

Dual practice and economic transformation: the case of China

Private practice in the health sector was re-introduced from 1980 when China began its economic reform from a planned economy to a market economy. Since then, the total number of private sector providers has grown substantially. However from the health policy perspective, little is known about dual practice (DP). The aim of this study is to describe policies and regulations relating to it, the current situation, its possible impact and to provide recommendations for future policies in this area.

This study was conducted in two provinces, Shandong and Sichuan. It involved a combination of key informant interviews, document analyses (including financial records) and questionnaire surveys.

Discussions with doctors indicated that out of those doctors who carried out such activity, it was undertaken, on average, less than 2 times per month and accounted for around 30% of their total income. However, this was seen to be an underestimate according to other stakeholders who argued that such activity amongst medical doctors (particularly surgeons) is much more prevalent. It is likely that this possible under-reporting by doctors is related to the ambiguous legal status of this activity and their reluctance to reveal higher levels of engagement.

Most of the doctors spoken to thought DP is acceptable and that it should be made legal. Many argue that DP helps establish important communication bridges between hospitals. Those doctors who reported that they abstained from DP said they did so because of a lack of time. Awareness of the regulations regarding DP amongst doctors was quite low (24% in our sample reported being familiar with them).

Because of the recent changes in Chinese society and the macro economy – in particular the transformation from a planning to a market-oriented model, the growing phenomenon of dual practice has highlighted some problems for the way in which public hospitals are managed and regulated. From the beginning of the 1990's, the Ministry of Health and provincial government have maintained bans on such activity. Currently, due to the limited financial capacity within the public sector, salary levels of public hospital doctors have fallen relative to the rest of the population. At odds with the bans is the reality that many public hospital doctors do have some experience of DP. Furthermore they feel that such activity has positive benefits for the hospitals in which they are employed and is an important means by which such doctors are able to maintain income levels. Therefore it is heavily supported by medical practitioners and public hospital managers who view it as a means of addressing the financial problems associated with maintaining medical staff. In the near future there are likely to be changes in the regulations regarding DP with growing acceptance by policy makers of the difficulty of enforcing existing bans in the face of overwhelming economic imperatives.

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Dual Practice among Public Medical Doctors in Thailand

In Thailand, as in other countries, the government allows public medical doctors to undertake private practice. Low salaries in the public sector is a significant motivation. Furthermore, there is a strong preference for private services in Thailand and therefore good opportunities in terms of both income generation and prestige associated with it. Previous evidence, however, has shown that dual practice may lead to negative impacts on public health services. Therefore, knowledge of the impact, patterns, behaviour, motivation and regulatory issues around dual practice may provide guidance on forming appropriate policies for solving problems that may result from it.

The study was conducted in five provinces of Thailand (Bangkok, Konkaen, Lopburi, Payao, Songkla) in 2001. Three methodologies were employed, namely, comprehensive document reviews, a survey of 1,808 public medical doctors using anonymous self-administered questionnaires, and in-depth interviews of key informants.

The response rate of the survey was 36 % or 659 completed questionnaires. Results revealed that 69 % of public doctors had dual practices. The main reason for having dual practice was "income from public service is inadequate". A logistic regression analysis showed that factors influencing dual practice engagement were being male medical doctors and medical specialists. The ratio of total monthly income between fully public and dual practice medical doctors was 2.2. In-depth interviews illustrated that implications of dual practice range from public-time corruption, neglecting public patients, poor performance in the public sector due to exhaustion from private work and related to this, differences in the quality of care between public and private. Existing regulations regarding dual practice tend to be indirect with poor enforcement. Responsible organizations such as the Ministry of Public Health and Thai Medical Councils have neither any policy in this area nor intention to regulate it.

As private provision still plays significant roles in the Thai health care system, dual practice performs two useful functions: compensating for the low salary of public medical doctors and increasing access to health care. However, the negative impacts of dual practice require regulations and measures to minimize these consequences. The strengthening of regulatory measures and administrative capabilities, the introduction of new methods for public medical doctor's payment which reflect performance and quality of care, and a reform of employment patterns into part-time and full-time may be options for policy recommendations. Moreover, indirect measures such as good dual practice guidelines, Quality Assurance (QA), and Hospital Accreditation (HA) should be introduced. This will control the adverse consequences of dual practice, and improve consumer choice and patient access to health care.

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