It takes two to tango:

Governance of dual practice in the public and private sectors

Introduction

Clearing House briefs are intended to provide short descriptive and comparative analysis of country implementation experience in relation to specific health governance and service delivery issues. As such, Clearing House briefs seek to contribute insights on "how, why, for whom, in what contexts and to what extent health systems, programmes and/or policies function" (1) to inform governance practice. The Clearing House is a service of the WHO Country Connector on Private Sector in Health (CCPSH) and is part of a compendium series that explores the strategies, tools and experience in governance of the private sector in national health systems.

Methodology

The literature reviewed for the Clearing House briefs draws from a larger scoping review. Scoping reviews have been used widely "to identify knowledge gaps, scope a body of literature, clarify concepts or to investigate research"(2). The scoping review was framed using the governance behaviours, conceptualised as part of the WHO strategy report on "Engaging the private health service delivery sector through governance in mixed health systems" (3).

Search strategies were developed, with the support of a WHO Information Specialist for each of the governance behaviours and organized by sub-assessment area. The searches, once confirmed in Embase, were translated to PubMed and Web of Science. The Information specialist relied on personal experience to determine best approaches to translation. Search strategies included studies published since January 2010 to ensure that the health systems context was relevant to the present day.

In order to manage the large number of citations generated through the search strategies and build familiarity with the screened literature, sub-analysis was undertaken on key thematic issues identified through the screening process, dual practice being one of these. Screening was done by the team members in the Systems Governance and Stewardship Unit. A broad approach was taken to include a range of contexts, study designs and publication status.

The dual practice literature was included under the sub-assessment area of health worker policy and regulation. Papers that included dual practice in the title and/or abstract were extracted and analysed for this brief.

WHAT is dual practice

Dual practice is ubiquitous in most national health systems. In simple terms dual practice, or dual job holding, is the combination of public and private practice in the same or different sites (4). This may take a variety of forms: private practice provided outside, in a separate private facility; beside, private practice that is physically associated with a public facility; within, private services offered in a public facility but outside of operating hours, for example; or integrated, private services offered alongside standard public ones, often informally (5). The provision of private services through online platforms has also emerged, enabling patients to access care virtually (6). Of all forms of dual practice, "informal" provision of private services in the public sector are the most difficult to typologize as these may be "illegal, erratic, unregulated and unreported", depending on context (7). Online practice also poses challenges as governments play regulatory catch up with technology and varied models of virtual care.

Within the literature, there has been more focus on the dual practice of physicians and specialists, although nurses, midwives and other health workers also engage in the practice (5) (8). We have retained a physician focus in this brief. Some studies further suggest that dual practice is engendered, with more male physicians engaged in some form of dual practice than their female counterparts (9) (10) (6). Within the literature, there has been less attention paid to the impacts of physician dual practice on other health workers in terms of workload, morale, and behaviour. As described by a participant in a study on absenteeism in Kenya, it was understandable that physicians would seek to practice in the private sector, "they have to make money", but it was also deeply discouraging that a system would facilitate such behaviour (8). Another study from Africa also noted a cascade of informal payments as part of integrated dual practice, starting with the physician, "then the nurse who attends the patient with me also asks for some payment, and so does the attendant. It is a whole set of undue payments" (7).

As suggested, motivations for dual practice, fundamentally come down to financial reward, particularly in low resource settings (11). This is driven by gaps in professional and economic expectations. As illustrated in the aforementioned African study, "If I were paid enough [by the government] don't you think I would gladly give up this life of hopping from one private practice to the other? This is not life!" (7). Even within 'well salaried' health systems, financial reward remains an important motivation (9). Other contributory factors include upholding public responsibility; enlarging professional contacts; access to information and the opinions of influential doctors; access to patients; building reputation and strategic influence; opportunities for professional development and teaching; control over work; social security benefits; and job security (11) (10) (12).

WHAT is the governance problem

Dual practice presents a challenge for universal health coverage (UHC) and its associated outcomes, including access to health services, equity, efficiency, and quality of care. The adverse consequences of dual practice for UHC vary by context and no consensus exists on its net effect (13). Evidence on dual practice is largely descriptive and fails to quantify and analyse its effects. As such, dual practice is considered double-edged, with both negative and positive effects (11). Cited effects found within the literature are outlined in **Table 1**; these may be overt or more subtle (11) and evolve over time, in response to changes in the health market (including out-migration opportunities). Illustrative of such dynamics, a three city study on dual practice described market contexts by physicians as 'saturated' in Praia, Cabo Verde (market covered based on current demand); 'difficult' in Bissau, Guinea Bissau (limited demand and uncertainty around recovering initial investment); and 'aggressive' in Maputo, Mozambique (increasing competition among physicians) (7).

NEGATIVE Effects

- Longer wait times in the public sector
- Lower quality in the public sector
- Diversion of patients to private practice
- Ignore poor/equity considerations
- Contribute to absenteeism, and skimping on hours in the public sector
- Contribute to urban bias

POSITIVE effects

- Improve access in the public sector by shifting those with an ability to pay to the private sector
- Improve overall productivity of physicians, e.g., number of hours worked
- Retain physicians in the public sector
- Address budget constraints through retention of physicians, e.g., moderate gap between professional and economic expectations and what public employment can offer
- Reduce unofficial payments
- Exposure to innovation and technology in the private sector, with the potential to bring this into the public sector

Table 1. Dual practice negative and positive effects

Irrespective of the net effect of dual practice, adverse incentives exist. These include the potential for misuse of public sector resources; diversion of patients into private treatment; and induced demand for unnecessary or low priority services. Dual practice may also create or exacerbate other structural problems such as urban bias in service provision and loss of government control of the health market. In Iran, for example, dual practice was associated with an influx of technology, "we noticed that suddenly the country has become full of MRI" (14) with implications for overall functionality and patient trust in the health system. Given this, some form of governance response is indicated as is empirical evidence.

WHAT is the policy response

Three main strategies are available to governments in relation to dual practice, to **ignore** it, to **manage** it, or to **ban** it. These strategies have a logical set of policy responses: (i) take no action; (ii) ban or significantly limit dual practice, and (iii) allow dual practice but regulate behaviour in public and private spheres (5).

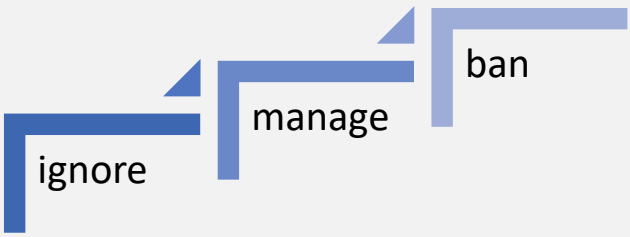

Figure 1. Strategies to dual practice

Banning dual practice is feasible in contexts where private sector competition is weak, public and private care are sufficiently close substitutes and there is regulatory implementation capacity (15). However, these contexts are likely to be few in practice. Within the literature, Canada is one country mentioned which resembles this scenario. In this context, physician dual practice is deemed 'contrary to official regulations' (15), however this is provincially determined, and more recent evidence suggests that dual-practice models are increasingly deployed, including in virtual-care settings (16). Other countries where the practice has been highly controlled include China, Greece, and some Indian states with a similar loosening of restrictions over time or in response to the adverse reactions of physicians. In Greece, and Mumbai, India, for example, banning of dual practice resulted in exodus of physicians and specialists from the public sector (15). Iran also imposed a complete ban on dual practice, which subsequently created the "dilemma of enforcing [national] law but not strictly following it" (17).

In many contexts, strict controls on dual practice presents risks in terms of brain drain of health professionals to other countries, or from the public to the private sectors (10) (12) (18). It may also encourage growth of the informal private sector and informal payments within the public sector (11) (19).

In resource constrained settings, governments may simply choose to ignore the practice, through either lack of recognition or regulation. In general, some form of governance response is preferable, to ensure that dual practice remains within the regulatory and policy jurisdiction of governments (11). Understanding the basis of strategies is recommended (15), free of ex-ante value judgement of the 'rights and wrongs' of dual practice (11).

WHAT governance tools are deployed

in response to dual practice

Governance response remains inherently contextual and varies by level of implementation intensity and capacity. Governance tools also vary, may be deployed singularly or in concert, to either limit the adverse effects of dual practice and/or reward public service. **Table 2** provides examples of governance tools and forms that these may take. On balance, higher income countries have a wider array of limiting and rewarding governance tools at their disposal (9). While definitive evidence of effectiveness is lacking, the literature describes implementation experience with governance tools.

Governance tools	Examples
Regulatory controls	Private sector entry requirements Caps on service earnings, quantity and types of services, service hours, location of services Restrictions on the use of public sector resources for private profit Employer codes of conduct, and requirements to seek permission from principal employers before engaging in dual practice
Reward/payment systems	Exclusive contracts for public service Increase public sector salaries Establish contracts with private physicians for public service Performance-based contracts for public service
Information and monitoring	Patient information/charters, e.g., opening hours, fees and charges, including free-of-charge services, responsibilities towards patients and clients Information on workplaces in the registry of private practitioners Monitoring and evaluation of data on practitioner performance or complaints, by consumers or third parties, e.g., civil society, consumer representative forums, insurers or government Self-regulation by professional bodies, e.g., accreditation, certification, and other means of performance assessment

Table 2. Governance tools and examples

Regulatory controls

As previously alluded, outright banning of dual practice is seldomly enacted or implemented and may only be viable under specific market conditions. This option was considered in a country in the Mediterranean region in 2014 alongside proposals to increase health workers' salaries, close existing private clinics and not approve new licenses, and ban private hospitals from hiring public sector employees (18). However, before proceeding, the Ministry of Health, with World Bank support, undertook an analysis of the potential impacts of the proposed reforms and found that an outright ban on dual practice would not have the intended policy outcomes. A key reason for this was financial, as dual practice reform had not been budgeted for; secondly, the proposed measures did not consider compensation plans for nurses and paramedical staff. The study itself provided an opportunity for consulting those most directly impacted by such reforms, health workers themselves.

In lieu of outright bans, restrictions on dual practice are more common; and, if governed well, they have been shown to shape patterns of dual practice. The three-city study from Africa (7) is instructive. In Praia, Cabo Verde, where governance was considered strong, there was evidence of the protection of the "public characteristics of services within time and space boundaries"; private sector activity was 'outside' of public space (in terms of both time and space) where it was formally recognized as dual practice. In contrast, in Bissau, Guinea Bissau, there was greater ungoverned practice as this was integrated within public space (in terms of both time and space). This situation was also reflective of the market conditions found in Guinea Bissau where there was lower patient ability to pay, and therefore limited potential profitability for 'outside' private practice.

Studies from Southeast Asia also suggest more regulated forms of dual practice. In Viet Nam, for example, dual practice is promoted by government as a means of addressing current and projected shortages of physicians in the country (10). In this context, a variety of choices of dual practice are available for public hospital physicians with the government actively encouraging the development of 'outside' practice in private health facilities. In Cambodia, the Ministry of Health estimated that just over two thirds of physicians operate or work in private practice; this was based on the number of consultation cabinets, clinics, polyclinics, and private hospitals in the country with the majority of patients utilizing these services (12). In this and neighbouring countries including Viet Nam and Indonesia, dual practice is often carried.

Reward/payment systems

Reward/payment systems are a feasible option in higher income contexts and have been employed in a number of countries. These can take different forms, such as exclusive contracts, which entail payments to public sector staff in return for their agreement not to engage in private practice. These may be combined with regulatory controls on dual practice or applied singularly. In the Norwegian context, where dual practice is not banned or regulated, dual job holding declined by thirty percent over the period 2001 to 2009 (9). This was attributed to increasing the hourly rate for extended working hours in hospitals, a policy that was instituted in 1996 to ensure a sufficient labour force (9). This achievement was in the context of a largely publicly financed health system with strong regulation of patient and health worker rights. Other countries that have introduced exclusive contracts include Spain, Portugal, Italy, Thailand, and some Indian states, with varying effects (13). In LMIC contexts, income satisfaction through exclusive contracts and competitive salaries may be prohibitively costly; rough estimates suggest that salaries would need to multiplied by at least a factor of five to be competitive with what is offered in the private sector (13). Reward/payment policy tools may also neglect other cadres, such as nurses, and create friction between professional groups (11).

Output or performance-related pay, as an alternative to fixed salaries, were also referenced, however, these were not a primary focus in the literature reviewed for this brief. Of mention, were the performance-based contracting schemes, introduced in Cambodia in 2009-2010 and funded through donor programmes, which included 'golden rules' (e.g., basic rules of reciprocity) as a means of discouraging private practice (12). However, it is uncertain if these so-called golden rules continue to influence dual practice, nor is it recommended that performance-based contracting replace fixed salaries.

Information and monitoring

The lack of information on physician dual practice, has been a major focus of studies. This is in recognition that a failure to understand "why, how and to what extent health workers engage in dual practice" (5) limits understanding of health system effects and the effectiveness of governance response. Within the reviewed literature, only the Norwegian context drew on routine health information, via a hospital physician registry, as the basis for longitudinal study. Other forms of information and monitoring were referenced but not elaborated in the literature reviewed for the brief. Some, such as self-regulation by professional bodies and monitoring through third parties, were noted to have been used with good effects, including in LMICs (11).

Tools with teeth

Overall, the effects of different governance tools in response to dual practice remain unexplored in the literature. Studies do not elicit much insight into the process of policy reform in response to dual practice. Notable exceptions include a Hungary study which explored health policy reforms introduced in 2020 to counter shortages of health professionals, low public financing, and informal payments in the public sector (19). This reform was 'pressurized' by the COVID-19 pandemic and pushed through hastily with limited consultation. It introduced physician employment status akin to that of the armed forces, alongside a 120 per cent salary increase and criminalization of informal payments. The reform met with strong resistance from the medical fraternity and wider society (highlighting the active role patients play in perpetuating dual practice). As concluded in the paper, "indispensable legitimacy [of reform] is unlikely to be established without wide and meaningful social consultations involving all stakeholder groups."(19).

In contrast, the analysis described in the country in the Mediterranean region was instigated by Ministry of Health to inform policy on dual practice. The conclusions from this work provided for a more measured response. Specifically, that reform be sequenced over time, be piloted and monitored, retain flexibility over design, be executed in the context of broader sectoral reforms, take into account intrinsic and extrinsic motivations of health workers, and be costed and feasible within the available fiscal space (18).

Conclusion

Many ministries of health have defined models of care for their populations; these outline how services should be delivered, including the processes of care, the organization of providers, and the management of services. Dual practice has implications for models of care (both conceptually and in practice), in particular, referral care pathways. Dual practice may also be leveraged as part of models of care (again both conceptually and in practice). However, this is only feasible if there is some form of governance response, as part of the regulatory and policy jurisdiction of governments. This is mission critical in many contexts, in light of human resources for health crises and health worker migration. More case studies on policy interventions on dual practice in different contexts are needed as well as greater understanding of the 'why, how, extent and effects' of governance responses to dual practice, and its evolution over time.

Forthcoming regulation guidance from the WHO Health Workforce Department recommends regulation to facilitate positive outcomes from dual practice and mitigate its adverse or unintended effects, especially when there is a shortage of health practitioners (20).

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