integrity | 1 | 2 | 3 | 4 | 5 |
| 3.2.9 | Poor rapport with colleagues and superiors | 1 | 2 | 3 | 4 | 5 |
| **3.3** | **To what extent do you agree or disagree that the following financial management challenges affect management of public expenditure in the public district hospitals?** | | | | | |
| 3.3.1 | Excessively complicated administrative procedures | 1 | 2 | 3 | 4 | 5 |
| 3.3.2 | Poor control of expenditures | 1 | 2 | 3 | 4 | 5 |
| 3.3.3 | Weak financial management system | 1 | 2 | 3 | 4 | 5 |
| 3.3.4 | Lack of compliance to set procedures | 1 | 2 | 3 | 4 | 5 |
| 3.3.5 | Weaknesses in financial reporting | 1 | 2 | 3 | 4 | 5 |
| 3.3.6 | Inadequate flow of information | 1 | 2 | 3 | 4 | 5 |
| 3.3.7 | Weak capacity in external and internal audit functions | 1 | 2 | 3 | 4 | 5 |
| **3.4** | **To what extent do you agree or disagree that the following political challenges influence management of public expenditure in the public district hospitals?** | | | | | |
| 3.4.1 | Directives from central government to the hospitals to undertake unplanned activities | 1 | 2 | 3 | 4 | 5 |
| 3.4.2 | Lack of political will | 1 | 2 | 3 | 4 | 5 |
| 3.4.3 | Partial decentralisation of Councils | 1 | 2 | 3 | 4 | 5 |
| 3.4.4 | Hospitals are managed at both the Council and Ministry resulting in dual management | 1 | 2 | 3 | 4 | 5 |
| **3.5** | **To what extent do you agree or disagree that the following legislative weaknesses affect management of public expenditure in the public district hospitals?** | | | | | |
| 3.5.1 | Lack of compliance to legislative provisions | 1 | 2 | 3 | 4 | 5 |
| 3.5.2 | Legislative provisions for penalties are not deterrent enough | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 3.5.3 | Legal provisions governing have inconsistencies | 1 | 2 | 3 | 4 | 5 |
| 3.5.4 | Legal provisions governing have loopholes | 1 | 2 | 3 | 4 | 5 |
| 3.5.5 | Legal framework is neither clear nor comprehensive | 1 | 2 | 3 | 4 | 5 |
| 3.5.6 | There is weak monitoring of compliance of legal provisions | 1 | 2 | 3 | 4 | 5 |
| 3.5.7 | There is weak enforcement of legal provisions | 1 | 2 | 3 | 4 | 5 |
| **3.6** | **To what extent do you agree or disagree that the following management issues contribute to public expenditure management in the public district hospitals?** | | | | | |
| 3.6.1 | There is lack of fiscal discipline by the management | 1 | 2 | 3 | 4 | 5 |
| 3.6.2 | Management is not accountable to expenditure of public funds | 1 | 2 | 3 | 4 | 5 |
| 3.6.3 | There is lack of monitoring of finances | 1 | 2 | 3 | 4 | 5 |
| 3.6.4 | Management does not consult on resource allocations | 1 | 2 | 3 | 4 | 5 |
| 3.6.5 | There is no autonomy over finances | 1 | 2 | 3 | 4 | 5 |
| **3.7** | **To what extent do you agree or disagree that the following procurement and supply chain challenges influence public expenditure management in the public district hospitals?** | | | | | |
| 3.7.1 | Compromised procurement function | 1 | 2 | 3 | 4 | 5 |
| 3.7.2 | Funding challenges affect compliance to procurement plans | 1 | 2 | 3 | 4 | 5 |
| 3.7.3 | Centralization of some procurements | 1 | 2 | 3 | 4 | 5 |
| 3.7.4 | Poor procurement planning and budgeting | 1 | 2 | 3 | 4 | 5 |
| 3.7.5 | Lack of effective supervision and monitoring | 1 | 2 | 3 | 4 | 5 |
| 3.7.6 | Poor stock management | 1 | 2 | 3 | 4 | 5 |
| 3.7.7 | Increasing prices constrain budget resources | 1 | 2 | 3 | 4 | 5 |
| 3.7.8 | Strict procurement regulations | 1 | 2 | 3 | 4 | 5 |

## SECTION FOUR

## STRATEGIES TO IMPROVE CONSTRAINTS/CHALLENGES

| **The following are recommendations for improvement of public expenditure management in the public district hospitals. To what extent would you agree or disagree with each of the following recommendations on a scale ranging from Strongly Agree = 5, Agree = 4, Neutral = 3, Disagree = 2 to Strongly Disagree = 1. *(Please put a "circle" on a number representing your preferred answer. If you make a mistake, put an "X" across the circle and choose another answer).*** | | | | | | |
|---|---|---|---|---|---|---|
| **4.1** | **Strategies for improved funding in the public district hospitals** | | | | | |
| 4.1.1 | Introducing fee paying sections in the hospitals | 1 | 2 | 3 | 4 | 5 |
| 4.1.2 | Lobbying for increased budgetary allocation | 1 | 2 | 3 | 4 | 5 |
| 4.1.3 | Enhance revenue generating capacity of hospitals | 1 | 2 | 3 | 4 | 5 |
| 4.1.4 | Charging additional taxes on alcohol and cigarettes and committing the funds generated to public health service delivery | 1 | 2 | 3 | 4 | 5 |
| 4.1.5 | Introducing national health insurance schemes | 1 | 2 | 3 | 4 | 5 |
| 4.1.6 | Entering into Public Private Partnerships | 1 | 2 | 3 | 4 | 5 |
| **4.2** | **Strategies for effective management of public expenditure** | | | | | |
| 4.2.1 | Improve the formula used in allocating government funding to hospitals | 1 | 2 | 3 | 4 | 5 |
| 4.2.2 | Enhance capacity of oversight functions | 1 | 2 | 3 | 4 | 5 |
| 4.2.3 | Provide training to staff | 1 | 2 | 3 | 4 | 5 |
| 4.2.4 | Enhance cost cutting in non-priority areas | 1 | 2 | 3 | 4 | 5 |
| 4.2.5 | Enhance use of ICT in production of reports | 1 | 2 | 3 | 4 | 5 |
| 4.2.6 | Consult on budget and funds allocation | 1 | 2 | 3 | 4 | 5 |
| 4.2.7 | Increase funding for hospitals | 1 | 2 | 3 | 4 | 5 |
| 4.2.8 | Hospitals should be able to easily move funds from one budget item to the other due to the nature of their operations | 1 | 2 | 3 | 4 | 5 |
| 4.2.9 | Full devolvement from Central government to District Councils | 1 | 2 | 3 | 4 | 5 |

| 4.2.10 | Improve quality and availability of financial information to monitor public spending | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 4.2.11 | Foster constructive dialogue with the civil society | 1 | 2 | 3 | 4 | 5 |
| 4.2.12 | Strengthen the performance management system | 1 | 2 | 3 | 4 | 5 |

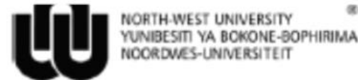
**As a respondent of this pilot study, the researcher would appreciate if you could also answer the following analytical questions relating to the questionnaire by marking the appropriate answer with a cross (X), or commenting on the space provided**

| **1.0 How many minutes did you take to complete this questionnaire?** | | |
|---|---|---|
| 1.1 | 0 to 10 minutes | |
| 1.2 | 10 to 20 minutes | |
| 1.3 | 20 to 30 minutes | |
| 1.4 | 30 to 40 minutes | |
| 1.5 | More than 40 minutes | |
| **2.0 To what degree did the questionnaire interested you and motivated you to respond?** | | |
| 2.1 | To no degree | |
| 2.2 | To a lesser degree | |
| 2.3 | To a fair degree | |
| 2.4 | To a high degree | |
| 2.5 | Totally | |
| **3.0 To what degree was the language understandable?** | | |
| 3.1 | To no degree | |
| 3.2 | To a lesser degree | |
| 3.3 | To a fair degree | |
| 3.4 | To a high degree | |
| 3.5 | Totally | |
| **4.0 How would you describe the questions as applicable to public expenditure management?** | | |
| 4.1 | Not applicable | |
| 4.2 | Applicable | |
| 4.3 | Totally applicable | |
| **5.0 Are the instructions for the questionnaire clear?** | | |
| 5.1 | Yes | |
| 5.2 | No | |
| **6.0 If your answer is no, please indicate where you have experienced** | | |

| **challenges / problems and what changes you would recommend** | | |
|---|---|---|
| **7.0 In your opinion to what degree do the questions follow a logic sequence?** | | |
| 7.1 | To no degree | |
| 7.2 | To a lesser degree | |
| 7.3 | To a fair degree | |
| 7.4 | To a high degree | |
| 7.5 | Totally | |
| **8.0 In your opinion to what degree is the scale applicable to the questions?** | | |
| 8.1 | To no degree | |
| 8.2 | To a lesser degree | |
| 8.3 | To a fair degree | |
| 8.4 | To a high degree | |
| 8.5 | Totally | |
| **9.0 In your opinion to what degree did you understand the aim of the questionnaire?** | | |
| 9.1 | To no degree | |
| 9.2 | To a lesser degree | |
| 9.3 | To a fair degree | |
| 9.4 | To a high degree | |
| 9.5 | Totally | |
| **10.0 In your opinion was the questionnaire too long?** | | |
| 10.1 | Yes | |
| 10.2 | No | |

**************Thank you for your time***************

## ANNEXURE C: ETHICAL CLEARANCE FROM NORTH-WEST UNIVERSITY




Private Bag X6001, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Web: http://www.nwu.ac.za

Economic and Management Sciences Research
Ethics Committee (EMS-REC)

5 December 2020

Prof W Musvoto
*Per e-mail*
Dear Prof Musvoto,

**EMS-REC FEEDBACK: 20112020**
**Student: Hanif, R (33489629)(NWU-00934-20-A4)**
**Applicant: Prof W Musvoto – PhD in Business Management**

Your ethics application on, ***A framework for improving expenditure management in public health sector in Malawi,*** which served on the EMS-REC meeting of 20 November 2020, refers.

**Outcome:**

Approved as a minimal risk study. A number **NWU-00934-20-A4** is given for one year of ethics clearance.

Due to the Covid-19 lock down ethics clearance for applications that involve data collection or any form of contact with participants are subject to the restrictions imposed by the South African government.

Kind regards,

Mark
Rathbone

Digitally signed by Mark Rathbone
DN: cn=Mark Rathbone, o=North-West University, ou=Business management,
email=mark.rathbone@nwu.ac.za,
c=ZA
Date: 2020.12.08 09:34:21 +02'00'

**Prof Mark Rathbone**
**Chairperson: Economic and Management Sciences Research Ethics Committee (EMS-REC)**

## ANNEXURE D: ETHICAL CLEARANCE FROM THE MALAWI NATIONAL COMMISSION ON RESEARCH IN THE SOCIAL SCIENCES AND HUMANITIES

NATIONAL COMMISSION FOR SCIENCE & TECHNOLOGY

Lingadzi House
Robert Mugabe Crescent
P/Bag B303
City Centre
Lilongwe

Tel: +265 1 771 550
+265 1 774 189
+265 1 774 869
Fax: +265 1772 431
Email:directorgeneral@ncst.mw
Website:http://www.ncst.mw

**NATIONAL COMMITTEE ON RESEARCH IN THE SOCIAL SCIENCES AND HUMANITIES**

**Ref No: NCST/RTT/2/6** **10th February 2021**

Ms Rabiya Hanif,

Principal Investigator,

University of Malawi, The Polytechnic,

Private Bag 303,

Chichiri,

Blantyre 3.

Email: rhanif@poly.ac..mw

Dear Ms Hanif

**RESEARCH ETHICS AND REGULATORY APPROVAL AND PERMIT FOR PROTOCOL NO. P.01/21/540: A FRAMEWORK FOR IMPROVING PUBLIC EXPENDITURE MANAGEMENT IN PUBLIC HEALTH SECTOR IN MALAWI**

Having satisfied all the relevant ethical and regulatory requirements, I am pleased to inform you that the above referred research protocol has officially been approved. You are now permitted to proceed with its implementation. Should there be any amendments to the approved protocol in the course of implementing it, you shall be required to seek approval of such amendments before implementation of the same.

This approval is valid for one year from the date of issuance of this approval. If the study goes beyond one year, an annual approval for continuation shall be required to be sought from the National Committee on Research in the Social Sciences and Humanities (NCRSH) in a format that is available at the Secretariat. Once the study is finalised, you are required to furnish the Committee and the

Committee Address:

***Secretariat, National Committee on Research in the Social Sciences and Humanities, National Commission for Science and Technology, Lingadzi House, City Centre, P/Bag B303, Capital City, Lilongwe3, Malawi. Telephone Nos: +265 771 550/774 869; E-mail address: ncrsh@ncst.mw***

Commission with a final report of the study. The committee reserves the right to carry out compliance inspection of this approved protocol at any time as may be deemed by it. As such, you are expected to properly maintain all study documents including consent forms.

Wishing you a successful implementation of your study.

Yours Sincerely,

Yalonda .I. Mwanza
**NCRSH ADMINISTRATOR**
**HEALTH, SOCIAL SCIENCES AND HUMANITIES DIVISION**

**For: CHAIRMAN OF NCRSH**

**Committee Address:**
***Secretariat, National Committee on Research in the Social Sciences and Humanities, National Commission for Science and Technology, Lingadzi House, City Centre, P/Bag B303, Capital City, Lilongwe3, Malawi. Telephone Nos: +265 771 550/774 869; E-mail address: ncrsh@ncst.mw***

**ANNEXURE E: INFORMED CONSENT FORM – QUALITATIVE PARTICIPANTS**

**North-West University**

**NWU School of Business & Governance**

**Researcher:**

Rabiya Hanif

North West University

NWU School of Business & Governance

Private Bag X1290, Potchefstroom

South Africa 2520

Cell: (+265) 997 245 399

(+265) 888 843 132

Email: *rhanif@mubas.ac.mw*

Dear Participant,

**INFORMED CONSENT TO PARTICIPATE IN AN INTERVIEW**

I am Rabiya Hanif, a PhD student at the NWU School of Business and Governance, North-West University in South Africa. In partial fulfilment for the requirements of the PhD in Business Administration that I am pursuing at the Potchefstroom campus of the North-West University, I have to undertake a study. The study aims at evaluating management of expenditure in the public healthcare sector in Malawi. The title of the study is 'Developing a framework for expenditure management in the Malawian public healthcare sector'. The University requires strict adherence to ethical standards and this study upholds to that requirement.

The main objective of the study is to introduce a framework aimed at enhancing management of public expenditure in the healthcare sector in Malawi. In order to achieve the main study objective, the following specific objectives will be pursued:

- Determine the funding situation in the public healthcare delivery sector in Malawi.
- Ascertain factors that influence optimization of public expenditure management in the public healthcare delivery sector in Malawi.
- Establish the extent to which budgetary systems are utilised in the effective management of expenditure in the public healthcare delivery sector in Malawi.
- Explore ways of enhancing efficiency in utilisation of financial resources in the public healthcare delivery sector in Malawi.

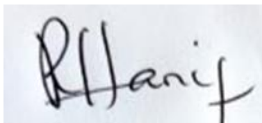
I appreciate your willingness to participate in the study. Kindly take note that your participation in the study is voluntary. Should you seek any explanations, have questions or clarifications pertaining to the study at any point, you are free to ask for any such information. You are also at liberty to withdraw from the study at any point or refuse to answer any particular question without reason; and without any consequences to you.  All the information that you provide in the study shall be treated with strict confidence and that you shall not be identified in the study report. Furthermore, as the information collected in this study is for academic research purposes, the results of the study will be published in a thesis, academic journals and other publications.

It is estimated that the interviews will take one hour. To accurately capture your words, with your permission, the interview will be recorded. If you so wish, you may ask for the recorded or transcribed information. Additionally, the interviewer will take notes during the interviews. This will be purely to aid data analysis.

The transcription of the interviews will be done by the interviewer and will be kept confidential in a password protected computer and all personal identification will be removed and further your identity will be concealed using codes. Interview excerpts could form part of the thesis, journal articles and other publications but these will not in any way reveal your identity.

My supervisor is Professor Wedzerai S. Musvoto and can be reached on email address: wedzerai.musvoto@nwu.ac.za or telephone number (+27) 18 389 2088, for any further questions and concerns relating to the project.

Yours Faithfully



**RABIYA HANIF**

## ANNEXURE F: INFORMED CONSENT FORM – QUANTITATIVE RESPONDENTS

**North-West University**

**NWU School of Business & Governance**

**Researcher:**

Rabiya Hanif

North West University

NWU School of Business & Governance

Private Bag X1290, Potchefstroom

South Africa 2520

Cell: (+265) 997 245 399

(+265) 888 843 132

Email: rhanif@mubas.ac.mw

26th November 2020

Dear Participant,

**INFORMED CONSENT TO COMPLETE QUESTIONNAIRES**

I am Rabiya Hanif, a PhD student at the NWU School of Business and Governance, North-West University in South Africa. In partial fulfilment for the requirements of the PhD in Business Administration that I am pursuing at the Potchefstroom campus of the North-West University, I have to undertake a study. The study aims at evaluating management of expenditure in the public health sector in Malawi. The title of the study is 'Developing a framework for expenditure management in the Malawian public healthcare sector'. The University requires strict adherence to ethical standards and this study upholds to that requirement.

The main objective of the study is to introduce a framework aimed at enhancing management of public expenditure in the healthcare sector in Malawi. In order to achieve the main study objective, the following specific objectives will be pursued:

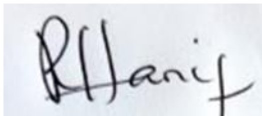
- Determine the funding situation in the public healthcare delivery sector in Malawi.

- Ascertain factors that influence optimization of public expenditure management in the public healthcare delivery sector in Malawi.
- Establish the extent to which budgetary systems are utilised in the effective management of expenditure in the public healthcare delivery sector in Malawi.
- Explore ways of enhancing efficiency in utilisation of financial resources in the public healthcare delivery sector in Malawi.

I appreciate your willingness to participate in the study. Kindly take note that your participation in the study is voluntary. Should you seek any explanations, have questions or clarifications pertaining to the study at any point, you are free to ask for any such information. You are also at liberty to withdraw from the study at any point or refuse to answer any particular question without reason; and without any consequences to you. All the information that you provide in the study shall be treated with strictest confidence. The completed questionnaires will be securely locked away. You shall not be identified in the study report as the only identification will be codes. Furthermore, as the information collected in this study is for academic research purposes, the results of the study will be published in a thesis, academic journals and other publications. It is estimated that completion of the questionnaire will take half an hour.

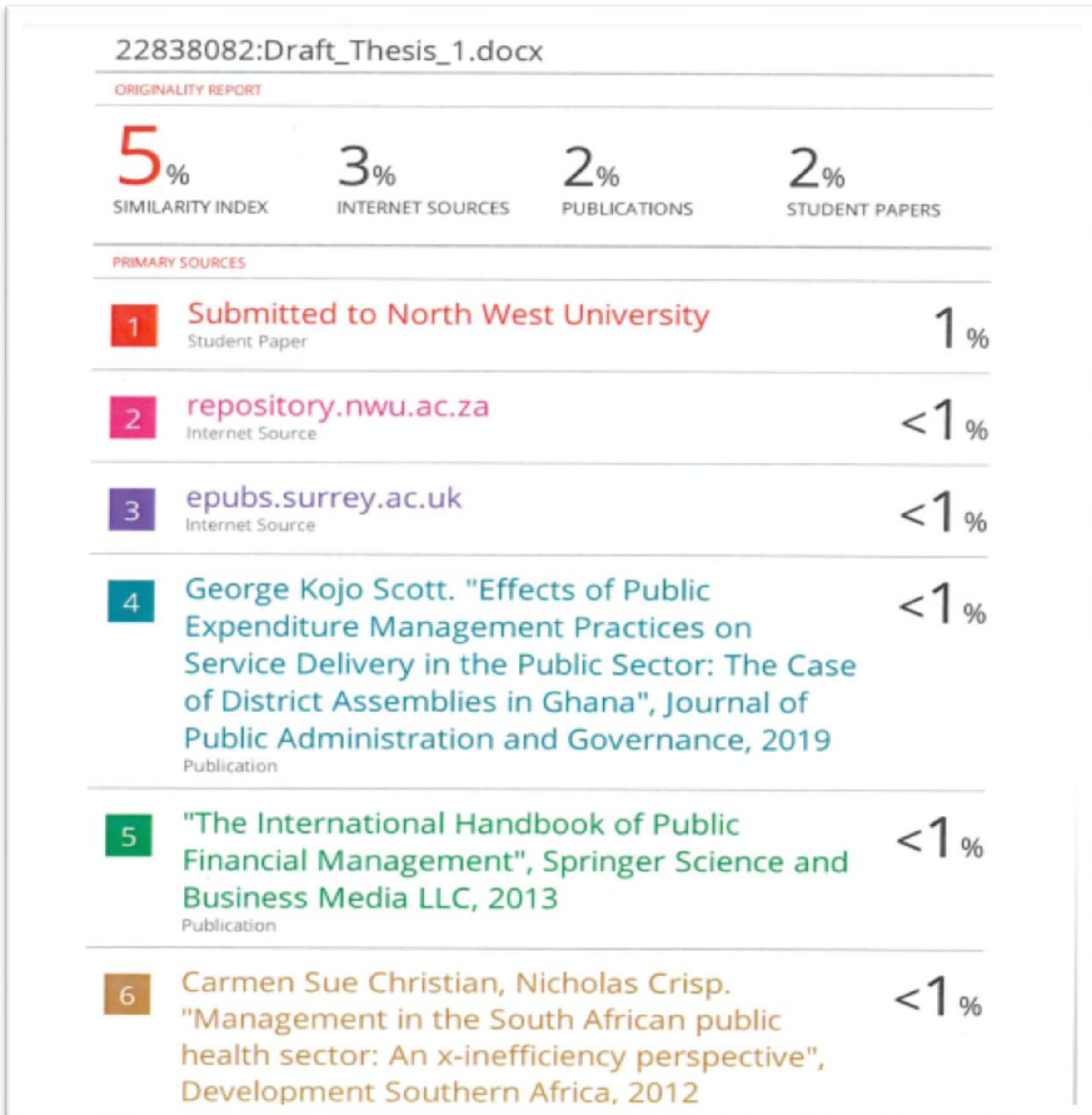
My supervisor is Professor Wedzerai S. Musvoto and can be reached on email address: wedzerai.musvoto@nwu.ac.za or telephone number (+27) 18 389 2088, for any further questions or concerns relating to the project.

Yours Faithfully



**RABIYA HANIF**

## ANNEXURE G: PLAGIARISM TURNITIN REPORT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## ANNEXURE H: CONFIRMATION CERTIFICATE FROM THE EDITOR

**Declaration**

**This is to declare that I, Dr. L Combrink**

**Language editor and translator**

**have language edited the study**

**with the title**

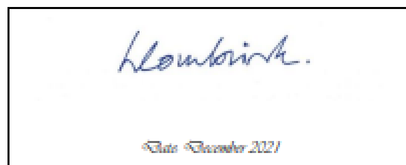
# Developing a framework for expenditure management in the Malawian public healthcare sector

**by**

**R Hanif**

***Non-disclosure clause:***

**I declare that I will not disclose any information from the above study.**



Date December 2021