Executive summary

Dual practice regulatory mechanisms in the health sector
A systematic review of approaches and implementation

Summary

Many health workers hold more than one job that is directly related to treating patients. This 'dual practice' can be a threat to quality of services. This systematic review examines the global evidence on what measures have been attempted or proposed to manage this practice. The review identifies some of the outcomes of the approaches implemented to manage dual practice while assessing the contextual issues that might affect these interventions. It concludes that dual practice may have both positive and negative consequences. Negative consequences mostly arise from its being allowed to proceed unacknowledged and unregulated. Recognizing the existence of dual practice, defining it and measuring its extent is a major step towards managing it. In any given setting, multiple approaches are required to manage dual practice.

Background

The Alliance for Health Policy and Systems Research (AHPSR-WHO) established a Centre of Systematic Reviews at Makerere University School of Public Health to generate evidence on policy issues related to human resources for health. The challenge of dual practice in the health sector is a priority especially given the shortage of health workers in the health sector leading to competition for health workers between the poorly resourced public sector and the well resourced private sector ultimately threatening the quality of services in the public sector.

Methods

Our review asked:

1. What mechanisms have been used to regulate or manage dual practice among health workers?
2. What challenges arise or may be anticipated to emerge from existing or proposed mechanisms to regulate dual practice?
3. What factors may enhance existing or proposed mechanisms to regulate practice?

We sought three main sources of evidence to answer these questions:

- Research about the existing or proposed approaches to manage dual practice (including descriptive studies and policy analyses);
- Evaluations of some of these approaches where they were implemented;
- Inputs from policy-makers and decision makers on what kind of approaches might work and in which contexts (stakeholder consultation).

The inclusion of these different types of research is an important feature of this review. Its conclusions are drawn from studies published globally and the input of policy-makers nationally.

We searched eight electronic databases, used Google and Google scholar, contacted key authors, and searched human resources for health and management websites for research to include in the review. After examining the research in detail and assessing it for relevance and quality, the review's conclusions are based on 28 reports and two reviews.

Findings

Total banning of dual practice did not seem to succeed where it was attempted and often this ban was lifted. Bans tended to fail because of lack of capacity to enforce them. In some countries, total banning was associated with the migration of health workers, especially

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specialists, from the public to the private sector as well as an international brain drain so might not be the best option for Lower-middle-income countries (LMIC) settings.

Allowing dual practice with restrictions was the most frequent approach. *Financial restrictions* included limiting private sector earnings, providing incentives to limit private sector activities, salary increases for public sector workers and performance-based payments. Financial restrictions require well-established and adequate health financing systems to fund and monitor public and private sector activity. Providing flexible contracts that allow degrees of dual practice revealed that public providers tended to favour more time working in the private sector. When offered the possibility of engaging in dual practice, providers maximise earnings from both sectors. In most LMICs where health sector budgets are small and salaries are very low, raising public sector salaries could be impossible.

In High-income countries (HICs) private practice was made unappealing to public providers by restricting the private sector services to those not offered in the public sector, placing restrictions on private sector charges, restricting services insurable in the private sector to only those not covered by the universal insurance and by restricting private provider access to public funding.

Licensure restrictions include mandatory licences to engage in private practice, restricting dual practice to more experienced senior practitioners, restricting time spent on private sector activities and allowing minimal dual practice within public facilities. Careful monitoring and enforcement of rules is necessary for this to work.

Promotional incentives used elsewhere by offering career or recognition incentives to full-time public sector workers might not work in situations where the principal driver of dual practice is economic gain.

Allowing dual practice without restrictions is unlikely to be feasible in countries with health worker shortages.

Recommendations

The most feasible option for LMICs is allowing dual practice with restrictions. With health workers who are underpaid, in short supply and working in areas with a high burden of disease, LMICs struggle to satisfy the demands of the public or the private sector alone. However, LMICs need robust financial systems to monitor financial restrictions. More feasible would be ensuring a minimum performance of work in public facilities while allowing health workers to work in private facilities. A combination of approaches could be attempted in different settings.

The contribution of this review

This review identifies different approaches for managing dual practice in different settings, their documented outcomes and their possible implications for low and middle income countries while at the same time eliciting views from policy-makers nationally about the feasibility of some of these approaches. This review posits that for a given country one or more approaches might be tried.

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