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Doctors with Dual Practices

KEY MESSAGES

- **More than 80% of government doctors are engaged in dual practice**
- **The main reason for adopting dual practice is to supplement income derived from the public sector**
- **Appropriate regulations and public policy do not exist**
- **Health human resource associations frequently have 'codes of conduct' for multiple job holding behaviors that can be reviewed**

Background

Dual practice among health providers is a widespread phenomenon in low and middle income countries. Also known as multiple job holding, dual practice poses a continuous threat to the provision of quality, equitable and efficient health services, especially in the public sector (1). The gap between public and private income in these countries has encouraged medical doctors to work in both public and private sectors (2). Corruption and unauthorized use of public resources have been identified as the adverse consequences associated with dual practice. Appropriate regulations are often lacking. When they do exist, they are either vague, or poorly implemented due to low regulatory capacity (1,3). In Bangladesh, dual practice is widespread, mainly due to the low pay offered

by the public sector. However, non-financial incentives such as status and recognition, strategic influence, and professional opportunities have also been identified as contributory factors (3,4). Although dual practice by government doctors is common, little is known about the organisational and economic aspects of these arrangements. It is believed that more than 80% of government doctors are engaged in private practice (5). The Government has a permissive attitude towards dual practice, as they see it as a way to further mobilise resources and to retain qualified staff. In the 1980s, the Government did attempt to regulate provider fees, but such rules were never enforced. Today, the Government has still not adopted the appropriate regulation and public policy to avoid the adverse consequences of this practice.

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Positive Impact	Negative Impact
<ul style="list-style-type: none"> ▪ Generates additional income for the physicians ▪ Increases contribution of the private health sector in the provision of health services ▪ May increase knowledge and experience of the providers, improving quality and efficiency in their work (1,5,6,7) 	<ul style="list-style-type: none"> ▪ Absenteeism and job shirking as health personnel reduce their work hours in government service to pursue private work ▪ Exploitation of patients where providers in dual practice have incentives to refer patients from public treatment to private treatment, in which providers can earn fees ▪ Brain drain, whereby the existence of the private sector makes it increasingly hard to attract and retain providers in the public sector ▪ Misappropriation of scarce public sector resources into the private sector

Recommendations

It may be unrealistic to assume that public professionals will be solely dedicated to the public sector. Policy-makers may need to accept the reality of dual practice, and create an environment for the effective co-existence of public and private practices.

The Government of Bangladesh may consider the following options:

- **Re-assess the rules and regulations set out by BMA and BMDC on doctors' 'codes of conduct', private-practice setup, and 'multiple job holding' behaviour in relation to private practices**
- **Because of limited resources, a 'non-practicing' allowance may not be an appropriate tool for curbing excessive private practice**
- **Include packages of financial incentives linked to public sector duties' performances, as a way of ensuring more public sector dedication and curbing negligence**
- **Use of public sector facilities for private practices against set 'rental' payments to the public sector**
- **Understanding and accepting that there is no single model that is applicable to Bangladesh**
- **Allocate additional resources for further research into establishing an appropriate model contextualized to the public and private practice environment of Bangladesh**

References: A full list of reference used in the development of this policy brief, and further information, is available at: www.icddrb.org/page_view.cfm?ID=129