SURE Rapid Response

Dual employment of health workers: what is it and its impact, why is it present, and what steps the government can take?

March 2011

This rapid response was prepared by the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

Key Messages

- The impact of dual practice includes predatory behavior, conflicts of interest, brain drain, and competition for time and access for public sector patients but also an increase in income for health workers.
- The reasons for its existence are mostly to compensate for low income levels and inadequate working environments that health professionals face.
- Despite it being proven unsuccessful, prohibition is the strategy that many governments choose to handle dual practice.
- Improvement is likely to come from a combination of small contributory measures that create a proper working environment.

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SURE
Supporting the Use of Research Evidence

REACH
Regional East African Community Health Policy Initiative

EVIPNet
EVIDENCE-INFORMED POLICY NETWORK

Who requested this rapid response?

This document was prepared in response to a specific question from a Senior Health policymaker in Uganda.

! This rapid response includes:

- Summary of research findings, based on one or more documents on this topic
- Relevance for low and middle income countries

X Not included:

- Recommendations
- Cost assessments
- Results from qualitative studies
- Examples or detailed descriptions of implementation

What is the SURE Rapid Response Service?

SURE Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing health systems, and strategies for implementing changes.

What is SURE?

SURE – Supporting the Use of Research Evidence (SURE) for policy in African health systems - is a collaborative project that builds on and supports the Evidence-Informed Policy Network (EVIPNet) in Africa and the Regional East African Community Health (REACH) Policy Initiative (see back page). SURE is funded by the European Commission's 7th Framework Programme.
www.evipnet.org/sure

Glossary

of terms used in this report:
www.evipnet.org/sure/rr/glossary

Background

The government of Uganda is concerned about Dual employment (also referred to as moonlighting) of health workers, as are so many other governments worldwide. In fact dual practice is considered present in most if not all countries irrespective of their income level. It is even present in those countries that have instituted major regulatory restrictions like China and in some places it has become a sort of norm, for instance, in many of the Latin American countries.

How this Response was prepared

After clarifying the question being asked, we searched for systematic reviews, local or national evidence from Uganda, and other relevant research. The methods used by the SURE Rapid Response Service to find, select and assess research evidence are described here:

www.evipnet.org/sure/rr/methods

Dual practice: the concept

There is diversity in what dual practice or employment is when one looks at the literature. Below are some definitions or concepts referred to:

- It can mean health professionals with multiple specializations – for example, physicians with specializations in cardiology and internal medicine, or cardiology and chest medicine.
- It can also mean health professionals working within different paradigms of health (allopathic medicine combined with complementary or traditional medicine – Chinese, African or otherwise – or with other paradigms such as osteopathy, homeopathy and others).
- It may also refer to the combination of different forms of health-related practice – clinical with research, with teaching or with management.
- It can also mean health professionals combining their professional health practice with an economic activity not related to health (such as agriculture).
- The commonest meaning or reference given to dual practice is that used to describe multiple health-related practices in the same or different sites.

In this paper dual practice refers to the last definition where the concern or debate is on health workers practicing in multiple sites.

Dual practice is usually a combination of public and private practice but may sometimes be a combination of public and public or private and private practice. Its definition also gets deeper, for example, “overtime” has in many cases been considered a form of dual employment. While it is increasing because of cost-containment measures or shortages of staff, in 1992, the German Union of Salaried Employees estimated that the overtime worked by health workers was equivalent to 20 000 extra full-time staff posts (1).

This paper will present evidence concerning dual practice, that is, its impact, reasons for its existence and what strategies the government can consider. The findings have been based on a comprehensive review of the evidence concerning dual employment in the health sector (2).

Summary of findings

The impact of dual practice

Predatory behaviour: Dual practice frequently leads to behaviour in which the health worker pursues their self-gain while compromising the legitimate interests of colleagues, services and patients. This is particularly strong in situations where market conditions – usually high physician supply, as is the case of capital cities in Africa and other urban more than rural areas – would otherwise reduce their incomes. In these situations practitioners use their authority to prescribe treatment for their patients to generate additional demand for their own services. For example in some countries like Thailand, Caesarean-section rates among private patients have been documented to be almost three times higher than among non-private patients, which may be explained in part by predatory behaviour.

Conflicts of interest: This depends on the context; when health officials get involved in dual practice to improve their living conditions, it may not interfere with their work as civil servants (although it is likely to compete for time and to reinforce rural-to-urban migration). When they take up teaching as an extra job, usually in public sector institutions, this may actually be beneficial to the public agenda, as it reinforces the contact of trainees with the realities of practice. For doctors who are basically managers, moonlighting in private practice presents less of a conflict of interest and yet for clinicians in public practice moonlighting in private practice may mean a conflict of interest where they must compete for patients with themselves, and thus have an incentive (and the opportunities) to lower the quality of care they provide in the public services. Other activities, such as agriculture, may be seen as neutral towards health services and therefore not a major cause of conflict of interest but they may constitute a de facto internal brain drain.

Brain Drain: often brain drain of health professionals is thought of only in terms of inter-country migration ignoring the question of internal migration. Internal migration may include public to private sector migration compounding the rural-to-urban migration because cities offer more opportunities to increase income generation and furthermore resistance against redeployment to rural areas. After a while professionals who have successfully taken advantage of these urban opportunities increase their market value over time, until they are ready to leave public service which further compounds public-to-private brain drain.

Competition for time which limits access: It is noted that public service medical staff involved in dual practice are available only nominally full-time to fulfil their assigned tasks. If public sector medical staffs are moonlighting in private practice, this evidently limits access by patients seeking services in the public centres. It also corresponds

to a net flow of resources out of the public sector. It has been shown that as the number of jobs increases, the amount of time spent in the second job, usually a government job, decreases. This reduces the access of low-income people to medical care, as they cannot afford to seek care in the private sector. Competition for time automatically results in a transfer of salary resources out of the public sector through reduced availability. Competition for time is also something that concerns health systems' managers, whose moonlighting strategies are often more oriented towards collaboration with development agencies. In Mali, for example, regional health staff and chief medical officers were found to spend 34% and 48% of their total working time respectively, in workshops and supervision missions supported by international agencies.

Outflow of resources: Besides competition for time, in many cases the use of the public sector's means of transportation, office infrastructure and personnel represent additional hidden outflows of resources. The overall impact of this outflow of resources is hard to quantify in any country. The loss to the public sector associated with redirection of diagnostic and therapeutic resources, such as pharmaceuticals, to private practice or into the black market is also difficult to assess. In Uganda, for example, it has been shown to result in a significant loss to the public health facilities: the median drug leakage in health facilities has been estimated up to 78%. This is further compounded by the fact that the best-trained and most competent officials are also the most likely to divert their time to other activities outside the health sector (another form of brain drain).

Impact on income: Individual income topping-up strategies allow professionals a standard of living that is closer to what they expect. Several studies have been done and one showed dual practice leading to more than double the median income of public sector health managers, and bringing it from 20% to 42% of that of a full-time private practice. In a study done in Phnom Penh, Cambodia, 90% of a physician's income in dual practice was shown to be derived from the private sector activity while in Thailand earnings from private practice among physicians constituted 55% of their total income. The advantage of this is that income topping-up helps to retain valuable expertise in public service, without them having to fully leave.

Corruption in the health sector: Health professionals in many countries the world over are expected to have a fairly good standard of living although this cannot be met by existing social systems, sometimes to a level where they cannot even satisfy their basic needs through their public sector salary. And so dual practice may be a strategy to meet theirs and their families' needs. However the context in which this is done is important as there is a fine line separating coping strategies, including dual practice, from corruption. The difficulty in differentiating between the two starts with the definition of corruption. One must distinguish between individual coping strategies and orchestrated activities, acknowledging, nevertheless, that they may be closely interrelated.

Reasons for the existence of dual practice

Dual practice allows a standard of living that is closer to what clinical health workers expect, and thus helps retain several of them in public service. And yet it is a surprise in many cases that a lot of health professionals remain in public service, when they could earn much more in private practice. Many spend comparatively little time, or none at all, in private practice, which means there must be other sources of motivation to keep working in public services. The involvement in teaching or in unpaid NGO work shows that other factors which include social responsibility, self-realization, professional satisfaction, working conditions and prestige still play a significant role. It has been shown in some studies from Cambodia, that links with the public sector are highly valued, as they give physicians access to information, opinions of influential doctors, recruitment of patients, privileges for treating and referring patients and an opportunity to make a contribution to the community.
The gap between income and expectations makes it unavoidable that managers, like other health care workers, will seize opportunities that are rewarding, professionally and financially, in fact, some are of the opinion that dual practice can at times be justified.

Some case studies from Portugal have suggested that the reasons for dual practice are contextual and vary between professional groups and site of employment (hospital versus health centres). The extent of dual practice seems to vary according to urban or rural residence, according to professional group (it is more common among health workers with university degrees and, for these, more common for doctors than for other professional groups) and within a professional group, according to specialty or occupation. For example, health system managers have fewer opportunities for dual practice than clinicians. The evidence therefore suggests that dual practice depends not so much on the personal (age and sex), social (marital status) and professional characteristics of health workers but on factors that are manageable.

It is interesting to note that sometimes dual practice may be the unexpected result of health care reform; take the case of Canada; within the public system, designating sites for different levels of surgical acuity during the early stages of regionalization resulted in a 3.5-fold increase in the number of surgeons working in more than one setting after the restructuring compared to before, as most surgeons do both high- and low-acuity surgeries. Reforms also frequently result in the increase of staff employed on fixed term and temporary contracts, which trend seems to induce dual employment.

Interventions to deal with dual practice

Authorities need to first acknowledge that at the very core of this dilemma is a very strong reason that sets the trend of events: the gap between the professional's financial (but also social and professional) expectations and what public service can offer. Most public responses to individual coping strategies, including dual practice, fail to acknowledge that this phenomenon is about individual employees reacting individually to the failures or

inadequacies of the systems in which they work, and that these de facto choices and decisions become part of what the system is.

For one to provide an adequate response the assumption is that the main underlying reason for the observed dual practice can be identified. In order to do this it calls for an understanding of how endemic the practices observed are; are they isolated, individual cases, and are they specific to the health sector or are they widespread in other sectors of society too?

It is equally important to identify the impact of these practices, particularly the impact in terms of reduced access, inequity and other dangers for the health of the public.

Dual practices have, in some countries, become so prevalent that it has been widely assumed that the very concept of a civil service culture has completely disappeared. But some of the literature reviewed reflects, from the health workers themselves, a conflict between what it means to be an honest civil servant who wants to do a decent job, and the realities that make them betray that image. This uneasiness provokes an important observation suggesting that even in the difficult circumstances observed in many countries, behaviours that depart from traditional civil servant duty and ethics have not been comfortably taken up as a norm. This ambiguity suggests that interventions to mitigate the erosion of proper conduct would be welcome. There are individuals practicing dual employment and yet if had a choice, would opt not to.

The most relevant conclusion is that there is no single recipe to address the reality of dual practice. Its cause and logic vary, and the resulting differences among situations need to be taken into account in the design of corrective measures.

What does NOT work

1. Imagining and pretending that the problem is non-existent or that it is a question merely of individual ethics, or approaching it as a problem merely of corruption, does not address the complex nature of the problem and will not make it go away.
2. Prohibition is equally unlikely to meet with success, certainly if the salary scales remain insufficient. In situations where it is difficult to keep staff performing adequately for want of decent salaries and working conditions, those who are supposed to enforce such a prohibition are usually in the same situation as those who have to be disciplined. Restrictive legislation, when not totally ignored, only drives dual practice underground and makes it difficult to avoid or correct negative effects. Despite this, many governments still resort to prohibition as the main means of controlling dual practice.
3. Closing the salary gap by raising public sector salaries to "fair" levels may not be enough to break the vicious circle. This was attempted in Greece, in the restructuring of the health sector in 1945. When public-sector doctors were prohibited by law from pursuing private practice, their average remuneration was raised to take account of their lost income. But there was great resistance by doctors not prepared to give up private practice and professional autonomy.

But one should note that this option is not a realistic one in many poor countries, where salaries would have to be multiplied by at least a factor of five to bring them to the level of the income from a small private practice. Doing this for all civil servants may not be feasible; doing it only for selected groups would be ethically and politically difficult.

4. Downsizing teams and delinking health service delivery from civil service would make it possible to divide the salary mass among a smaller workforce, leaving a better individual income for those who remain. However, a lot of studies and experience where retrenchment becomes a reality it is rarely followed by substantial salary increases, so that the problem remains and the public sector is even less capable of assuming its mission.

What strategies the government can consider

Improvement is likely to come from a combination of small contributory measures that rebuild a proper working environment.

1. Address problem openly: A prerequisite is to address the problem of dual practice openly. Where it is not realistic to expect health care workers to dedicate 100% of their time to their public service job, this should be acknowledged. It is one way of creating the possibility of containing and discouraging income-generating activities that present conflicts of interest. Besides minimizing conflicts of interest, open discussion can diminish the feeling of unfairness among colleagues. It then becomes possible to organize things in a more transparent and predictable way.
2. Incentives: These may be able to address the problem of competition for working time, one of the major drawbacks of dual practice. However, one needs to note that such approaches require well-functioning and transparent bureaucracies, making the countries most in need also those where they are most difficult to implement on a large scale. Where, for example, financial compensation for work in deprived areas is introduced in a context that provides a clear sense of purpose and the necessary recognition, this may help to reinstate lost civil service values and this applies to the introduction of performance-linked financial incentives.
3. Improving working conditions: It would make little sense to expect health workers to perform well in circumstances where the equipment and resources are patently deficient. But improving working conditions involves more than providing an adequate salary and the right equipment. It also means developing career prospects and providing perspectives for training. Perhaps most important, it requires a social environment that reinforces professional behavior free from the arbitrariness prevalent in the public sector of many countries.
4. Professional value systems: The value systems of the professionals are a major determinant in making the difference between good and bad service to the public. With the building up of pressure from

governments, donors and from peers as well as from users, civil servant health professionals will be more likely to invest in patterns of behaviors and practices that visibly uphold the professional value system.

5. Peer pressure*:* The social and professional culture within a profession may have a major impact on the practice. The effect of peer pressure may be positive or negative. Practice styles can be changed through "peer influence meetings", particularly if the change is seen as building up public reputation and status, once more showing that simple income topping-up may not be the principal driving force of professional behavior. It points to the importance, in the absence of effective regulatory mechanisms, of the role of professional societies in ensuring peer-pressure mechanisms to reduce undesirable coping strategies associated with dual practice. A significant problem with individual coping strategies associated with dual practice is the difficulty of assigning individual responsibilities in situations where these are endemic. In these circumstances it might be relevant to introduce legislation that makes the head of the professional body legally responsible for the actions of that body. This would be a further means of increasing peer pressure and accountability.
6. Pressure from users: Civil society has a particularly important role, specifically in linking reform measures to the experiences and expectations of the people. In many countries, users/clients/patients are not protected against the consequences of the asymmetry of information they face – with health and financial consequences. Perhaps the most effective way to help the government regulate professional practice is to increase pressure from civil society. Creating opportunities for users to voice their discontent effectively implies that patient's rights must be clear, channels for complaints must be simple, regulatory agencies must be strong and trusted by the public, processes must be explicit and transparent and the judiciary system must be strengthened.
7. Recruitment practices: International development agencies, even when they do not have formal, explicit policies regarding dual practice, have become more sensitized to the problem over recent years. This has resulted in a number of recommendations to help minimize the problem. To limit the brain drain due to their own employment policies, organizations such as the World Bank, Norwegian Agency for Development Cooperation (NORAD), German Technical Cooperation (GTZ) or the World Health Organization in principle implement human resources recruitment policies that emphasize the employment of task-specific and short-term consultants, with a commitment of national institutions to retain such staff.
8. Regulating the private sector: A lot of anti-corruption literature actually blames government monopoly of service provision as one of the key determinants of the emergence of some of the coping strategies including dual practice. It has also been argued that the presence of a significant quasi-private system operating within the public sector, i.e. the form of dual practice most common in transitional economies and in developing countries, is detrimental to the development of a strong private sector. A key policy question is whether doctors should be allowed to work in both the public and private sectors. As discussed before, prohibition is unlikely to be effective. The real issue is what types of private practice should be

allowed in order to minimize conflicts of interest, and what forms of regulatory mechanisms can be introduced to isolate coping strategies that are associated mostly with lack of regulation rather than just with low income. It seems that efforts should be undertaken to ensure multiple and independent channels of accountability, by means of penalties for not satisfying contractual obligations, through channels of accountability to professional councils and associations and to the public. Regulation is one important factor influencing the coping strategies that result from the interface with the private sector. Even when regulations exist, effective enforcement mechanisms are often absent in low- and middle-income countries. Therefore good legislation is not enough, the state must have the means to enforce it.

9. Pressure on donors: International collaboration is seen as particularly important regarding the support of international development agencies for actions such as: good-governance interventions in specific domains; supporting methods to curb corruption, including policy dialogue, capacity building, documentation and analysis of best practices and support to national programs; and making reformers aware of the importance of country conditions in program development. Anti-corruption strategies have also been approached by donors with different objectives: to reduce poverty, to improve the functioning of democratic institutions, to sustain economic development, political stability and social justice. The lesson for the management of coping strategies and dual practice is that international collaboration cannot be neglected, as donors may be important inducers of coping strategies and dual practice as well as essential partners in the search for solutions. One way to increase donors' and governments' commitment to deal with the causes of individual coping strategies as well as dual practice might be to include a formal "human resources impact assessment" as a condition for the approval of health projects or components of sector-wide approaches. This could force governments and their partners to face the problems caused by dual practice before it becomes part of the public organization's culture. This would not be a guarantee that it would be effectively dealt with, but might limit the damage.

Conclusion

Dual practice is a very diverse issue with equally diverse causes. It among other things, causes competition for resources including time and access for patients in the public sector. It is in most cases a personal coping strategy for low earnings and inadequate working environment. Despite it being proven unsuccessful, prohibition is the strategy that many governments choose to handle dual practice. Improvement is likely to come from a combination of small contributory measures that create a proper working environment.

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