Human Development **Network**

# 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**

# 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 I: Typologies of dual practice**

| | Public | Private, for-profit | Private, not-for-profit |
|---|---|---|---|
| Public | + | + | + |
| Private, for-profit | | + | + |
| Private, not-for-profit | | | + |

# 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***

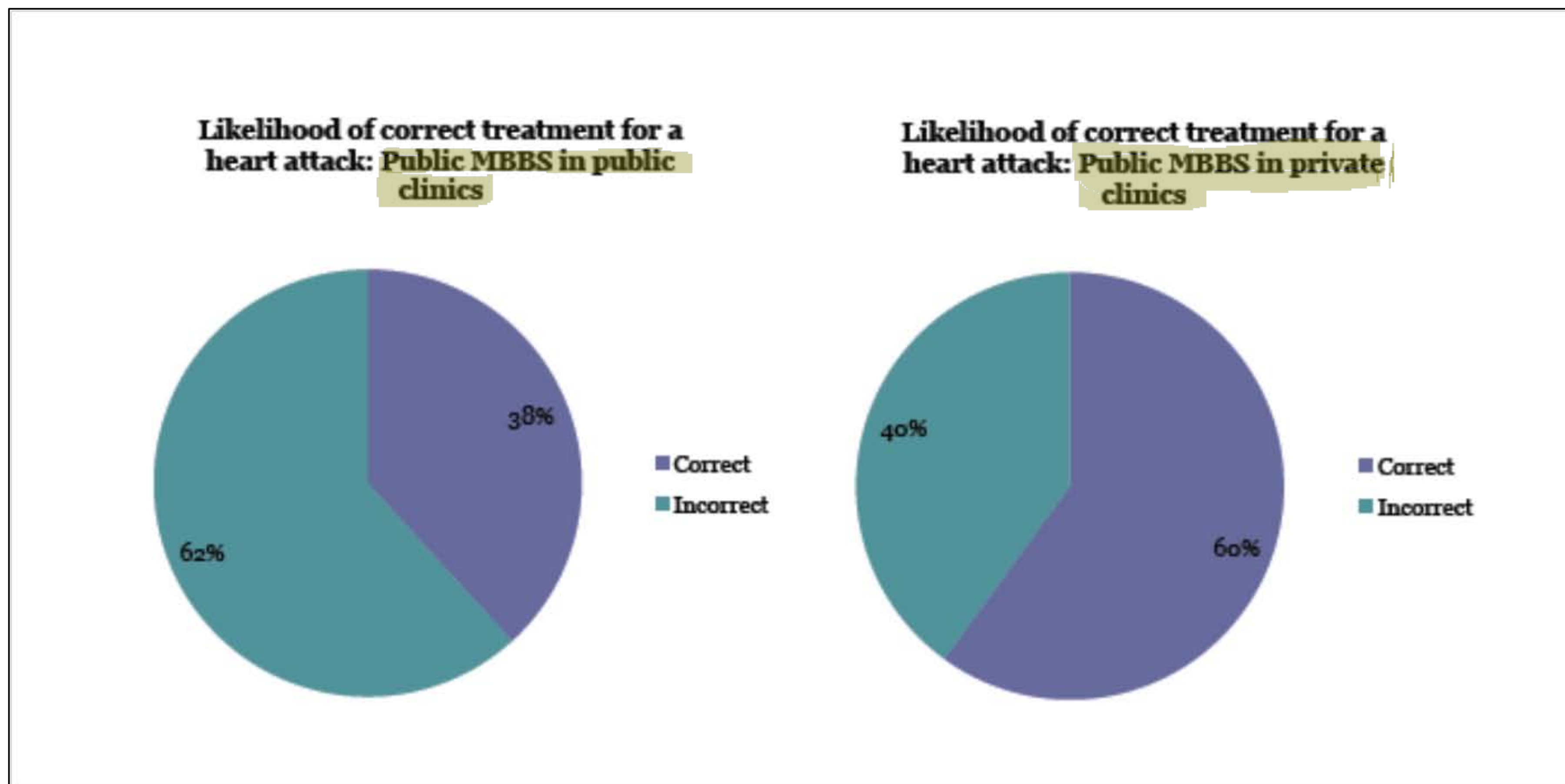
**4. Incentives to distort quality towards (not technical) dimensions**

# Impacts of DP: Summary

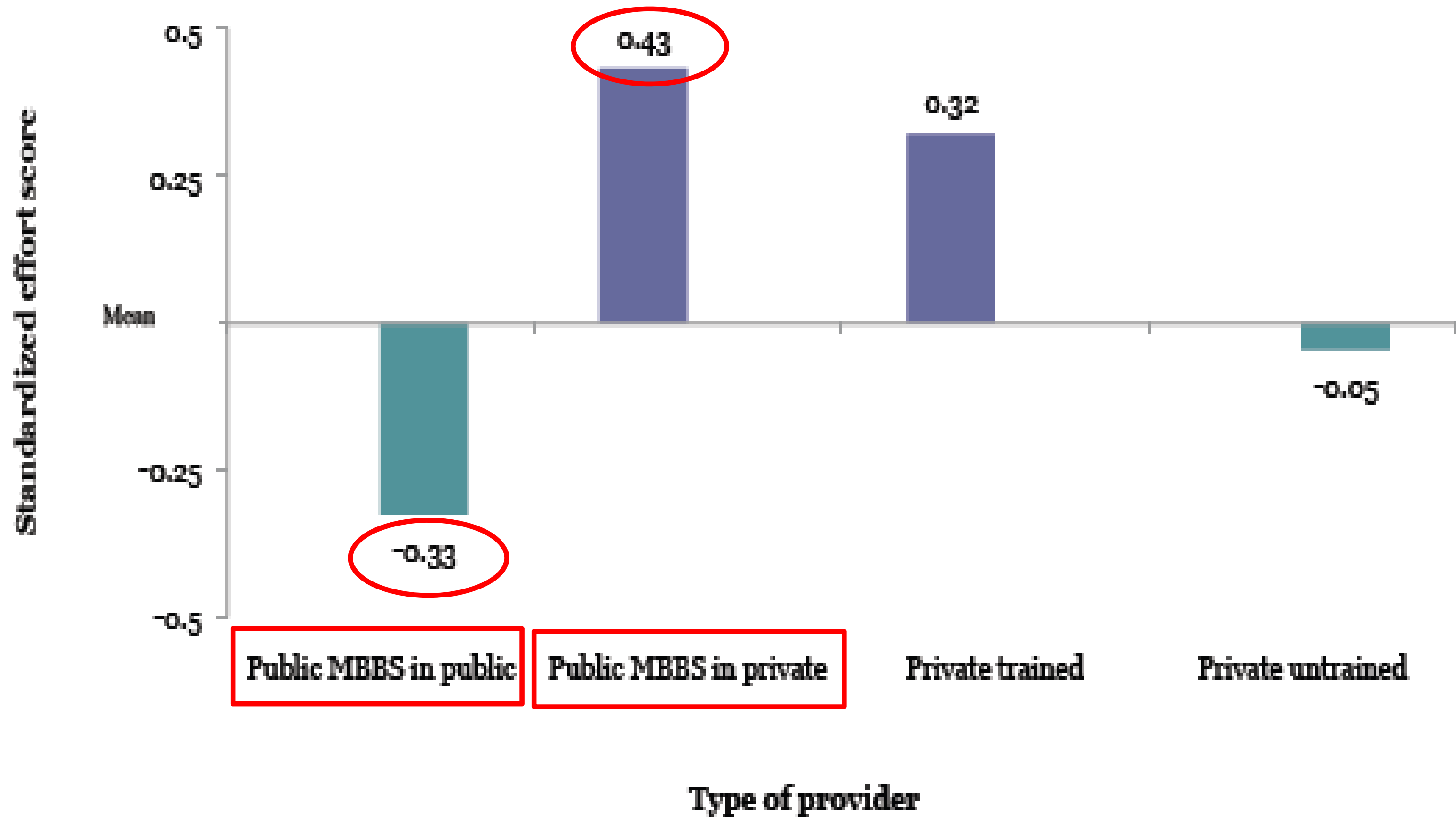
| Advantages | Disadvantages |
| --- | --- |
| 1. Government can hire high quality doctors at reduced cost<br>2. Increased income for physicians<br>3. Increased prestige, clinical autonomy & professional satisfaction for doctors<br>4. Reduction in unofficial payment to HW<br>5. Reduction in waiting times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

# Evidence from India

## Public sector doctors do much better in their private clinics




**Source: Das, 2011.**




Source: Das, 2011.

# 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 <u>cross country heterogeneity</u> in government responses to dual practice**
- **Differences in the characteristics and particularities of health systems and <u>differences in government priorities</u>**
- **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 earns 2-3 times more 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)

# Policy responses (3/3)

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)

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

# Policy responses – Summary (2/2)

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

# Impact not clear…

- **Depending on the context, DP has potential for both positive and negative consequences:**

  - ***The impact of DP on <u>social welfare</u> remains an empirical question that needs to be addressed***

  - **The impact of DP In presence of a <u>universal risk pooling</u> mechanism, dual-job practice <u>may not be a major issue for equity of healthcare access</u>**

# Wrap-up

- **<u>Dual practice is more a symptom than a disease</u>**
- **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 <u>reduced</u>**
  - ***However, <u>DP can be managed</u> and can even be an opportunity for Government sectors (attracting highly skilled doctors, generating revenues, e.g.)***

# Thank you

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