Managing Dual Job Holding among Health Workers
A Guidance Note

Strengthening Human Resources for Health Policies in the Developing Countries

May, 2013
Overview

1. Dual Practice – a typology

2. Motivations for dual practice

3. Why Regulate dual practice?
   - Consequence: advantages and disadvantages

4. Regulatory and Policy responses – in brief

5. Points for further discussion

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Dual Practice: what is it?

- Health workers working simultaneously in government and private facilities
- Present in almost all countries, regardless of income level and health system structure

Table 1: Typologies of dual practice

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<thead>
<tr>
<th></th>
<th>Public</th>
<th>Private, for-profit</th>
<th>Private, not-for-profit</th>
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<tbody>
<tr>
<td>Public</td>
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Motivations for Dual Practice

• The common assumption is that dual-practitioners are rational profit-maximizers

• However, profit-maximization assumption seems to fail to explain dual jobholder labor supply (HW remain in the low-paid job – usually public)

• Other aspects may be important:
  - social responsibility, self-realization, professional satisfaction, working conditions and prestige
  - need for empirical evidence on the dual practitioners’ decisions on the division of labor between the sectors

⇒ Practice in low-paid job may be a profit-maximizing strategy
Consequences of Dual Practice

• The literature on dual practice (DP) is inconclusive

  - However, arguments about negative effects prevail
  
  - Described as consequence of government “failure”, HW’s coping strategy, leakages, etc...
  
  - ...and may lead to “predatory behavior” and “delegitimizes public sector service delivery”

• Arguments ignore possible POSITIVE effects of DP

• Mix existing health system problems with DP

  - **Question**: whether or not the involvement in dual practice intensifies HW undesirable behaviors?
Advantages of dual practice

1. Enables government to recruit and retain high quality HW with limited budget
   - *May improves access to quality health services (poor)*
   - *Increase public services quality as HWs are willing to improve reputation*

2. Dual practice can help to reduce waiting times for treatment
   - *Faster private provision for those willing to pay (opt-out public services)*
   - *Reduces public sector demand*

3. May lead to a reduction of informal payments
Disadvantages of dual practice

1. Providers may skimp on work hours in the public sector to spend time in private practice

2. Misuse of public resources to treat private patients
   - *Free riding, regressive income distribution*

3. Incentives to induce demand for private practice
   - *Lowering quality of public services*
   - *Cream-skim profitable patients*
   - *Over treat in public facilities to build reputation*

4. Incentives to distort quality towards (not technical) dimensions
## Impacts of DP: Summary

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
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</thead>
<tbody>
<tr>
<td>1. Government can hire high quality doctors at reduced cost</td>
<td>1. Incentives for physician underperformance in public facilities to induce demand for private practice</td>
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<tr>
<td>2. Increased income for physicians</td>
<td>2. Physicians skimp work hours &amp; increase absenteeism in public hospitals</td>
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<tr>
<td>3. Increased prestige, clinical autonomy &amp; professional satisfaction for doctors</td>
<td>3. Diverting patients to private practice causes financial burden on patients</td>
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<tr>
<td>4. Reduction in unofficial payment to HW</td>
<td>4. Misuse of public resources: equipment, facility, drugs</td>
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<td>5. Reduction in waiting times for treatment</td>
<td>5. Reduced quality of care in public hospitals</td>
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<td>6. Mobilization of private sector in healthcare</td>
<td>6. Physician exhaustion due to increased work hours</td>
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<td>7. Additional income for the government (when in public facility)</td>
<td>7. Over-treatment in public hospitals to build reputation at the cost of public funds</td>
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<td>8. Incentives for better performance in public sector to build a reputation</td>
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Evidence from India

Public sector doctors do much better in their private clinics

Source: Das, 2011.
Effort Index by provider type

- Public MBBS in public: -0.33
- Public MBBS in private: 0.43
- Private trained: 0.32
- Private untrained: -0.05

Source: Das, 2011.

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Incentives matter

• **Public sector doctors** in their **public practices** are the **WORST** in the entire system

• The **same public sector doctors** in their **private practices** are the **BEST** in the entire system
Policy and Regulatory responses

• Extensive cross country heterogeneity in government responses to dual practice

• Differences in the characteristics and particularities of health systems and differences in government priorities

• Adverse consequences of DP are context specific

• When selecting policy intervention needs to consider:

  1. the government ability to enforce contracts

  2. the budget constraints
Why regulate dual practice?

• Positive and negative side-effects on:
  - Equity (access to health care)
  - Efficiency (costs)
  - Quality of care (health outcomes)

• No consensus exists on the net effect

• The questions for health policy are:

  1. Whether dual practice ought to be regulated or not

  2. Which policy intervention is optimal in terms of avoiding its adverse consequences
Policy responses (1/3)

1. Banning dual practice:
   – Very difficult to enforce
   – Even if it can be strictly enforced, it may well lead – in low-income countries – to:
     (i) doctors resigning from the Government sector (see Uganda) and/or
     (ii) doctors staying in the Government sector but asking for more informal payments (see Sierra Leone)
Policy responses (2/3)

2. Exclusive contract with a salary raise
   – Salary raises are obviously part of the solution
   – But:
     • **How much salary increase is needed?** DP doctors usually earn 2-3 times more than their second (private) job
     • **Will it be enough?** Will the salary increase be a “free lunch”? Better accountability for results (in the Government sector) is also needed. (see Sierra Leone when user fees were removed in 2011)
3. Allowing for DP within Government facilities (“private wards”)

– What is it?
  • Doctors would be allowed to have a private practice within the Government facilities
  • But they have to pay back a portion of their revenues to the facility.

– Private wards will not reduce DP, but:
  • It can generate additional resources for Government facilities
  • More importantly, it give a higher stake for doctors in the management of their Gov facility
## Policy responses – Summary (1/2)

<table>
<thead>
<tr>
<th>DP policy</th>
<th>Countries</th>
<th>Rationale</th>
<th>Challenges</th>
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<tbody>
<tr>
<td><strong>Complete ban</strong></td>
<td>China, Greece (past), some States in India</td>
<td>Avoids adverse effects of dual practice</td>
<td>• Difficult to enforce</td>
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<td>• Increase in informal payments in public hospitals</td>
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<td>• Brain drain of qualified/senior physicians to private sector/ other countries</td>
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<td>• Extra cost to monitor activities</td>
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<td><strong>Licensure restrictions</strong></td>
<td>Kenya, India, Zimbabwe, Zambia</td>
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<td>• Difficult to monitor</td>
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<td></td>
<td></td>
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<td>• Violation of policy</td>
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<td><strong>Restriction of earnings</strong></td>
<td>France, UK</td>
<td>Reduces profit maximization intention of physicians</td>
<td>• Only with efficient systems to monitor private sector activity</td>
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<td>• Physicians quit public practice if private sector revenue is very high</td>
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<tr>
<td><strong>Exclusive contracts and perks in public sector</strong></td>
<td>Spain, Portugal, Italy, Thailand, some Indian states</td>
<td>Discourage physicians from private practice</td>
<td>• Only if DP is for financial reason &amp; salary increase &gt;= non-practice in private sector</td>
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<td><strong>Increase in public sector salary</strong></td>
<td>Studies in Norway and Bangladesh</td>
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<td>• Low income countries cannot afford very high increase</td>
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<td>• Creates resentment among other HW</td>
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### Policy responses – Summary (2/2)

<table>
<thead>
<tr>
<th>Dual practice policy</th>
<th>Countries where implemented</th>
<th>Rationale</th>
<th>Challenges</th>
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<tr>
<td>Allow private practice in public hospitals</td>
<td>France, Germany, Ireland, Austria</td>
<td>Efficient regulation &amp; monitoring of private health provision Synergies between public &amp; private sector Adds revenue to public sector Prevents physician brain-drain to private sector</td>
<td>• Appropriate policies to avoid misuse of public resources &amp; determine the types of private practice to be allowed • Conflict of interest for physicians • Difference in price &amp; treatment can be seen as socially discriminatory</td>
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<td>Experimented in Spain, Portugal, Ethiopia</td>
<td>Bahrain, Nepal, Ghana</td>
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<td>Limitation of services offered in private sector</td>
<td>Canada</td>
<td>Discourage people from using the private sector</td>
<td>• Only with universal health coverage &amp; financial monitoring systems</td>
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<td>Self-regulation</td>
<td>UK, USA</td>
<td>Ensure high quality of care &amp; discourage ill effects of dual practice</td>
<td>• Does not work in developing countries with low salary, low morale &amp; weak/absent monitoring systems &amp; less empowered professional bodies and civil society</td>
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Impact not clear...

- Depending on the context, DP has potential for both positive and negative consequences:
  
  - The impact of DP on social welfare remains an empirical question that needs to be addressed.

  - The impact of DP in presence of a universal risk pooling mechanism, dual-job practice may not be a major issue for equity of healthcare access.
Wrap-up

• **Dual practice is more a symptom than a disease**

• it simply reflects underlying and deeper issues (weak salaries, weak accountability, lack of universal risk pooling):
  - *This is why removing (i.e. banning) DP without addressing the underlying issues can make things worse*
  - *This is also why the net impact of DP on social welfare is hard to assess*

• Unless the underlying issues are addressed, DP cannot be reduced
  - *However, DP can be managed and can even be an opportunity for Government sectors (attracting highly skilled doctors, generating revenues, e.g.)*
Thank you

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