Dynamics of Ethics on Health Resource Allocation Priority Setting During Covid-19 Pandemic in Zimbabwe

BY

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Abstract

The study sought to evaluate ethics and Covid-19 resource allocation priority setting in Zimbabwe's health sector. Globally, healthcare systems have undergone fast transformation as a result of the COVID-19 (SARS-CoV-2) pandemic. The study was guided by Positivism research Philosophy rooted in quantitative research approach. In this study, a cross-sectional survey design was utilized. Using purposive sampling 30 Zimbabwean health professionals who work in different medical facilities in the country were taken as the study population. As the population was too tiny to be studied, this research used all the study target population as a sample size. Questionnaires were research instruments employed to collect data in this study. The data was represented in the form of tables, figures, charts and themes. Quantitative data was analysed using descriptive statistics and correlations. The findings of the study revealed that the health sector in Zimbabwe has a wide range of criteria in place for allocating covid-19 resources. Respect for autonomy, the absence of maleficence, beneficence, and justice, all of which were in accordance with mainstream biomedical ethical practise, were also in place. As a result of the study, it was determined that nonclinical patient characteristics, such as race/ethnicity, gender, age, the presence or absence of disabilities, and presumed health-related quality of life before or after resource allocation should be avoided, and that the process should take a systems view, taking regional rather than health system–specific triage and resource allocation into consideration. The study's findings suggested that prioritisation was carried out by the health-care sector, as proven by the fact that those who were at the highest risk of being sick and extremely sick were able to obtain the largest possible benefit from the vaccination in Zimbabwe. Rationing and prioritisation should be based on normative values that have at least some public legitimacy. Aside from the Covid-19 epidemic, the report recommends that a longitudinal research be conducted on resource allocation and priority setting for other illnesses in Zimbabwe.

Key Words: Ethics, Health Resource Allocation, Priority Setting, Covid-19 Pandemic, Zimbabwe

Introduction and Background of the Study

Governments, international bodies, and health systems all have a commitment to guarantee that everyone has access to sufficient health care. This may be impossible, however, during a pandemic, when health resources are likely to be scarce. Prioritizing and allocating resources in this framework required making sad decisions, yet these sad decisions could be justified ethically. This is why ethics exist. This study intended to establish the ethics of prioritizing resource distribution during times of scarcity. Access to hospitals, ventilators, immunizations, and medications are examples of such decisions. It is critical that policies and practices are ethically justified in such circumstances, as this study aimed to prove in the Zimbabwe health sector. Numerous ethical

frameworks for resource allocation have been developed, some of which have been incorporated into pandemic strategies. These frameworks are instructive in the current environment. That is, while the ethical norms governing resource allocation may be the same throughout pandemics, they may result in different outcomes depending on the environment.

Globally, healthcare systems have undergone a fast transformation as a result of the COVID-19 (SARS-CoV-2) pandemic. The virus has touched both individuals who were directly infected and those who were indirectly influenced by the infection's repercussions. Healthcare systems are under tremendous strain, and governments have implemented public health measures to suppress the infection wave and reduce the resulting strain on hospitals. Hospitals prepared for and responded to this calamity in two ways: by forecasting COVID-19 hospital admissions and resource requirements and by establishing the capacity to serve COVID-19 patients optimally. This response implies that the focus is solely on patients with COVID-19. However, the necessity for non-COVID-19 care has not been eliminated, and patients continue to require critical healthcare. Therefore, it is critical from an ethical and strategic standpoint to allocate precious resources to both COVID-19 and non-COVID-19 treatment.

Health care companies, which are now integrated into large corporations, are not immune to the "ethical gap." Indeed, they are in the thick of it, as a result of the decade-long reorganization of health care. Typically, this reorganization has taken the shape of some form of managed care. Canavan (2019) explored ethical concerns associated with mismanaged treatment, including gag regulations, a lack of complete information, and remuneration structures that reward withholding health care services. Despite professional and popular indignation over these ethical violations, there is a shortage of evidence on ethics and resource allocation during pandemics in Zimbabwe, a gap that this study attempted to rectify.

According to Silva (2020), individuals in leadership positions in health care frequently micromanage or overlook ethical issues, or allow legal concerns to trump ethical decisions. Silva (2020) claimed that when the executives micromanage, they lose sight of the big picture. As a result, Raiser (2020) suggested that CEOs are unable to appreciate the value of an ethics infrastructure that encompasses not only their own departments but also all other departments within a business. When health care executives are ethically blind, they are prone to operate with little knowledge and insight, frequently resulting in deficient decision-making (Raiser, 2020). The allocation of scarce resources is a frequent example. Silver (2020) said that if a health care executive views resource allocation solely as a monetary issue, the executive is blind to the fact that all resource allocation decisions are ultimately ethical.

Infectious disease outbreaks on a worldwide scale have impacted the social, economic, and political landscapes of countries. Multiple obstacles in managing health care resources were caused by the Coronavirus Disease 2019 (COVID-19) pandemic (WHO, 2020). From February 2020 on, rates of illness, hospitalization, and death associated with Severe Acute Respiratory Syndrome

Coronavirus (SARS-CoV-2) infection increased dramatically in the United States and other nations (Wilson, 2020). Variation in or absence of health care resource allocation policies among health care settings has resulted in instances where some clinical personnel became de facto resource allocation decision-makers, frequently with life or death implications for their patients and even for themselves (Wilson, 2020).

Ethics are principles of morality, as stated by Hiller (2020). Based to Hiller (2020), executives in the health care industry should use the following six ethical standards. They have the following traits: beneficence, non-maleficence, respect for others, justice, usefulness, and telling the truth. The values of autonomy, beneficence, and justice are guiding medical ethics decisions (Beauchamp & Childress, 2020). When policy-makers, managers, and service providers are presented with tough resource allocation decisions, they can benefit from looking at distributive justice.

A new analysis released by the Ministry of Health (2020) demonstrates that in Zimbabwe, both communicable and non-communicable diseases contribute to the country's double burden of disease. Both diarrhea and anthrax and rabies outbreaks are prevalent in Zimbabwe. This highlights the important role that good public health surveillance and disaster preparedness and response programs play in containing epidemics. However, this study sought to assess ethics and Covid 19 resource allocation priority setting in Zimbabwe's health sector.

Statement of the Problem
Ethical models for allocating resources have been developed, some of which have been incorporated into pandemic strategies. These frameworks are instructive in the current environment. However, when implementing them, it is necessary to consider the type of health care resource, the context, and the stage of the pandemic. That is, while the ethical norms governing resource allocation may be the same throughout pandemics, they may result in different outcomes depending on the environment. Different principles or values may provide ethical arguments for resource distribution. Once a novel vaccination is established to be safe and effective, it is appropriate to prioritize individuals at greatest risk, as well as populations such as health care workers who may act as vectors for transmission. While there is a substantial body of research on clinical ethics in health care, there is significantly less on ethics and resource allocation priority setting in the context of Zimbabwe, which this study intended to create.

Research Objectives
1. To evaluate ethics and Covid 19 resource allocation priority setting in Zimbabwe's health sector.

Methodology
The study was guided by Positivism research Philosophy rooted in a quantitative research approach. In this study, a cross-sectional survey design was utilized. Using purposive sampling 30 Zimbabwean health professionals who work in different medical facilities in the country were taken as the study population. As the population was too tiny to be studied, this research used all the study target populations as a sample size. Questionnaires were research instruments employed to collect data in this study. The

data was represented in the form of tables, figures, charts and themes. Quantitative data was analysed using descriptive statistics and correlations.

Theoretical Framework

Social Utility theory guided this research study. The theory was utilized as a guide for allocating resources across governments and two critical factors are needed: first, the formulation of clear criteria and mechanisms for the reconciliation of differences in people's relative utilities for different combinations of goods in order to come up with a comprehensive social utility function; and second, a single denominator of utility as a common reference point for comparisons of alternative uses of public funds. Efforts to find measures of cost-effectiveness cannot be considered to be capable of providing this one factor, and offer only a partial sector or program-specific solution to the second. More efficient and efficient methods of determining cost-benefit have been discovered in the idea of allocative efficiency and the monetary valuation of costs and benefits, both of which are employed in cost-benefit analysis approaches. Following this approach, public interventions are said to display the property of optimality or allocative efficiency, when at least one individual is made better off and no individual is made worse off: There are only winners. Since identifying all winners and losers would be nearly impossible, this criterion is not realistic to implement. Also, in this situation, the winners would have a motive to underreport their losses in order to get a bigger prize, which significantly restricts the ability of the public to step in.

Review of Related Literature

1. Ethics and Covid 19 resource allocation priority setting in Zimbabwe's health sector

In order to deal with the crises caused by the first virus outbreak known as the Covid-19 pandemic, the responsibilities of ethics in resource allocation in the health sector in Zimbabwe were important. When using ethical rules for resource allocation, we should assess the extent to which resources are overloaded in the current situation (Moore, 2019). When one decides to take responsible action, health authorities should define criteria for the priority-setting judgments that might be essential in this situation. For instance, it would be unethical to exclude demographic groups from being assigned a resource (such as ventilators) during the onset of a pandemic when there is still room for growth. Resources are always few, and hence we must have a method for resource distribution that is governed by broad, generally applicable ethical standards, especially in the event of an outbreak where characteristics of the disease should lead our course of action (Hiller, 2019). The focus of all pandemic preparedness and response efforts should be on relevant characteristics of populations within countries, such as ethnicity, race, or creed. These irrelevant qualities should have no bearing on any type of resource allocation during a pandemic. This represents our promise to offer the same treatment to all of our patrons.

The allocation should be designed to advance equality: first come, first served, or by random allocation, when no relevant characteristics affect the chances of an individual being chosen in a given distribution system (for example, among those with similar needs, or among those who can be expected to benefit similarly from the resources, or among those that are at similar levels of risk). Additionally, more than one principle may be used inside an allocation scheme. Also, for example, a scheme for PPE (e.g., insurance coverage) may find its justification in principles such as the following: prioritizing those who are most at danger, as well as a principle that prioritizes those who serve others, which would justify the allocation of PPE to health care workers.

Most judgments deal with more than one ethical value or principle, and numerous values and principles will thus be important when considering how to allocate resources (Mohr and Mahon, 2019). According to Mohr and Mahon (2019), this is likely to cause some disputes because the weighting of the values may vary by person. Some could prioritize equality, while others might place greater emphasis on achieving the best possible outcomes or in identifying and helping the people who are in the worse positions. Because these values must be fairly applied across all the various allocation questions, it is critical that they be weighed and applied individually according to sound methods. Therefore, according to Mohr and Mahon (2019), equitable resource allocation processes must support ethical principles such as equality, equity, and social justice.

It is absolutely critical to guarantee that the country's health resources are equally distributed and available to those who need them the most during a medical crisis. Furthermore, Hiller (2020) states that having precedence of justice and equality in distributing healthcare resources is likely to have a lower chance of spreading diseases and minimizing the burden of health crises on the economy. When healthcare executives undermine their patients' well-being, healthcare personnel lose their motivation, and relationships are established that increasing distrust throughout the entire system, the workforce, and the general community.

While it is crucial to be efficient in the acquisition and production of resources (i.e. having a healthy workforce, great facilities, medications, equipment, and knowledge), this also has an impact on resource allocation decisions. Public health experts would argue that equity in access to quality institutions and health care facilities, as well as equitable distribution of health care facilities, is a critical priority in terms of health equity over real estate developers' goals or the preferences of for-profit hospital owners. In order to secure the availability of multiple facilities that provide individuals the freedom to choose, policymakers and managers should make an effort to assure the availability of these resources. It will have a huge impact on whether you can get care, especially if you want it from both public and private hospitals, community clinics, health centers, inpatient and outpatient mental health facilities, or long-term care institutions and hospices. In many urban places, where there is a lack of choice, the stakes are high since facilities that offer a massive amount of care for the poor are on the line. In this situation, being optimistic seem to be an appropriate mindset.

Although one may assume that rationing and priority setting in health care appear to be two separate concepts, it is, in fact, only semantics. In an economic context, rationing describes the act of

distributing goods with an allocation that is restricted due to budget constraints encountering an unconstrained demand. By rationing health care services, health care rationing therefore occurs. Health care setting features a process of determining priorities, which differs from the healthcare prioritization process in which governments, public authorities, or physicians designate priority for distinct services, programs, or patients.

Results and Discussion

Response Rate Analysis

Only 25 of the 30 surveys given were completed properly and were useable, resulting in an 83 percent response rate. Similarly, Saunders et al. (2007) argue that a response rate of 50% is acceptable in a study, while 60% is considered acceptable, and 70% or above is considered extremely acceptable. As a result, the study's response rate of 83 percent was extremely acceptable, and the results from such a low response rate were not only reliable but also helped build a thorough foundation for making conclusions.

Reliability Analysis

The internal consistency of constructs was determined using Cronbach's Alpha (). Cronbach's () reliabilities for the constructs in the investigation are shown in Table 1.1.

Table 1. 1 Construct, Number of items and Cronbach's (α)

Construct	Number of Items	Cronbach's alpha (α)
Ethical dimensions of resource allocation	5	0.857
Criteria for priority setting on resource allocation	5	0.739
Resource production	5	0.822
Access to health care	5	0.787

Source: Survey (2021)

As demonstrated in Table 1.1, the reliabilities of all structures examined were more than the 0.6 cut-off mark (Bagozzi and Yi, 1988). All constructs had Cronbach's coefficients () greater than 0.6. (Gunday et al., 2011). This indicated that the data for the research were trustworthy.

Factor Analysis

EFA was used to decipher the structure of a collection of variables and also to ascertain whether questions accurately assessed the questionnaire's underlying components.

Adequacy Sampling

Prior to conducting an EFA, the data were evaluated for factor analysis sustainability using the Kaiser Meyer Olkin Measure of Sampling Adequacy (KMO) and Bartlett's Test of Sphericity in SPSS Version 22. The results obtained in Table 1.2 (KMO = 0.751, Approximate Chi-square = 12730.345, Degrees of freedom [DF] =

1243; p 0.001) indicated that the sample was eligible for exploratory factor analysis (Field, 2009). Additionally, EFA was used to filter and reduce the vast number of associated variables to a manageable amount prior to employing them in subsequent studies. Zikmund and Babin (2016) defined component rotation as a mathematical technique for simplifying factor findings in order to make them easier to comprehend. To simplify factor analysis, the Varimax approach was utilized. The strategy was chosen because it maximizes the distribution of loadings within factors, resulting in clearly interpretable clusters of factors (Field, 2009).

Table 1. 2 KMO and Bartlett's Test of Sphericity

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.751
Bartlett's Test of Sphericity	Approx. Chi-Square	12730.345
	Df	1243
	Sig.	.000

The study's findings indicate the loadings of each component. Factor loadings less than 0.4 were suppressed, in accordance with Steven's recommendation that only factor loadings greater than 0.4 be interpreted, therefore simplifying interpretation (Field, 2005). Due to their low factor loadings, the following elements FM1 and FMS6 were omitted (Field, 2009). As a consequence, the data indicate that all factor loadings exceeded 0.6, the cut-off value for factor loadings (Bagozzi& Yi, 1988; Lewis-Beck, 1994).

Table 4. 6 Constructs, Items, Factor Loadings

Construct	Items	Factor Loadings
Ethical dimensions of resource allocation	DM1	0.646
	DM2	0.876
	DM3	0.943
	DM4	0.722
	DM5	0.923
Criteria for priority setting on resource allocation	DBM10	0.654
	DBM12	0.549
	DBM13	0.923

	DBM14	0.876
Resource production	DBM15	0.756
	DBM16	0.903
	DBM17	0.867
	DBM18	0.564
	DBM19	0.968
Access to health care	GREF1	0.726
	GREF2	0.666
	GREF3	0.664
	GREF4	0.678
	GREF 5	0.645

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

Rotation converged in 4 iterations.

Based on Eigenvalues > 1.00

Total variance explained = 87.072%

Loadings of less than 0.4 were suppressed

Source: Survey (2021)

The rotation of the study findings converged after four iterations, and the total variance explained by the data was 74.07 percent, above the allowed limit of 60% (Atalay et al., 2013). As predicted, the rotational component matrix solution yielded four components, namely GREF, DBM, BFM, and DM.

Descriptive Statistics

The scale used in the study had the following response points: 1 Strongly Disagree, 2 Disagree, 3 Neutral, 4 Agree, 5 strongly agree.

Ethical dimensions of resource allocation in Zimbabwe's health sector during the Covid-19 outbreak.

Table 1.3 Descriptive Statistics on the ethical dimension on resource allocation

Item Code	Item Description	Mean score	Mean response	SD
GREF 1	The company practices moral awareness	5.34	Agree	0.999
GREF3	The company has done procedural justice in resource distribution.	5.12	Agree	0.967
GREF 5	The organization understand the decision making process and are consistence with its mission	5.22	Agree	0.867
GREF 7	Quality processes are adhered to	5.28	Strongly Agree	0.873
GREF 8	Fair allocations of resources	5.33	Agree	0.886
	Overall	5.67	Agree	0.950

Source: Survey (2021)

The mean replies varied between 5.12, SD = 0.967 (item GREF3) and 5.34, SD = 0.999 (item GREF4), as shown in Table 4.5. (Item GREF1). The mean total was determined and averaged (overall mean = 5.67; SD = 0.950). (Strongly Agree). This indicates that respondents were in agreement with the many ethical features of resource allocation in Zimbabwe's health system during the Covid-19 epidemic. However, the extent to which a healthcare facility ensures fair resource allocation across programs and services is dependent on a number of factors, including decision makers' awareness that strategic planning and allocating resources is an ethical enterprise (moral awareness), the accessibility of a consistent process that includes key stakeholder groups (procedural justice), and consensus (distributive justice).

Criteria for determining the priority of Covid 19 resources in Zimbabwe.

Table 1. 4: Descriptive Statistics for criteria in determining the priority of covid 19 resources

Item Code	Item Description	Mean score	Mean response	SD
PERF1	Clinical criteria for determining clinical prognosis clearly stated in health institutions	3.64	Agree	0.698
PERF2	Respect for autonomy, no maleficence, beneficence, and justice in accord with general biomedical ethical practice	3.69	Agree	0.694
PERF3	Responsible resource stewardship	4.69	Strongly Agree	0.974
PERF4	Avoidance of bias in allocation decisions based on nonclinical patient characteristics, such as race/ethnicity, gender, age, presence or absence of disabilities, and presumed health-related quality of life before or after resource allocation	4.12	Agree	0.968
BDRF5	The process takes a systems view, considering regional rather than health system-specific triage and resource allocation	2.76	Neither Agree nor Disagree	0.465
	Overall	3.74	Agree	0.860

Source: Survey (2021)

The results in Table 4.8 demonstrate that the mean replies varied between 2.76, SD = 0.465 (Item BDRF 5) to 4.69, SD = 0.974 (Item BDRF 6). (Item BDRF3). The mean score was calculated and averaged (overall mean = 3.74; SD = 0.860) to ensure that the scores agreed out of a possible five (strongly agree). This indicates that respondents agreed that health institutions in Zimbabwe used resource allocation criteria. Accordingly, the World Health Organization (WHO) (2020) said that any policy should include attempts to preserve individual rights. Individual rights and civil freedoms must be limited only when they are essential, reasonable, proportionate, fair, non-discriminatory, and consistent with applicable national and international law. In underdeveloped nations, low resources and pressing health care demands may make comprehensive plans difficult to establish and execute (WHO, 2020). Moore (2019) emphasized that when applying ethical principles to resource allocation, healthcare facilities should consider the degree to which resources are now overwhelmed. Delma (2018) also said that a variety of different ethical standards might be used to health care rationing and priority setting. For example, the concept of utility says that funds should be used to offer the greatest potential health benefits, which is often interpreted as "saving the most lives." Equitable distribution of rewards and liabilities is required under the notion of equity. When these principles clash, the right balance should be found via a clear and public process that takes local needs and cultural values into consideration.

Conclusions and Recommendations

An important goal of the study was to determine the ethical elements of the allocation of resources in the Zimbabwean health system during the Covid 19 outbreak. The findings of the study indicate that the health service sector in Zimbabwe adheres to ethical dimensions through practices such as moral awareness, trying to exercise procedural justice in resource allocation, equitable allocation of resources and that organizations understand the decision-making process and are consistent with their mission. The mean answers varied between 5.12 and 5.34 with a standard deviation of 0.967 (item GREF3) and 5.12 and 5.34 with a standard deviation of 0.999 (item GREF3) (item GREF1). The mean total was determined, and the average was determined (overall mean = 5.67; standard deviation = 0.950). Agree out of a potential score of five (Strongly Agree). Consequently, it seems that the respondents were in agreement with the numerous elements pertaining to the ethical aspects of resource distribution in Zimbabwe's health system during the Covid-19 pandemic. The findings of the study revealed that the health sector in Zimbabwe has a wide range of criteria in place for allocating covid 19 resources. In health-care facilities, the clinical criteria for assessing clinical prognosis were explicitly defined and documented. Respect for autonomy, the absence of maleficence, beneficence, and justice, all of which were in accordance with mainstream biomedical ethical practice, were also in place. As a result of the study, it was determined that nonclinical patient characteristics, such as race/ethnicity, gender, age, the presence or absence of disabilities, and presumed health-related quality of life before or after resource allocation should be avoided, and that the process should take a systems view, taking regional rather than health system-specific triage and resource allocation into consideration. The study's findings suggested that prioritization was carried out by the healthcare sector, as proven by the fact that those who were at the highest risk of being sick and extremely sick were able to obtain the largest possible benefit from the vaccination in Zimbabwe. Considerations of equity may lead to the prioritization of the following groups: the most vulnerable (in terms of severity of illness), vulnerable and disabled populations,

uninfected persons who are at high risk of developing severe complications, and dying from influenza if they become infected, and pregnant women. Furthermore, according to the World Health Organization (WHO) (2021), the present incarnation of influenza vaccine manufacturing technologies used in several countries suggests that the very first doses of a vaccine against a new pandemic flu virus will not be accessible until 5–6 months after the pandemic influenza virus has been declared. Production of sufficient dosages to meet worldwide demand might take many months longer than anticipated.

As a result of the study, it was determined that nonclinical patient characteristics, such as race/ethnicity, gender, age, the presence or absence of disabilities, and presumed health-related quality of life before or after resource allocation should be avoided, and that the process should take a systems view, taking regional rather than health system-specific triage and resource allocation into consideration. The study's findings suggested that prioritization was carried out by the healthcare sector, as proven by the fact that those who were at the highest risk of being sick and extremely sick were able to obtain the largest possible benefit from the vaccination in Zimbabwe. Rationing and prioritization should be based on normative values that have at least some public legitimacy. Aside from the Covid 19 epidemic, the report recommends that longitudinal research be conducted on resource allocation and priority setting for other illnesses in Zimbabwe.

References

1. Mutsaka F. Zimbabwe's health minister fired over the COVID-19 graft scandal. July 7, 2020. Updated July 7, 2020. Accessed July 17, 2020. Available at: https://www.washingtonpost.com/world/africa/zimbabwes-health-minister-fired overcovid19graftscandal/2020/07/07/9ff98c1c-c07f 11ea-8908- 68a2b9eae9e0_story.html

2. GoFundMe. Zimbabwe COVID-19 citizens healthcare support fund. GoFundMe. Updated September 11 2020. Accessed September 22, 2020. Available at: https://ca.gofundme.com/f/ covid-Zimbabwe.

3. Emanuel JE, Persad G, Upshur R, et al. Fair allocation of scarce medical resources in the time of COVID-19. N Engl J Med. 2020: 382(21):2049-2055.

4. Dalglish S. COVID-19 gives the lie to global health experts. Lancet. 2020;395(10231): 1189Khemani S. An opportunity to build legitimacy and trust in public institutions in the time of COVID-19. World Bank E-library. Washington, DC: World Bank 2020. Updated May 2020. Accessed July 26, 2020. Available at: https://elibrary.worldbank. org/DOI/pdf/10.1596/33715

5. Armstrong. R.,& Whitlock, R. (2018). The cost of care: Two troublesome cases in health care ethics. The Physician Executive, 24(6), 32-35.

6. Beauchamp, T.L. & Childress, J.F. (2019). Principles of biomedical ethics (3rd ed.). New York: Oxford University Press.

7. Borawski, D. (2016). Ethical dilemmas for nurse administrators. Journal of Nursing Administration, 25 (7/8), 60-62.

8. Brosnan, J., & Roper, J. M. (2017). The reality of political ethical conflicts. Journal of Nursing Administration, 27 (9), 42-46.

9. Fogel, L.A., &MacQuarrie, C. (2018). Benefits and operational concerns of health clinics. Healthcare Financial Management, 11 (3), 40-46.

10. Hiller, M.D. (2016). Ethical decision-making in health management. Arlington, VA: Association of University Programs in Health Management.

11. Lutz, H.S. (2019). Health maintenance organizations: Dimensions of performance. New York: Wiley & Sons.

12. Mohr, W.K., & Mahon, M. M. (2016). Dirty hands: The underside of marketplace health care. Advances in Nursing Science, 19 (1), 28-37.

13. Roseneau, P.V., & Roemer, R. (2016). Ethical issues in public health and health services. In R.M. Andersen, et al., Changing the U.S. health care system. San Francisco: Jossey-Bass.

14. Silva, M.C. (2020). Ethical decision-making in nursing administration. East Norwalk, CT: Appleton and Lange.

15. vanAmerongen, D. (2019). A guide for approaching controversial, high-tech procedures. The Physician Executive, 24 (6), 26-30.

16. Brosman, J., & Roper, J. M. (2019). The reality of political ethical conflicts: Nurse manager dilemma. Journal of Nursing Administration, 27(9), 42-46.

17. Brodeur, D. (2018). Health care institutional ethics: Broader than clinical ethics. In J. Monagle& D. C. Thomasma (Eds.), Health care ethics: Critical issues for the 21st century (pp. 497-504). Gaithersburg, MD: Aspen.

18. Bucaro, F. (2018). The ethics gap provides a dilemma for businesses. The Akron Beacon Journal, G11.

19. Canavan, K. (2019). Nursing addresses troubling trends in managed care. The American Nurse. Washington, DC: American Nurses Association.

20. Chapin, J. L. (2020). The inappropriate distribution of primary health care funds. In M. C. Silva, Ethical decision making in nursing administration (pp. 210-212). Norwalk, CT: Appleton & Lange.

21. Chapin, J. L. (2020). Case commentary. In M. C. Silva, Ethical decision making in nursing administration (pp. 227-228). Norwalk, CT: Appleton & Lange.

22. Darr, K. (2020). Ethics in health services management (3rd ed.). Baltimore, MD: Health Professions Press, Inc.

23. Grosenick, L. E. (2017). Governmental ethics and organizational culture. In T. L. Cooper (Ed.), Handbook of administrative ethics (pp. 183-197). New York: Marcel Dekker.

24. Harper, D. C. (2020). Principle of justice versus the principle of beneficence: Case analysis. In M. C. Silva,

Ethical decision making in nursing administration (pp. 212-227). Norwalk, CT: Appleton & Lange.

25. Mill, J. S. (2019). Utilitarianism (G. Sher, Ed.). Indianapolis: Hackett. (Original work published in 1861)

26. Mohr, W. K., & Mahon, M. M. (2016). Dirty hands: The underside of marketplace health care. Advances in, Nursing Science 19(1), 28-37.

27. Petrick, J. A., & Quinn, J. F. (2017). Management ethics: Integrity at work. Thousand Oaks, CA: Sage.

28. Reiser, S. J. (2017). The ethical life of health care organizations. Hastings Center Report, 24 (6), 28-35.

29. Renz, D. O., & Eddy, W. B. (2016). Organizations, ethics, and health care: Building an ethics infrastructure for a new era. Bioethics Forum, 12(2), 29-39.

30. Silva, M. C. (2020). Ethical decision-making in nursing administration. Norwalk, CT: Appleton & Lange.

31. Weston, A. (2017). A practical companion to ethics. New York: Oxford University Press