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**Dual Practice of Public Sector Health Care  
Providers in Peru**

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## **ABSTRACT**

In Peru, medical practice has had private and public dimensions for a long time. Such arrangements have been regulated more by social consensus than by written rules. The traditional combination of public and private practices has produced a framework of few known interactions. Little is known about these interactions and little has been done to regulate them in Peru.

To explore the extent, characteristics, incentives, effects and possible regulation of private medical practice in public facilities this study undertook a cross sectional quantitative – qualitative analysis. A close end questionnaire was randomly administered to 1173 doctors working at the Ministry of Health, the Peruvian Social Security (ESSALUD) and private health facilities placed in five departments of Peru (Lima, Huancavelica, Loreto, Piura and Tacna). Furthermore 26 in depth-interviews were made with doctors and key informants from Lima.

Results from the survey and focus groups reveal that DP is mainly a strategy to obtain better incomes in the face of low public salaries. Furthermore this situation is influenced by the Peruvian macroeconomic environment characterised by an oversupply of doctors caused by the deregulation medical practice and education. DP is common in all types of health facilities and working institutions, and it is closely associated to clinical practices. DP has some negative and positive effects on public health: channelling patients to private clinics, long queuing patients and downgrading the quality of care have been reported as negative aspects; better income for hospitals, better managerial procedures, and quick health care were reported as positive aspects.

Interviews suggested that the negative effects must be regulated by developing full public health jobs as well as improving career opportunities and doctors' income. Other suggestions to regulate DP were regulation of medical education as well as formalisation of fair medical practice and reinforcement of the judiciary framework. Some of these measures are being developed by Peruvian Ministry of Health, though they would be reinforced and accelerated. There needs also to be recognition of DP as a real problem and development of monitoring structures and mechanisms of supervision. This structures must incorporate representatives of all stakeholders (state, professional bodies, hospital boards, consumer organizations, and ombudsman) in Ministry of Health headquarters as well in its decentralised offices

## INTRODUCTION

### Background

Doctors usually undertake dual job holding to cope with modest incomes; however this frequent but little known activity has deep effects on the efficiency, quality of care and equity of the overall health system. This is not surprising since dual practice is a key point related to private and public mix in health care and to government regulation.

Dual job holding or dual practice (DP) is “the situation where a public sector health worker (e.g. doctor, nurse, midwife, etc) establishes a private practice as an additional source of income, although it may also cover instances where individuals work as employees at another facility” (Jan, 2003).

DP is performed by doctors as well as by nurses, midwives, and technicians. However, the influence of doctors is stronger than others in decisions that affect efficiency or quality of health services. Doctors’ DP is frequent in Portuguese countries, in African countries (Ferrinho, 1998) as well as in Asian countries (Mills, Bennett and Russell, 2001).

Doctors undertake DP because they want greater income, more job opportunities, or to improve their social status and family opportunities. As quoted by Ferrinho doctors engage in private activities “to meet the cost of living” as well as “to support the extended family” (Ferrinho et al. 1998). However contrary to the hypothesis that doctors are able to target incomes by supply-inducement (Evans 1974), there are broad socio-medical constraints on the amount individual doctors can earn in Peru e.g. the way the public system and private system have been configured, macro-economic factors such as restructuring of the state, cutting public expenditures in the public budget, or national policies such as deregulation of medical labour or educational laws.

DP influences the internal health system in many ways. Private medical care delivered by public doctors has been described as an obstacle for health reforms (Roemer, 1990). International evidence (Roenen 1997) suggests that private practice interferes with the public practice. Negative and positive effects have been described in many Asian countries (Bath 1993, Chawla 1995, Berman 1997). In Bangladesh it has been shown that “private services are used by people of all income levels” (HEU 1996). Negative effects of private practice on

public facilities such as channelling patients, crossover arrangements and abuse of government position have also been mentioned (Mills, Bennett and Russell, 2001). But, DP has also positive effects of retaining qualified personnel in public facilities, realization of professional goals, and better income for doctors (Ferrinho, 1998). For policy makers DP can be seen as a useful policy tool to maintain staff rather than necessarily a problem (Jan, 2002).

Understanding the dynamic of incentives behind DP should have positive effects on developing appropriate regulative measures. Financial and non-financial incentives are potentially effective in regulating the private practice in dual job-holding practitioners. Gruen (2002) sets out a number of measures:

- better income
- an allowance for non-private practices
- improving training and career opportunities for retaining staff in rural areas .

Some governments have a permissive attitude towards the joining of private and public practices because it allows them to mobilise resources from the private sector as well as to “retain qualified staff in the public health sector”. Government hospitals also have incomes generated from the fees of private practices (Gruen, 2002).

The congruence of incentives in a principal–agent relationship would provide efficient or responsive health services. Nonetheless, a potential conflict emerges when the incentives are oriented in favour of doctors' self interest. Thus, incorporating incentives into the regulative framework is important. As quoted from Gruen, a “better-regulated qualified practice could be more economically efficient than widespread unregulated services offered by unqualified practitioners” and can cope with potential conflict of interests related to the joining of private and public services (Gruen, 2002).

Coping with multiple and commonly conflicting interests requires a clear perception of regulation as a complex interaction among stakeholders (Bennett et al. 1994). Governments, professional bodies, hospital boards, consumer organizations and interest groups are actively working to frame the public private connection. Hence, formal and informal interests need to be accommodated.

### *The Peruvian context*

Dual practice is older than the public healthcare system. Private practitioners were common during colonial and republican times in Peru. Until 1968 Lima's main hospitals had been managed by religious orders; they were charitable private institutions, with private doctors bringing public services. In 1968 the national health system was created: hospitals shifted from charitable religious orders into the national public health system; doctors were contracted under governmental conditions and became public servants (Bustíos, 1997). In the last ten years, private practice has been relocated, mostly as a complementary job, into private doctors' offices and private clinics

The private sector is increasingly important for health provision. According to the Peruvian College of Physicians, there are 29,431 physicians (Peruvian College of Physicians 2000); 66 percent are in government institutions (CIRHUS 1996), and 65 percent are in Lima (Lip 2000). Historically, regulation of doctors' practice started in 1888 (Bustíos, 1997); in 1935 the just created Ministry of Health (MOH) also regulated medical practice (Bustíos, 1998). Recently the Medical Working Act was passed to regulate medical practice in private and public health centres (DL 559, 1990).

Dual practice is widespread. Although there is little evidence, it is commonly recognised that Peruvian doctors are multi job practitioners. Some of these jobs are health care related, while others are not. Therefore there is potential overlap in job schedules among them and conflicting interests as a consequence. Ethical and legal concerns arise from these practices.

The most common form of private practice is at a doctor's own office or private clinic; however, this is progressively decreasing, because patient demand has declined. Other common practices are teaching medicine and working in hospital clinics. Nevertheless, there is some evidence that Peruvian doctors' dual practice is more multifaceted than previously the case as doctors are pushed into other income earning activities due to the competition for medical services.

The regulatory framework of the health system has not taken into account of DP, mainly because it has not been seen as a problem. Thus, the Ley General de Salud (Law of Health) rules that doctors governed by their professional body in providing medical care, and the professional bodies are empowered to supervise their members' professional behaviour

(Government of Peru, 1997). The Peruvian College of Physicians Law (PCP, 1968) simply rules that professionals must observe the ethical rules of medical practice. The most specific reference to DP is in the Doctors' Working Law (PCP, 1990) stating the norms, conditions, hours and salary of Peruvian doctors. This Law permits DP through three articles: the 5<sup>th</sup>, 8<sup>th</sup> and 14<sup>th</sup>. Article 5 mentions that doctors have freedom to exercise the "medical act" in whatever circumstances. Article 8 rules that "medical acts" modes are: health care, teaching, management, production and other related to the medical act. And finally, Article 14 indicates that teaching is permissible simultaneously with health care (PCP, 1990).

### *Conceptual framework and aims of the study*

The study is based on two complementary theories. Dual practice is explained by the motivational theory of Lawler, and the regulation framework is explained by the principal – agent theory.

According to the theory of motivation (Lawler, 1973), "dual job holding is a conscious decision based on expected results of alternative behaviour". So, under the present system, dual practice is a way to "accommodate both jobs and to maximise the rewards derived from them". As the state needs to assure services for the whole population, problems with the private for-profit sector must be anticipated if the state is seen to be acting as an agent for the population (principal).

The study should address the following questions:

- a) What are the types and patterns of private practice by public providers?
- b) What is the extent of this practice, comparing public and private in terms of individual providers and institutions?
- c) What are the incentives and consequences of these practices, from a public sector and population perspective, for equity, efficiency and quality?
- d) What is the policy and regulatory framework surrounding the issues of private practice by public providers? What are the mechanisms for its implementation, and how effectively do they operate?
- e) What policy measures can be taken to promote and protect equity, efficiency and quality, where individual providers or institutions engage in dual public-private practice?

## METHODS

This is a cross-sectional quantitative and qualitative analysis to identify the main characteristics of dual job holding (dual practice) of Peruvian doctors working both in public and in private health facilities, the incentives behind dual practice (DP), as well as its effects on equity and quality of care and on government policies.

### 1. Physicians' survey design

#### *Survey population*

The questionnaire survey was applied to 1,173 physicians subscribed to the Peruvian College of Physicians, in five departments of Peru (Lima, Huancavelica, Loreto, Piura and Tacna. The planned survey population was 1038. Quotas were calculated according to the number of local physicians. The Primary Sample Unit (PSU) was the district's place of work, the Secondary Sample Unit (SSU) was the physician's institution of work, and the Tertiary Sample Unit (TSU) was the physician. The sample was probabilistic, stratified by departments. The sample was proportional to the number of physicians by the PSU, and the SSU. See Table 1.

**Table 1. Survey population planned and completed**

	HUANCAVELICA	LIMA	LORETO	PIURA	TACNA	TOTAL
Population	128	21,604	314	812	275	23,133
Planned	58	569	112	198	102	1,038
Completed	59	507	186	257	164	1,173
<b>Percentage done</b>	<b>102%</b>	<b>89%</b>	<b>166%</b>	<b>130%</b>	<b>161%</b>	<b>113%</b>

#### *Designing the questionnaire*

The Lima based research team prepared a questionnaire draft, which was sent to the LSHTM based research team for their approval. After the LSHTM team had approved the questionnaire, it was tested by a pilot focus group in Lima and then used in the regional surveys.

#### *Pilot preparation*

In order to test the questionnaire the researchers conducted a pilot survey in Lima. The hospital Arzobispo Loayza, three health centres close to Lima and one health post at Canta (a

highland Province close to Lima) were selected for the pilot. Results from the pilot survey were used to redesign the questionnaire (Annex 1).

#### *Organizing the operational group in Lima*

The Instituto de Estudios Economico Sociales of the National University of Engineers (UNI - IECOS) organized a group of five experts in regional surveys, each one responsible for one region. The UNI-IECOS group received both information about the survey and training for interviews. They in return helped in developing the pilot survey as well as analysing its results in order to design the final questionnaire. The UNI experts contacted regional experts from the Instituto Nacional de Estadísticas to do the survey.

#### *Organizing survey groups in the five regions*

The UNI-IECOS experts travelled to five regions. They contacted personnel from the Instituto Nacional de Estadística e Informática (INEI) and the regional Peruvian College of Physicians. The regional Peruvian College of Physicians granted the experts permission to access the health services as well as to access the key informants.

The UNI experts trained the INEI surveyors in using the questionnaire. They distributed the surveyors in the survey areas, some of them at the regional capital others at close provinces. Physicians, randomly selected in their work centres, completed the structured questionnaire. The surveys were collected and sent to Lima. A total of 1,173 doctors were interviewed in the five regions, 13% more than originally planned.

#### *Typing the survey data*

In order to assure the quality of the data typed, two people entered the data collected in regions into an Access database; one of them read the data and watched the data being entered, while the other typed the data. A special software produced tables and figures for analysis and observation.

#### *Analysing the results*

The researchers analysed the survey data using Microsoft SPSS 10.00. They analysed the frequencies and cross tabulations according to the research analysis plan.

## **2. Physicians' in-depth interviews**

### *Pilot preparation*

Results from the survey were tested by two focus groups to verify: a) the type and extent of dual practice, b) dual practice predictors, c) financial and non financial incentives, d) perception of dual practice, and e) incentives to regulate dual practice. A draft questionnaire was sent to LSHTM for consultation in order to design a final version, which once approved was tested by a focus group. The test provided useful information for both the final questionnaire (Annex 2) and the strategy for developing in-depth interviews.

### *Organizing in-depth interviews*

Thirty-five doctors were randomly selected by convenience from the Peruvian College of Physicians records. Only twenty answered. The selection was proportional to quotas from institutional cohorts: six from private clinics, five from the MOH, and six from ESSALUD. Additionally three doctors were interviewed because they are policy makers of the Peruvian College of Physicians.

The Peruvian College of Physicians gave an updated list of its Metropolitan Lima membership; doctors from Lima provinces were not considered. The interviewers telephoned doctors to request their participation.

### *Conducting in-depth interviews: duration, method, questions used*

Doctors were collected from their place of employment, and conducted to the Peruvian College of Physicians building. There, a special room was prepared to give the participants an appropriate environment. A one-hour session for each, led by a specialist in qualitative studies (Mss. Susana Mendoza), started with an explanation of the reasons for the study followed by broad questions related to the doctor's professional activity. A step-by-step approach, from the easiest to the hardest questions, was used to progress through the interview stages.

### *Analysing the results: recorded, decoding records*

The in-depth interviews were tape-recorded and transcribed in Spanish; the main researcher and the specialist discussed the results.

## RESULTS

### 1. Quantitative survey results

#### *Extent of dual practice*

Dual practice is common in Peru. Of the doctors surveyed, 57% are dual practitioners: in Piura, Loreto and Tacna, the proportion is over 60%; in Huancavelica, the poorest region, 13% undertake DP and there is almost no private practice. In Lima, the Peruvian capital, 50% of doctors are dual practitioners (Table 2; Tables 2 to 13 are all provided in Annex 3).

DP is again a normal practice at most levels of health care. With the exception of the health post (Level I) and the National hospital (Level IV), all health facilities have dual practitioners (Table 3). DP is also common at the Ministry of Health, ESSALUD and private facilities (Table 4).

The most frequent form of public DP is working as a health adviser as well as teaching at public universities (Table 5). In private DP (Table 6), almost 81% of work is related to health care: 45.3% at private clinics and 36.2% at a private doctor's office.

#### *Financial incentives*

Dual practitioners have a better income level, almost double that of doctors in public practice and triple that of doctors in private practice. The monthly average for dual practitioners is S/. 3184 (Table 7).

Dual practitioners also have relatively higher social status measured by owning automobiles; 53% of them have automobiles compared with 32% of public and 52% of private practitioners (Table 8). A different pattern exists in housing, where dual practitioners (60%) own their house more often than public doctors (39%), but less than private doctors (72%) (Table 9).

Specialists tend to be dual practitioners rather than single practitioners: 72% of specialists are dual practitioners; however, 68% of specialists are private practitioners (Table 10).

The majority (54%) of dual practitioners do not want to leave the public sector (Table 11).

### *Non-financial incentives*

After income, the best non-financial incentives for DP are professional improvement and training (Table 12). As shown by Table 13, dual practitioners participate in training activities more frequently than single practitioners, particularly those in private practice.

## **2. Qualitative results**

### *Extent of dual practice*

Dual practice is a widespread form of medical practice:

“The vast majority, almost all doctors working in the public sector have another job: their own doctor's office as well as at the private clinics” (PM #2)

“It is rare that a doctor has only one job” (PM #2).

“Due to external conditions, in the last ten years the classical dual practice (public job in the morning, doctor's office in the afternoon) is declining; the multi-job practice is replacing it” (PM # 1).

Young-male doctors are the most frequent dual practitioners, especially those without specialization, and without a second home income from a spouse:

“They are more aggressive, because they have lower opportunities” (Rheumatologist – I#16).

“All doctors have dual jobs, however junior doctors are increasingly sub-contracted by others, which is called professional dichotomy” (PM #3).

“We must divide doctors by generations; the new generation will decide on for new alternatives. I would not give up my public job, for instance” (Paediatrician I#9).

Parallel dual practice sometimes is overlapped by simultaneous dual practice:

“I teach medicine and I am a surgeon. Normally teaching and consultancy are parallel activities, however sometimes they clash. In those cases I ask a colleague to replace me or simply I run out of the hospital (Surgeon I#13)”

### *Incentives for dual practice*

The main incentive for dual practice is to obtain a better income. Neither private jobs nor public jobs offer by themselves a comfortable income. Doctors say that a doctor's private

office is complementary to their public job: “The main cause of DP is to improve doctors’ income” (PM #2).

These days doctors engage in multi-job practice (more than two different jobs) to complete their income because their earnings from public and private practice are too low.

The income from a job in the public sector brings confidence to doctors because it offers a monthly salary and social benefits (social security, retirement pension, vacations). This regular income is very important in the insecure employment environment of Peru: “I wanted to work at the social security because I needed experience and because they pay better; at least that is what matters, isn’t it?” (Gynaecologist I#2).

Moreover, doctors at public facilities have other incentives. For example, ESSALUD doctors like to work at ESSALUD hospitals because they have high medical standards, good laboratories and skilful management; while the MOH’s doctors like their hospitals because there doctors can teach medicine.

Another incentive of public facilities is the ability to maintain clinical practice. This is very important for junior doctors: “instead of doing nothing at home, or working in non clinical jobs, I prefer the clinical practice even for a minimal wage. I am a doctor and I need to be in touch with patients” (General medicine I#3).

Conversely, the private sector is not a magnet for doctors:

“Private clinics are nowadays working at 30–40% of their capacity (Gynaecologist I#2)”;

“The doctor's private office is no longer working. Many of them are now closing down” (Paediatrician I#12);

“Things have changed, and nowadays clinics such as the Hogar de la Madre are declining. Doctors are totally exploited” (Gynaecologist I#2).

Young doctors are particularly affected by the private sector's financial problems: “young doctors wait for an opportunity at the private sector, though they are exploited” (General medicine I#3). However, senior doctors see young doctors as more able to migrate to the

private sector: “young doctors are just beginning, maybe they are able to live earning US\$1.5 for each patient” (Dermatologist I#5).

#### *Factors shaping private and public practice*

“Doctors do DP because of their home requirements (food, children's education, maintain social status), and their quality of life. Other causes are the economic crisis..., low salaries, fragility of the medical labour system (e.g. doctors on temporary contracts do not have social insurance, do not have professional career incentives); ...oversupply of new doctors which leads to more competition and lower fees.” (PM #3)

The country's macro-economic situation has had a great influence in shaping DP: “Due to the country's economic crisis, doctors need to find other jobs to survive” (PM #3).

Deregulation of medical working conditions has led to a reduction in the number of formally contracted doctors. Increasingly doctors are employed under temporary contracts with lower wages and no social insurance: “nowadays, the medical labour system is precarious; they do not have social security, nor progressive income increments” (PM #3).

Lack of professional career path/development also has an influence on DP: “there are no professional careers at public institutions. Hospital Directors are hand picked; there is no respect for seniority or postgraduates degrees” (PM #3) , in consequence there is no income progression in the public sector and doctors look for other income alternatives.

Another factor mentioned is the conditions of work imposed on healthcare suppliers by insurance companies: “the insurance companies have imposed abusive conditions on health suppliers” (Paediatrician I#12).

Deregulation of medical education also influences DP. There is an increasing number of newly graduated professionals: “in Lima alone there are seven medicine faculties... and still growing” (General Medicine I#3).

Similarly, DP is affected by the lack of planning of health resources. The number of new doctors and specialists was one example mentioned:

“One of the problems is the excessive number of specialists. That is because the universities are forming professionals without matching the country needs. Neither the universities nor the MOH actually know how many specialists are needed.” (Surgeon I#13)

Another concern relates to the role of medical corporations in shaping private practice:

“Private practice has changed its shape: actually the medical corporations are filling the market. To operate in private practice you now have to fit into the corporation network” (Paediatrician I#12).

Managerial conditions also affect DP, such as the mechanisms of productivity:

“It is hard to do simultaneous DP at the ESSALUD facilities because doctors should accomplish a weekly number of patients (almost 15 minutes attention for each). It is quite easy to do DP at the MOH hospitals since they have not introduced productivity mechanisms” (Rheumatologist I#16).

#### *Adherence to a public sector job*

“Adherence to a public job is seen as linked to exclusive dedication and better income remuneration concordant with a good standard of life” (PM #3).

On the subject of incentives to keep to a public sector job and leave private practice, doctors have ambivalent answers:

“It is hard to leave the private clinical job; it is related to practice of your speciality... However, if I am appointed to manage a hospital and it has a good income I could think twice” (Otorrinolaringologist I#1),

“You do not have to leave teaching medicine because is based on clinical practice, both are complementary” (Gynaecologist I#6).

Adherence to a public job is also related to expected income: “I would leave the private job if the public income would pay the equivalent of teaching, researching, private practice” (Paediatrician I#12).

Career improvement and professional challenges were often mentioned in relation to maintaining only public employment:

“It is more intense and challenging working in public hospitals. You improve yourself. Take the public paediatric emergency, for instance, or surgery in hospitals. You have many and complex cases and scarce resources. You should do your best. It is not routine”. (Surgeon I#13)

The increase in competition has made it more difficult for doctors to migrate to private practice: “the problem is there are many doctors and nobody regulates the entrance of more doctors” (Gynaecologist I#6).

Decisions on whether to work solely in the public sector require consideration of seniority, specialization and income expectations:

“For senior doctors it is rather more attractive to have professional improvement and better health equipment in hospitals than more income. Young doctors may be intensely motivated for having a job anywhere.” (Paediatrician I#8)

Decentralization of medical practice is related also to security of income: “in provinces there are better possibilities of having a public job, a monthly payment to start; and then after, who knows” (General Medicine I#11).

The public job must be considered as a platform for subsequent incursions and rush back to private sector:

“My operational basis is the social security; from it I expand my medical activities.” (Dermatologist I#15)

“More or less one needs a salary to feel at ease, being the sole income or the principal income at least.” (Paediatrician I#8)

### *Perception of DP legitimacy*

Some activities are seen as legitimate because both patients and doctors benefit: “teaching medicine is not an ethics issue because it benefits patients and doctors” (Traumatologist I#4). However, in private clinics, teaching is not allowed: “teaching is done in public hospitals; the private clinics do not accept students on their facilities” (Dermatologist I#5).

DP has a sense of natural legitimacy grounded on the nature of medical health care: “There always has been DP; it is the main *characteristic* of medical professional exercise” (PM #1); “The DP has always existed” (PM #2).

### *Effects of dual practice*

Dual practice frequently has an effect on the quality of health care. Some positive effects are: hospital better income, a small percentage of which is used for free care for lower income patients; better quality of health care; managerial improvements; and doctor’s permanence in the hospital. The negative effects are: patient two tierism – unequal access to procedures and pharmaceuticals; waiting times; and doctors' exhaustion.

Some doctors favour dual practice: “teaching and clinical practice reinforce each other. Doctors are updated, patients are seen more carefully (General Medicine I#11)”.

A repeated concern of doctors’ was higher expenses and discomfort for patients due to DP. Doctors mentioned that patients would have higher expenses by paying privately under-the-table to physicians at public facilities for surgical procedures, obstetrician procedures, and specialised treatments which are otherwise rather more expensive at private facilities. Patients also would have increased expenses because doctors at public facilities would induce demand to buy medicines and diagnostic procedures from private bodies connected with those doctors.

Some doctors interviewed criticised the existence of quasi-private clinics (public facilities that function as private clinics) inside public hospitals. Though these clinics improve the income of medical staff as well as generating more hospital revenues, they put unequal barriers to patients' access to health care: “patients should have equal access at public facilities; money should not establish differences at government facilities ... the private clinics create conditions to benefit the self interest of doctors” (General Medicine I#17). However, others disagreed: “the quality of care is the same for everybody, what changes is the ‘hotel’ facilities” (PM #2); “The quality of care is similar because it is provided by qualified doctors. What makes a difference is the speed of bureaucratic procedures” (PM #3).

Another frequent source of discomfort is the endless examinations of patients by students of medicine who are being taught by senior doctors. This kind of examination also increases the

patient's waiting time for medical care. While teacher-doctors agreed that there is a mutual benefit for the patient's quality of diagnosis as well as for the students' learning, non-teacher doctors were critical of the longer waiting times and greater discomfort experienced by patients. One doctor said that: "patients at public hospitals feel like guinea pigs because many students unnecessarily examine them. The ESSALUD do not allow this practice; they know their rights better" (Paediatrician – I#8).

Despite its financial difficulties, the private sector has other attractions such as efficiency, lower risk and better equipment: "the private clinics manage their own budget, updated technology and better equipment. This allows the provision of better health care and professional satisfaction" (otorrinolaringologist – I#1). Also private sector patients are healthier than those in the public sector, hence doctors have better success in caring for them: "patients have better quality of life, so they have lower risks in caring for them" (Otorrinolaringologist – I#1).

Cross subsidies between sectors are perceived as potential problems: "they are present in public services. Diverse surveys have shown cross subsidies among the MOH, ESSALUD and the private clinics" (PM #1); "it is possible; it has not been well studied, and however it is possible" (PM #2).

### *Regulation*

Policy makers think DP must be regulated: "Yes, it must be regulated (...) the state must allow the existence of an exclusive public career (PM #2)"; "Regulation would be convenient if it is linked to developing exclusive dedication to public facilities" (PM #1). However, these opinions are tempered by the following: "I do not think it is necessary. Doctors have a free right to have a public and a private job. I do not know how we could regulate it. To start there is no legal framework to do it. Secondly, if generating a legal framework it must be related to providing a unique source of highly sufficient income" (PM #3).

The state as well as the professional bodies and hospital boards are perceived as necessary for regulation; participation of public lobbies is seen as more limited: "The state, the Peruvian College of physicians and the hospital boards, all them would regulate DP" (PM #3).

Income is seen as the principal mechanism for regulation: “The principal mechanism for regulation is contracting doctors for exclusive dedication to public employment and providing them an adequate income” (PM #2). However, external influences should also be attended to: “DP will continue if its cause persists: medical regional distribution, lower income, deregulation of medical education and other main factors” (PM #2).

Doctors have differing perceptions about what could be regulated, who should be responsible for the regulation, how to regulate, and when to regulate. A few doctors think the MOH should regulate dual practice: “yes, the MOH should regulate teaching and clinical practice” (General Medicine – I#3). Others differ: “What should be regulated is the quality of care to patients... Hospital boards must do it” (Otorrinolaringologist – I#1); “the PCP must regulate the number of medicine students on each medicine faculty” (Gynaecologist I#2). In the opinion of some doctors, medical practice regulation is mostly an ethical self-regulative issue related to the doctor–patient relationship. Other doctors believe that hospital boards should have a substantial role in regulating dual practice: “the hospital boards must regulate the number of students for patients, meanwhile the PCP should regulate the quality of care because it is related to ethics and morals” (Otorrinolaringologist – I#1).

## **DISCUSSION**

Dual practice is an extensive practice that can undermine the public and private mix, but also offers opportunities to improve it.

Few people see DP as a problem rather than a socio-cultural medical-related activity. DP is being practiced extensively by doctors and other health personnel. It is conditioned by numerous macroeconomic factors, but also by factors related to doctors' income.

Dual practice has been a widespread practice for a long time. It is not exaggerating to say that DP is a substantial part of the Peruvian medical tradition. It is rooted in both the tradition of liberal professions (medicine, law) and the historical configuration of the Peruvian health system.

However, DP is a hidden and powerful influence shaping health services. As related by experiences in Africa, Portuguese African and Asian countries, DP is associated with channelling patients, crossover arrangements, cross subsidies, and overlapping job schedules. Positive influences have also been related by Peruvian doctors as well as by international experience. While DP has both negative and positive impacts on access to services, quality of health care and equity, the interviewees in this study tended to relate the positive outcomes but were reluctant to talk about sensitive issues such as the negative impacts of DP.

Because DP is rooted in the Peruvian medical tradition, and because of the lack of a regulatory framework, DP is not commonly perceived as a problem, although policy makers are concerned about it. This means that implementing regulation becomes a complex, strongly contested process.

DP is influenced by macro-economic, socio-cultural, and income-related factors. However, doctors' expected income is the trigger for dual or multi job practices. Thus the main incentive for Peruvian DP is better income. Differences arise around non-financial incentives: while Peruvian doctors are sceptical of their importance, Ferrinho et al. (1998) maintain that "social security and access to other resources" as well as "payment of a tax-free regular income and social security offered by public pensions scheme". Gruen et al (2002) similarly

highlight that “perception of social status and teaching possibilities” have positive effects on adherence to public jobs.

The Peruvian perception on non-financial incentives probably relates to negative past experiences of training policies or of a medical career in the public sector. If this is the case, strong governmental action on building up training policies and restabilising medical careers in the public sector would create credible non-financial incentives.

Since these incentives have better effects on young doctors who have not become established as dual practitioners, these incentives must be introduced early in their professional life. Senior doctors who are specialized, have their own staff, and have worked in private practice for more than three years, are more reluctant to follow government incentives.

Policy makers must be aware also of macro-economic and governmental policies influencing the DP dynamics. Cuts in public expenditure, steep declines in the purchasing power of government employees, as well as employment and medical education deregulation, all increase DP because they affect doctors’ home income, tempting them to find other income sources.

While DP is rooted in Peruvian medical tradition, there are current social actors influencing its development: government, professional bodies, interest groups and consumer organizations, each one influencing DP in its own way.

Government is the main actor in Peruvian DP because it provides the macro-economic environment as well as the legal and political framework, and because the private institutions have little influence in shaping DP. The government has not recognised DP as a problem; for example, the current Health Policy (MOH, 1991) mentions the private sector mainly in terms of the health decentralising strategy without reference specifically to DP. The current MOH’s organization (MOH, 1992) also does not take into account DP. Moreover, the legal framework to regulate medical practice hardly mentions the potential conflict of interest of private and public practice.

The Peruvian College of Physicians, the medical professional body in Peru, does not have specific regulations to prevent the negative effects of private practice or DP. The PCP is ruled

by the physician's ethical code but has no specific rules for DP. Doctors interviewed mentioned the need to regulate the entry of new doctors into the health market. As Gruen et al (2002) affirm, doctors agree with regulation because of their self interest in protecting their professional prerogatives. So, even if Peruvian doctors do not currently accept that either the MOH or the CMP have a role in regulating DP, they eventually would accept regulatory measures to protect themselves.

Since the doctors who run the PCP may find it difficult (due to conflicting motives) to monitor the medical DP and the standards of their colleagues, the PCP could instead regulate through parastatal or professional organizations. The PCP no doubt would have a strong role in monitoring aspects of accreditation, professional training and examinations, and in disciplining members.

Hospital boards are taking the lead in DP regulation on a day-to-day basis. Using their managerial tools, such as doctor's productivity, timing and monitoring, they are succeeding; the ESSALUD experience is informative on this possible way of regulation.

There are no consumer organizations in Peru, but there are initiatives from the government as well as from civil society organizations to organize the health ombudsman.

The positive results of consumers and community organizations in other areas are well known. They are also included in the hospital boards and have a role in regulating hospital management and represent the community's viewpoint.

## CONCLUSION

Must dual practice be regulated? Will dual practice be regulated? The answer in both cases is yes. Even if its extent and complexity suggest that regulation will require a complex and careful policy making process, regulation is merited because of the benefit in terms of public interest and health outcomes.

DP regulation needs to create a strong regulatory framework based on defining clear rules as well as specifying the regulative bodies: MOH, Peruvian College of Physicians, Hospital Boards. DP needs to create a stimulating environment for private activities as well as regulating them. DP regulation needs to lead with major problems such as professional self – interest, lack of information, powerless government organizational structures. Regulation cannot be successful without political will nor managerial capacity.

Firstly, it needs to develop specific financial incentives together with complementary non-financial incentives; for instance, the establishment of an improved, substantial minimal income for exclusive public health practitioners accompanied by restabilising the medical public career and training programs (Gruen et al. 2002). This may be not a universal measure for all doctors; a substantial proportion of public doctors would be exclusive public practitioners. There is no reason to extend DP for all public doctors, as suggested by Ferrinho et al. (1998), because this would reduce the government's regulatory options without any compensation.

Secondly, to reinforce the legislative framework, the law need to be reviewed to prevent the potential conflict of interest on DP as well as to protect the public from malpractice and negative outcomes. Articles related to DP must be introduced into the General Health Law, into the Peruvian College of Physicians Law, the Ministry of Health Law as well as into the MOH – ESSALUD Hospitals' management rules.

To reinforce the judiciary framework, accreditations schemes for private clinics need to be formulated, information obtained about the providers, a quality assurance system formulated, and coordination between the private and public sectors improved. Some of these measures are being developed by the Peruvian MOH.

Other possible regulatory measures are: the renewal of licenses for private practitioners and private institutions, defining health standards for premises, referrals between private and public sectors, registration of private hospitals, and the organizational structure responsible for regulation (Bennett et al. 2001).

Thirdly, monitoring structures and mechanisms of supervision need to be developed. Such structures must incorporate representatives of all incumbents (state, professional bodies, hospital boards, consumer organizations, and ombudsman) in the MOH headquarters as well in decentralised offices.

In brief, for the regulation of DP, the following are needed: to define the agenda, gather the main actors and agree on an implementing process recognising issues of government capacity, and developing key tools such as a new legal framework, monitoring capacities, training programs. None of these measures will succeed without other underlying conditions: a substantial income improvement for doctors (and health personnel), medical public career development and, last but not least, the decision by government to accept that DP is a real problem that requires regulation.

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## ANNEXES

### Annex 1: final survey questionnaire

#### *Institutional Code*

- 1) Department (01)\_\_\_\_\_ Province (02)\_\_\_\_\_ District (03)
- 2) Working place I(01) IIa(02) IIb(03) IIIa(04) IIIb(05) IV(06)
- 3) Institution: Ministry of Health (01) ESSALUD (02) Private (03)

#### *Personal Information:*

- 4) Age \_\_\_\_\_ (01)
- 5) Gender Male (01) Female (02)
- 6) Marital status Single (01)\_\_\_ Married (02)\_\_\_ Widow (03)\_\_\_ Divorced (04)\_\_\_
- 7) Occupation of the spouse: Physician (01) Other non medical profession (02) Non Professional (03) N.R.(04)
- 8) Do you live in your own house?: Yes (01) Not (02)
- 9) From which year is your automobile? \_\_\_\_\_ (01) I have no car (02)

#### *Qualification/Current Position*

- 10) Current position : Assistant (01) Section Head (02) Department head (03) Director (04) Resident (05)
- 11) How long have you been in your current position? \_\_\_\_\_
- 12) How many years do you have as a graduate and from which institution did you obtain your medical degree?  
Year s(01)\_\_\_\_\_ Institution (02)\_\_\_\_\_
- 13) Are you a specialist? Yes (01)[go to 14] No (02)[go to 16]
- 14) If YES: what specialty do you have? Medicine (01) Paediatrics (02) Gynaecologist (03) Surgeon (04) Other (05)
- 15) When and from which institution did you obtain your specialization degree?  
Year\_\_\_\_\_ Institution\_\_\_\_\_

#### *Dual Practice (Multiple Answer)*

- 16) Have you:  
Exclusive private practice (01) [go to 17] exclusive public practice (02) [go to 18] both practices (03) [go to 17 and 18]
- 17) What type of private practice do you have?  
Health care at clinics (01) Private University lecture (02) Health Adviser (03) management (04) private office(05) other (06) \_\_\_\_\_
- 18) What type of other public practice do you have?  
Public University lecture (01) Management (02) Health Adviser (03) Other (04)  
\_\_\_\_\_

### **Training/CME**

- 19) How often have you participated in activities of training or continuous medical education in the last year?  
Frequently +5 (01)      A few 2-4(02)      Rarely -2 (03)      Never (04)
- 20) Rate the training opportunities in your hospital/health centre  
Excellent (01)      good (02)      average (03)      poor (04)

### **Career Development**

- 21) Are you worried about your future career prospects?  
Very Concerned (01) A little concerned (02)      Not Quite Concerned (03)      Absolutely Not Concerned (04)
- 22) Do you want to change your current position?  
Absolutely Yes (01)[go to 23]      Thinking On (02)[go to 24]      Not Quite Sure (03)[go to 24]      Absolutely Not (04)[go to 24]
- 23) If YES, why?  
Professional development (01)      better income (02)      opportunities for family (03)      better education of children (04)      other (specify) (05)\_\_\_\_\_
- 24) Rate the career opportunities of your current position:  
Excellent (01)      good (02)      average (03)      poor (04)
- 25) If you obtain a better position in your current job, would you give up the private practice?  
Absolutely Yes (01)      Thinking On (02)      Not Quite Sure (03)      Absolutely Not (04)

### **Service Quality**

- 26) In your opinion patients prefer public or private health care:  
Public (01)      Private (02)      Both, but Public more than Private (03)  
Both, but Private more than Public (04)
- 27) In your opinion, many patients prefer paying for private services though they could get public health care usually:[Multiple choice]
- i) Are misinformed:      Yes(01) No(02) Not Related(03)
  - ii) Are diverted by doctors to private practice: Yes(01) No(02) Not Related(03)
  - iii) Lack of pharmaceuticals in public practice: Yes(01) No(02) Not Related(03)
  - iv) Insufficient number of doctors:      Yes(01) No(02) Not Related(03)
  - v) Patient wasting times in public services:      Yes(01) No(02) Not Related(03)
  - vi) Public facilities are not clean enough:      Yes(01) No(02) Not Related(03)
  - vii) Better quality of care:      Yes(01) No(02) Not Related(03)
  - viii) Cheaper prices:      Yes(01) No(02) Not Related(03)
  - ix) Better equipment:      Yes(01) No(02) Not Related(03)
- 28) Do you think that the increasing number of new doctors will affect the health care quality?  
Greater improvement (01)      Little improvement (02)      Neither better nor worst (03)      Worst (04)

### **Incentives for Doctors**

- 29) What the government should do to encourage doctors to work in rural areas?[single choice]
- i) Better salary (01)
  - ii) Improve training (02)
  - iii) Better career perspectives (03)
  - iv) Housing (04)
  - v) Education facilities (05)
  - vi) Medicine & supplies (06)
  - vii) Other (specify) (07)
- 30) If you obtain a substantial income from private practice, would you like to leave up public practice?  
Yes (01) No (02) Not Applicable(03)
- 31) If Not, Why? \_\_\_\_\_

***Income Expectations***

- 32) Considering the next year development of your private practice, you think your income will:  
absolutely rise (01) small increase (02)                      neither increase or fall (03)    fall (04)
- 33) What should the doctor's monthly salary be from government in public services?\_\_\_\_\_
- 34) What is your personal average monthly income?  
Public Practice (01)\_\_\_\_\_      Private Practice (02)\_\_\_\_\_      Total(03)\_\_\_\_\_
- 35) How important is working at this health facility for your private job?  
Very important (01)              Important (02)      Somewhat important (03)    Not important (04)

## **Annex 2: Focus Group final questionnaire**

### **I. GENERAL INFORMATION**

- How did you start your medical practice?
- What reasons did you have to start?
- Currently what kind of activities do you do?
- Would you like to change your private activity?

### **II. INTERMEDIATE INFORMATION**

- What is the attractive of the private medical practice?
- What do you like more of your activities?
- What do you like less of your activities?
- In what cases would you like to leave the private medical practice?

### **III. FINAL INFORMATION**

- Has Dual Practice affected the quality of care?
- The Dual Practice should be regulated?
- Who must be in charge of the dual practice regulative issues?
- Would you like to leave your job at the MINSA? Why do?
- Do you know other cases of Dual Practice?
- How much is your current monthly salary
- What would be the optimal monthly salary for medical doctors?
- if you were better paid from public than private clinic, Would you leave the medical private practice?

### Annex 3: Tables and Figures

Table 2. Public, private and dual practice (percentage)

	Lima	Piura	Loreto	Huancavelica	Tacna
Public Practice only	44	17	17	86	30
Private Practice only	6	14	18	1	2
Dual Practice	50	69	65	13	68
Total	100	100	100	100	100

Table 3. Medical practice by place of working

	I	IIA	IIB	III	IV
Public Practice only	65.2	26.5	19.3	27.6	46.5
Private Practice only	2.1	2.8	19.7	10.4	1.14
Dual Practice	32.6	70.5	60.9	61.9	52.2
Total	100	100	100	100	100

I=Health Post; IIA Health centre without beds; IIB=Health centre with bed

III= Regional Hospital; IV= National Hospital

Table 4. Medical practice by working institutions

	MOH	ESSALUD	PRIVATE
Public Practice only	42.9	44.5	0
Private Practice only	0	0	40.3
Dual Practice	57.0	55.4	59.6
Total	100	100	100

Table 5. Public-public forms of dual practice

	Number	Percentage
Health Adviser	177	15.2%
Public University	164	14.1%
Manager	30	2.6%
Other	791	68.1%
Total	1162	100%

Table 6. Private–public forms of dual practice

	Number	Percentage
Private Health Care (Clinic)	395	45.3%
Private Office	316	36.2%
Private University	50	5.7%
Private Health Adviser	42	4.8%
Private Manager	3	0.3%
Private Other	66	7.6%
Total	872	100%

Table 7. Income frequencies (in new soles S/.)

	Mean	Median
Public Practice Income	1,817	1,920
Private Practice Income	1,367	1,000
Dual Practice Income	3,184	2,800

Table 8. Car owners by medical practice (percentage)

	Car owner	Not car owner	Total
Public Practice only	32	68	100
Private Practice only	52	48	100
Dual Practice	53	47	100

Table 9. House owners by medical practice (percentage)

	Own house	Do not own house	Total
Public Practice only	39	61	100
Private Practice only	72	28	100
Dual Practice	60	40	100

Table 10. Medical practice by specialization (percentage)

	Specialized	Non specialized	Total
Public Practice only	35	65	100
Private Practice only	68	32	100
Dual Practice	72	28	100

Table 11. Intention of leaving public practice (percentage)

	Yes	Not	Total
Public Practice only	66	34	100
Dual Practice	46	54	100

Table 12. Incentives for medical practice in rural areas (percentage)

	Better salary	Training	Professional improvement	Housing	Facilities to study	Medicines and supplies	Other	Total
Public Practice only	54	12	27	1	2	2	2	100
Private Practice only	55	6	28	1	2	7	1	100
Dual Practice	58	9	25	1	1	4	2	100

Table 13. Participation in training activities (percentage)

	Frequent	Few	Rare	Never	Total
Public Practice only	45	39.7	12	3.2	100
Private Practice only	46.6	26.2	20.3	6.7	100
Dual Practice	54.4	34.3	8.9	2.2	100