DOI: 10.7860/JCDR/2019/42594.13174

Review Article

Health Management and Policy Section

Dual Practice on Health Service- Should it be Promoted in Qatar?

SAAD AL KAABI[1], BETSY VARUGHESE[2], ANIL K JOHN[3]

ABSTRACT

Dual Practice (DP) is a widespread phenomenon of public healthcare employees working concurrently both within and outside the public-sector environment for personal profit. The impact of dual practice varies in its potential for access, quality, cost and equity of healthcare services. Unregulated growth of the private sector, low salaries and poor working conditions in the public sector have made an attractive opportunity for healthcare workers to work simultaneously at both public and private facilities. This generates additional income for healthcare workers which are minimising the budgetary burden of the public sector to retain skilled staff, especially at the scarcity of resources. However, its negative impact far exceeds the positive impact, which includes the rise of detrimental and predatory behaviour, ethical issues and migration of healthcare workers. Also, there are limitations for time and resources that compromises the service delivery, where healthcare workers who are engaged in dual practice are available only for a limited time at public facilities; many times found as absenteeism, tardiness, inefficiency and lack of motivation. In many countries, the health sector managers are forced to accept dual practice to retain their highly skilled employees, sometimes detrimental to health service provision. Though several reasons for dual practice such as a wide gap between physicians' income expectations and their wages, long waiting lists and unsatisfactory working conditions prevail in the public sector of many countries, none of these factors is reflecting in Qatar. Most of the healthcare professionals in Qatar are expats and dual practice may further inflate substantial workforce shortfall in the public healthcare sector. Hence policymakers should pursue strict policies to prevent dual practice of healthcare workers in Qatar.

Keywords: Dual employment, Ethical issues, Migration of healthcare workers, Moonlighting, Public-on-private

INTRODUCTION

Dual practice is an emerging challenge to healthcare policymakers across the globe as it has direct implications for healthcare workers' labour supply, and quality of care provided [1,2]. Dual practice refers to permanent public sector physicians practising simultaneously in the private sector for profit-earning, also termed as "Dual employment", "Locum work", "Public-on-Private," "Moonlighting," or "Multiple job holding." In most of the economic literature, it is explained as a situation where a physician combines clinical practice in the public sector with any other jobs in the private sector mainly research, teaching, or management. Physicians engaged in dual practice usually have better salary opportunities in private practice than working in the public sector that makes them more inclined, to concentrate their attention and work effort more on private practice. Their commitment to public patients is compromised by the pursuit of profit-maximisation [3-5]. A thought-provoking question arises here is why dual practitioners do not focus exclusively on the lucrative jobs in the private sector than practising in both the sectors?

In many countries, physicians engage in dual practice is mainly because of their low salaries in the public sector, which do not allow them for a comfortable standard of living or even do not exceed the minimum costs of living [6]. In such situations, dual practice can be considered as a potential system solution to very limited financial resources in the public health care sector [7-9]. However, the negative impact of dual practice far exceeds its benefits which are discussed in detail in this article.

Negative Impacts of Dual Practice

Detrimental and predatory behaviour: Dual practitioners are mostly rational profit-maximisers, who compromise their patients' care whenever they get an opportunity for earning an additional income. Dual practice may lead to the detrimental and predatory behaviour of healthcare professionals where self-gain is achieved to the detriment of the legitimate interest of colleagues, services and/or patients; often found as absenteeism, tardiness, inefficiency and lack of motivation of healthcare workers. Many clinicians use their authority to prescribe treatment for their patients to generate additional demand for their service [10]. Such detrimental or predatory behaviour of dual practitioners jeopardises the essential relation of trust between patients and public healthcare providers. It creates a financial barrier to access to healthcare and in the long run, it delegitimises the public sector from healthcare service delivery.

Corruption and drain of public resources: Dual practice induces many unfavourable behaviours like supplier-induced demand and cream-skimming in healthcare workers [9]. It is often associated with redirection of diagnostic and therapeutic resources mainly equipment and pharmaceuticals from public sector to private practice or into the black market. The use of the public sector's means of transportation, office infrastructure and personnel represent additional drain of public resources yet the overall impact of this outflow of resources is hard to quantify in any country [4]. This may lead to an increase in costs in the government sector either due to an overprovision of health care by dual practitioners who want to earn good reputation to support their private practice, or the public resources are used for private practice without any payment [4,11].

Ethical issues: A more serious problem with dual practitioners is that of conflict of interest in clinical practice. A financial conflict of interest occurs when doctors are involved in any profit earning services especially indecorously obtaining money from patients, inappropriately prescribing medications, ordering more laboratory tests, performing unnecessary surgeries and fee-sharing or obtaining commissions from the referral of patients in which he has a final interest. Clinician's self-referrals or unwanted referrals to persons not competent for the patient's problems may also occur when doctors have own imaging or laboratory testing facilities in

their offices or possess ownership of a free-standing facility [12]. It is unethical to justify subjecting private patients to unnecessary tests and treatments if avoiding doing the same to public healthcare patients. So, to ease the stress of this cognitive dissonance, it is important to operate the same system in both wings of practice, which is hardly happening with dual practitioners [13].

The inflow of patients to public hospitals is more when compared to the private sector. Many times, doctors are unable to devote enough time with patients which create a negative impact on diagnosis, treatment and follow-up in public hospitals. In contrast, doctors give better care in the private hospitals which attract the patients towards the private sector. Some of the doctors intentionally alter the quality of treatment and reduce communications with patients in the public hospital. They divert patients to their private practice by keeping a minimal level of care at the public hospitals, later referring these patients to their private practice [2].

Many doctors who are looking for dual practice early in their careers are keen to foster their reputation in public facilities to attract more private practice in future. Then, they have potential incentives to skimp on work hours and divert patients to private clinics, with a negative impact on service provision in the public sector. Financial benefits seem to be the main thrust of dual practice, even in countries with high public wages like Norway [14].

Migration of healthcare professionals: International migration is often thought as the main reason behind the brain drain of healthcare professionals in low and middle-income countries [15]. It happens mainly because of the failure to post and retain the right personnel at the right place in rural areas and getting more opportunities for income generation in urban areas. Healthcare professionals who have successfully taken advantage of such opportunities increase their market value over time and later compounded by dual practice [4].

Inequity of access: In many countries, public sector medical staffs are available only nominally full-time to fulfil their assigned tasks. Increased absenteeism of physicians from public hospitals to focus their time and attention to generate more income in private practice is widely reported in the literature [16-19]. In many cases, physicians were unjustifiably absent from work or, even if present at work, often consult private patients during their work at public facilities [20]. Dual practice intendedly increases patients' waiting time to boost the physicians' demand for their private practice [9,21-23]. The doctors who are interested in boosting demand for their private care, redirect wealthier patients from public waiting lists to earlier appointments in their private practice [24]. This raises potential inequity of access and patients able to pay can queue-jump the others, irrespective of their different clinical needs.

Feasibility of Dual Practice in Qatar

Qatar has experienced exponential growth and extraordinary development in the healthcare sector over the past two decades [25]. Qatar's health system has been ranked 5th best in the world and first in the Middle East region [26]. Qatar has imported healthcare systems from other countries and currently enables these foreign systems to their unique indigenous culture. Current healthcare system includes a countrywide network of public hospitals and healthcare centres that offers the most advanced medical equipment and highly qualified staff which caters access to the highest quality treatment in all fields of medical specialities and care to all patients irrespective of their nationality. Hamad Medical Corporation (HMC) being the principal public healthcare provider in the State of Qatar, provides excellent professional opportunities to its employees and ensures the safest, most-effective and compassionate care to all patients throughout the country. The private hospitals work with public hospitals especially with HMC facilities whenever any specific conditions require more specialist treatment. Thus, the potential of dual practice is negligible in Qatar. Another major challenge found in the healthcare sector is the lack of Qatari healthcare workers. Most of the professional expertise in medicine has been hired from different countries and these expats are coming to Qatar for a short period. Hence dual practice may further inflate substantial workforce shortfall in the public sector. In many countries, several reasons such as a wide gap between physicians' income expectations and their wages, long waiting lists and unsatisfactory working conditions in the public sector encourage dual practice of the physicians [27]. However, none of these factors are reflecting in this country as Qatar provides competitive salary to the public healthcare workers like western world.

CONCLUSION

World Health Organisation (WHO) reaffirms that the ultimate responsibility for the overall performance of a country's health system lies with the government, which in turn should involve both private and public sectors in its stewardship. However, good policies are needed to differentiate between healthcare providers who are contributing to health goals and who are detrimental to the healthcare sectors. Since the negative implications of dual practice far exceeds its potentials which include the rise of detrimental and predatory behaviour, corruption and drain of public resources, ethical issues, inequity of access and migration of healthcare workers; dual practice should be forbidden in Qatar to further strengthen the socially important profession like medicine in the public sector.

REFERENCES

[1] Eggleston K, Bir A. Physician dual practice. Health Policy. 2006;78(2-3):157-66.
[2] Das J, Holla A, Mohpal A, Muralidharan K. Quality and accountability in health care delivery: audit-study evidence from primary care in India. Am Econ Rev. 2016;106(12):3765-99.
[3] Biglaiser G, Albert Ma C. Moonlighting: public service and private practice. Rand J Econ. 2007;38(4):1113-33.
[4] Ferrinho P, Lerberghe WV, Fronteira I, Hipólito F, Biscaia A. Dual practice in the health sector: review of the evidence. Hum Resour Health. 2004;2:14. doi:10.1186/1478-4491-2-14.
[5] The world health report 2000- Health systems: improving performance. [Internet]. Who.int. 2019 [cited 14 August 2019]. Available from: https://www.who.int/whr/2000/en/.
[6] Do N, Do Y. Dual practice of public hospital physicians in Vietnam. Health Policy Plan. 2018;33(8):898-905.
[7] Moghri J, Rashidian A, Arab M, Akbari Sari A. Implications of Dual Practice among Health Workers: A Systematic Review. Iran J Public Health. 2017;46(2):153-64.
[8] González P, Macho-Stadler I. A theoretical approach to dual practice regulations in the health sector. J Health Econ. 2013;32(1):66-87.
[9] Socha K, Bech M. Physician dual practice: A review of literature. Health Policy. 2011;102(1):01-07.
[10] Lambertini L, Scarpa C. Minimum Quality Standards and Predatory Behaviour. University of Brescia, 1999. SSRN Electronic Journal. 2000. http://papers.ssm.com/sol3/papers.cfm?abstract_id=200550.
[11] Gruen R, Anwar R, Begum T, Killingsworth J, Normand C. Dual job holding practitioners in Bangladesh: an exploration. Soc Sci Med. 2002;54(2):267-79.
[12] Jih CJ, Thirumoorthy T. Conflicts of interest in medicine- understanding the concepts to preserve the integrity of professional judgement and promoting public trust in the profession. SMA New [Internet]. Sma.org.sg. 2019 [cited 14 August 2019]. Available from: https://www.sma.org.sg/UploadedImg/files/Publications%20-%20SMA%20News/4502/CMEP.pdf.
[13] Dean J. Private practice is unethical-and doctors should give it up. BMJ. 2015;350(may05 1):h2299.
[14] Johannessen K, Hagen T. Physicians' engagement in dual practices and the effects on labor supply in public hospitals: results from a register-based study. BMC Health Serv Res. 2014;14(1):299.
[15] Gacevic M, Santric Milicevic M, Vasic M, Horozovic V, Milicevic M, Milic N. The relationship between dual practice, intention to work abroad and job satisfaction: A population-based study in the Serbian public healthcare sector. Health Policy. 2018;122(10):1132-39.
[16] Gonzalez P, Montes-Rojas G, Pal S. Dual Practice by Health Workers: Theory and Evidence from Indonesia [Internet]. Ideas.repec.org. 2019 [cited 14 August 2019]. Available from: http://ftp.iza.org/dp11038.pdf.
[17] Jaén MH, Paravisini D: Wages, capture and penalties in Venezuela's public hospitals. In Diagnosis Corruption. Fraud in Latin America's Public Hospitals. Edited by: Di Tella R, Savedoff WD. Washington DC: Inter-American Development Bank, 2001:57-94.
[18] Alcázar L, Andrade R: Induced demand and absenteeism in Peruvian hospitals. In Diagnosis Corruption. Fraud in Latin America's Public Hospitals. Edited by: Di Tella R, Savedoff WD. Washington DC: Inter-American Development Bank. 2001:123-62.
[19] Giedion U, Morales LG, Acosta OL. The impact of health reforms on irregularities in Bogotá hospitals. In Diagnosis Corruption. Fraud in Latin America's Public Hospitals. Edited by: Di Tella R, Savedoff WD. Washington DC: Inter-American Development Bank. 2001:163-98.

[20] Di Tella R, Savedoff WD, editors: Diagnosis Corruption. Fraud in Latin America's Public Hospitals. Washington DC: Inter-American Development Bank. 2001.
[21] Humphrey C, Russell J. Motivation and values of hospital consultants in south-east England who work in the National Health Service and do private practice. Soc Sci Med. 2004;59(6):1241-50.
[22] Morga A, Xavier A. Hospital specialists' private practice and its impact on the number of NHS patients treated and on the delay for elective surgery. Heslington, York: Department of Economics, University of York; 2001. (Discussion Papers).
[23] Iversen T. The effect of a private sector on the waiting time in National Health Service. J Health Econ. 1997;16(4):381-96.
[24] Garattini L, Padula A. Dual practice of hospital staff doctors: Hippocratic or hypocritic? J R Soc Med. 2018;111(8)265-69.
[25] Goodman A. The Development of the Qatar Healthcare System: A review of the literature. Int J Clin Med. 2015;6:177-85.
[26] Qatar Ranks 5th Globally in the Health Index. https://portal.www.gov.qa/wps/portal/media-center/news/news-details/qatarranksfivtthinthehealthindexglobally.
[27] Bayat M, Salehi Zalani G, Harirchi I, Shokri A, Mirbahaeddin E, Khalilnezhad R, et al. Extent and nature of dual practice engagement among Iran medical specialists. Hum Resour Health. 2018;16(1):61.

PARTICULARS OF CONTRIBUTORS:
1. Chairman, International Medical Affairs Office, Hamad Medical Corporation, Doha, Qatar.
2. Clinical Quality Administrator, Department of Medicine, Hamad Medical Corporation, Doha, Qatar.
3. Senior Consultant, Division of Gastroenterology and Hepatology, Hamad Medical Corporation, Doha, Qatar.

NAME, ADDRESS, E-MAIL ID OF THE CORRESPONDING AUTHOR:
Anil K John,
Senior Consultant, Division of Gastroenterology and Hepatology, Ambulatory Care Centre,
Hamad Medical Corporation, Doha, Qatar.
E-mail: ajohn7@hamad.qa

FINANCIAL OR OTHER COMPETING INTERESTS: None.

Date of Submission: **Aug 07, 2019**
Date of Peer Review: **Aug 14, 2019**
Date of Acceptance: **Aug 20, 2019**
Date of Publishing: **Sep 01, 2019**