Dual Practice in the Health Sector: Policy and Regulatory Responses

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Introduction

The policy possibilities for regulating dual job holding by medical professionals in resource-constrained contexts are examined in this research. Such conduct has been linked to the improper use of public resources and corruption and is often motivated by a lack of resources in the public sector and low compensation. It is also frequently underregulated; restrictions are either absent or, when there, are ambiguous or poorly executed due to a lack of regulatory ability. This study evaluates several regulatory choices in connection to the objectives of quality of care and access to services, as well as some of the policy restrictions that can stymie implementation in resource-poor settings, based on the minimal evidence available on the topic. Physician dual practice is a common occurrence that has ramifications for healthcare equity, efficiency, and quality. The trade-off between the benefits and costs of physician dual practice, as well as the ease of regulating it to mitigate its negative implications, are at the heart of the analysis. We examine and evaluate several government reactions to this behavior in this report. We discovered that governments approach this issue in a variety of ways around the world. While some governments outright prohibit dual employment, others regulate or restrict it with varying degrees of severity and regulatory instruments. Limiting the money physicians can earn through dual job holding, providing work advantages to physicians in exchange for working only in the public sector, raising public salary, and permitting physicians to practice private medicine at public facilities are among the measures enacted. Physicians frequently work in both government and private facilities at the same time. In many developing and developed countries, this is the case. Full-time civil officials committed solely to the public sector are no longer common in poor and middle-income countries. Medical practitioners in these countries have been encouraged to work in both the public and private sectors due to the disparity in income between the two. Similarly, most developed countries have physicians who alternate between public and private employment. Canada, where such practices are illegal, and the United States, where the dual practice is uncommon, are two notable exceptions. As a result, many countries are debating whether the dual practice should be regulated or not, as well as which policy action is best for preventing the negative implications of this practice. There haven't been any attempts in the literature to examine this subject in-depth, as far as we're aware. Concisely discuss dual practice regulation. However, they are limited to a few countries with limited resources. Dual practice regulation is a major concern for health authorities all over the world, so this absence in the literature is remarkable. The strategies and restrictions that governments in a variety of developing and developed nations have implemented to address multiple jobs held among medical providers are examined in this paper.

Policy and regulatory responses

While the majority of health economists agree that dual practice has both positive and negative consequences for healthcare equity, efficiency, and quality, there is no agreement on the net effect. In emerging nations, particularly those with burgeoning private sectors, dual practice, in which government-employed health personnel takes on other jobs, is common. According to recent surveys, 29% of physicians in Cote d'Ivoire, 35% of physicians in Vietnam, 42% of physicians in Sri Lanka, 41% of physicians in Zimbabwe, and up to 80% of physicians in Indonesia and Bangladesh have second occupations. In some cases, dual practice might encompass more than just private for-profit service delivery, such as research and NGO work. In developing nations, researchers and policymakers are becoming increasingly interested in how dual practice affects the health system. One of these countries is Uganda. The private health sector in the country is thriving. Within this, the private not-for-profit health sector has served as an extension of the public one for decades, particularly after the public health sector was largely decimated during the civil war and continues to be underfunded to this day. Although Uganda's private for-profit industry is big, fragmented, and unorganized, little is known about it. Although there is a growing interest in public-private collaborations in health, dual practice is rarely discussed, and data on the subject is scant. In a nationally representative survey of private health facilities in Uganda in 2005, it was discovered that more than half (54%) of private-sector doctors also acknowledged being nominally employed in the public sector. Despite the lack of figures from public institutions, health practitioners and policymakers believe that practically all government-employed health personnel practice dual medicine. Furthermore, due to media reports of negative health service delivery outcomes, as well as suspected links to absenteeism and the waste associated with it, the dual practice has risen in relevance on the legislative agenda. A recent study aimed at determining policymakers' research objectives indicated that dual practice was a major worry "According to reports, this has a significant impact on the public sector's performance. The dual [practice] of public health workers has negative consequences for the quality and management of health-care delivery, including indiscipline, time waste, and poor work ethics ".Despite these issues, there is a scarcity of information on dual practice in Uganda and elsewhere. Even though various types of health workers are thought to engage in the dual practice, the extant literature solely looks at it from the perspective of doctors. Furthermore, existing research offers few answers to questions about dual practice policy and management, other than agreement that the effects of dual practice on the organization of the health system and service delivery can be positive or negative, and that these effects, as well as policy responses, are highly dependent on the local context. Dual practice, for example, may help prevent doctors from leaving the nation by allowing them to augment their salaries without harming the country's doctor supply if it is carefully regulated. Absenteeism and pilfering, on the other hand, if poorly managed, can harm public sector care standards and lead to inefficiency. The variables and interactions that cause these effects have yet to be thoroughly investigated. These aspects are likely to be influenced by how dual practice has grown and is handled in a specific health system. Studying the dynamic characteristics of dual practice and related interactions both within and outside the bounds of a health system necessitates a departure from the literature's linear, theoretical approaches. A better model recognizes the holistic, multifaceted, and adaptable nature of health systems and their surrounding environment. Complex systems are made up of numerous interconnected components that dynamically organize themselves, are long-term unpredictable, and can learn from previous experiences. A research methodology that takes into account the characteristics of complex systems, as well as the possibility for interactions owing to contextual factors, is excellent for guiding the investigation of phenomena like a dual practice from many viewpoints. It makes it easier to investigate properties of complex systems like feedback, emergence, and self-organization.

The policies and regulations that governments in several developing and industrialized countries have put in place to deal with medical providers who work two jobs. The institutional frameworks in which government solutions to dual practice have been enacted are of special interest to us. There are significant differences in how dual practice is regulated around the world. In several countries, the government has taken the position of prohibiting the holding of public-private jobs. Others allow the practice, but other laws are in place to prevent or mitigate some of the activity's possible negative implications. The dual practice among physicians can be controlled by setting a maximum number of services that can be provided in the private sector by the government.

This strategy has been used in Austria and Italy. The practice can also be controlled by defining the maximum income that physicians can earn by working two jobs at the same time, as France and the United Kingdom have done. Dual practice can also be discouraged by increasing public salary or providing allowances or other employment incentives to physicians who only work for the government. Countries such as Portugal and Spain have chosen to respond to dual practice in this way. Finally, physicians may be permitted to practice some aspects of private medicine in public facilities. Germany and Ireland are two countries that have used this method to deal with dual practice. In the next sections, we'll look at these and other options for regulating the dual practice.

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