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Patterns of Practices and Impacts of the New Public-Private Practice in Health: The Case of Selected Public Health Facilities in Shashemene Town, West Arsi Zone, Oromia, Ethiopia

Bewunetu Zewude*

Wolaita Sodo University, SNNP Region, Sodo, Ethiopia

***Corresponding author:** Bewunetu Zewude, Wolaita Sodo University, SNNP Region, Sodo, Ethiopia, Tel: 4176259717; E-mail: bewunetuzewude@gmail.com

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Abstract

In many lower- and middle-income countries, engagement of health professionals in dual practices is very common mainly due to the fact that the amount of salary earned from working in public hospitals is not sufficient for good standard of living. The present study was meant to analyze the patterns of practices and impacts of public-private practice in Shashemene town, West Arsi zone of oromia regional state.

Ample qualitative data were collected using depth interview and focus group discussion methods. 20 health care professionals, a record and documentation officer, 3 managers of public health facilities, and 18 patients seeking treatments in the private wing were interviewed from three public health facilities selected through purposive sampling technique. The collected data were thematically analyzed and presented in a narrative manner.

The highest share of income from the private wing goes to the health professionals though it didn't save them to engage in multiple jobholding practices. Impact on quality of health services for public patients due to boredom, exhaustion, and tardiness of physicians in dual practice, unfair distribution of benefits and burdens, and cream-skimming are the challenges faced. Above all, besides providing patients additional alternative of treatment, public-private practice couldn't achieve its goal of retaining physicians.

With qualified practitioners still in the mood of constantly searching better way outs from the public sector, it is important that the Federal Ministry of Health monitor and evaluate its project to come up with remedies.

Keywords: Dual practice; Private wing; Impact; Multiple jobholding; Challenge

Introduction

Financing as well as provision of health services has historically involved in public and private sector actors [1]. In recent years, there has been a considerable growth in private health facilities especially in urban areas. In many low and middle income countries the balance between the private- public sector practices of the health care over the past decade has slanted towards the former [2].

The concept of public-private practice, or sometimes known as dual practice has been defined differently by different authors. Some define it as the holding of more than one job [3,4]. Ferrinho et al. [5] giving emphasis to the location of the practice, defined it as health professionals engaged in public and private work. According to this definition, the work may include both health and non-health related activities such as undertaking research and teaching in medical schools or doing business of any type.

In many lower- and middle-income countries, engagement of health professionals in dual practices is very common mainly due to the fact that the amount of salary earned from working in public hospitals is not sufficient for good standard of living [6]. Consequently, health workers engaged in dual practice and under government employment have been labeled unproductive, frequently absent, late, inefficient, and corrupt [5]. The impact of dual practice on equity of health services in the public sector in terms of compromising equity and efficiency has been documented thereby making it an important issue to consider [7].

In Ethiopia, the Ministry of Health of the Federal Democratic Republic of Ethiopia established private wing in federal hospitals in 2009 having various objectives such as retaining the medical specialists thereby reducing the high attrition rate, and to provide quality health care services to patients with alternatives. Accordingly, federal hospitals designate some of their rooms and equipments for use in the private wing. In this wing, doctors' practice beyond the regular working hours of the hospital and charge fees for their services where eighty five percent of the income is distributed to the practicing doctors and the rest fifteen percent goes to the hospital [8].

Indeed, public/private practices apart from enabling health professionals earn additional money and maximizing patients' alternatives, also has negative aspects. For instance, a WHO assessment of ten countries' case study found "a tendency for professionals in the public sector to spend most of their time and energy in private practice, or to charge informal fees, where salary levels are low, or pay is delayed" Hicks and Adams [9]. Gonzalez [4] concludes that due to the different structure of the physician's remuneration in each system, a problem of cream-skimming arises, i.e., physicians prefer to treat the less severe cases in their private practices.

A study conducted in Tanzania by Joseph [10] about the public/private practice, on the other hand, found that the introduction of private practice within public hospitals has led to higher overall quality and quantity of health care services as doctors strive to attract and keep more patients. Moreover, it was found that physical infrastructures have been improved including wards, consultation rooms and theatres, resulting in to an increased number of procedures performed for both public and private patients.

Another study by Oliver [11] in Zimbabwe came up with the finding that the fees in the private sector health care services are too high compared to those charged by the public sector; they are based on what the market can bear rather than what is in the best interest of consumers as is probably the case with public sector pricing. Above all, the tendency of practitioners in the private practice of becoming less supportive of public sector simply because they see little return from public services was also found by Joseph [10]. Amid such research findings of both the opportunities and risks of public-private practice in other countries of Africa, the present study therefore, aims at assessing the situation of the practice in selected public health care facilities in Ethiopia.

In Ethiopia, Vilassini [12], studied factors affecting the development of the private sector hospitals in Addis Ababa and found that growing disposable income, improvements in literacy, road networks, population growth, and long-standing diseases to be the factors that contributed for the development of the private hospitals. Ambelie et al. [13] also studied patients' satisfaction and associated factors among private wing patients at Bahirdar Felegehiwot Referral Hospital and came up with the finding that over all patient satisfaction of health care services provided under the private wing was lower as compared to the public hospitals.

Others such as Tateke et al. [14], studied determinants of patient satisfaction with outpatient health services at public and private hospitals in Addis Ababa and concluded that patients treated at the private health care are better satisfied than those treated in the public hospitals. However, no study has been undertaken and published about the patterns of practices, challenges, and impacts, of the public/private mix in Ethiopia in general and in West Arsi zone in particular. Therefore, this research was aimed at narrowing this gap by undertaking an assessment of the issue in Shashemene town, West Arsi zone, Oromia regional state.

Objectives of the Research

General objective

The general objective of this research was to explore the patterns of practices, challenges, and impacts of the public/private practice in West Arsi zone, Shashemene town, Oromia-Ethiopia.

Specific objectives

The specific objectives of the research are:

- to see the patterns of dual practices and multiple jobholding in the study area,
- to assess the overall challenges and impacts of dual practice.

Research Methods and Materials

Research design

An institutional based cross-sectional research design was used in undertaking the study in which qualitative data were collected from the practitioners, patients, and managers/medical directors of the public health care facilities involved in dual practice at a point of time.

Method of data collection

The major method used in the study as a tool to gather primary data was depth interview. This method was intentionally chosen by the researcher because it helps one to obtain rich and depth data, as its name implies, about an issue at hand from the perspective of the research participants. Accordingly, the researcher has tried to approach participants, create and maintain a good rapport, and raise unstructured questions in which the interview was made to have a form of informal-normal conversation to make interviewees feel free and provide adequate data. Moreover, probing and follow-up questions were raised where necessary in order to further clarify questions and create better mutual understanding. Interview guide containing unstructured and flexible questions relevant to the specific research objectives were prepared to smoothly guide the interview process. In addition to the depth interview, two focus group discussions (one focus group of physicians containing six members, and another one among patients having eight participants) were conducted in which the researcher moderated.

Sampling and sample size

The study populations of this research are all medical practitioners regularly employed in public hospitals and engaged in dual practice or multiple job holdings, and the beneficiaries of the health care services provided in the private wing in Shashemene town of West Arsi zone. There were two hospitals- one primary and the other referral, and seven health centers in Shashemene town during the time data collection. Among the currently available public health facilities in the area, Melka oda primary hospital and other two health centers (Abosto and Dida boke) were selected purposively for convenience on the basis of the fact that public-private practice in these facilities started since the implementation of the program and hence, known to have been widely practiced. Accordingly, 20 health care practitioners (doctors/HOs, nurses, midwives, and laboratory technicians) and 18 patients found seeking (getting) treatments from such a practice were finally selected using judgmental sampling technique. Above all, the administrative personnel/medical directors of each hospital have participated and interviewed. Data saturation determined the number of women to be participated in the interview. Therefore, sample size has not been predetermined and the researcher stopped as more redundant responses appeared and at a point where no more new data could be discovered.

Method of data analysis

Data obtained through in-depth interview method were organized and analyzed using thematic analysis. In addition, patterns were identified from the organized data where narration was used for the presentation of findings.

Limitation

It would have been better had there been a chance to organize two focus group discussion sessions (each for both the physicians and patients) with an acceptable number of participants in the groups. However, due to the different locations of the health facilities and the physicians, and the busy engagement of research participants to gather them in one area for this purpose, only one focus group discussion was undertaken. Perhaps, that could have limited the quantity and quality of data collected from this method.

Results

The major objective of the current research was to assess the patterns of practices, challenges, and impacts of the new public-private medical practice among selected health care facilities of Shashemene town, West Arsi zone, oromia regional state. To this end, qualitative data were collected from health care professionals, managers/ medical directors of the health facilities, and patients found seeking treatment in the private wing during the time of data collection. In this section therefore, major findings of the study are presented along with some discussions.

The patterns of dual practice and multiple jobholding in the study area

It has been found that the public health facilities in Shashemene woreda are providing "extra time" health care services in the private wing since earlier years following the introduction of the program by the federal ministry of health. The service is delivered to patients that are unable or unwilling to arrive during the regular working hours (8:30-5:30) and Monday-Friday. Accordingly, any patient visiting the health facilities before 8:30, 12:30-2:00, and after 5:30, and during the week-ends will receive treatments in the private wing. Patients arriving to the health facilities during the private wing will be informed ahead as there is some additional cost of treatment compared to the public one. Some patients opt to wait the onset of the public wing in an attempt to save the additional fee, as revealed from depth interview.

Most medical services, except emergency cases, commonly delivered during the public time are provided in the private wing. While the additional medical charge is reserved for OPD (Out Patient Department), registration (commonly called card), and laboratory services, the cost of drugs remains unchanged both for the public and private wings. According to reports, 70% of the total income from the private wing goes to the physicians while the remaining amount is distributed for administrative and the health facility- considered as government revenue. This distribution is done after deduction of the cost of medical supplies from the gross revenue. Professionals working in the out-patient department are the highest earners (39%), followed by nurses, laboratory technicians, and pharmacists (34%, 22%, and 5%, respectively). However, the implementation of public-private practice remains informal in many health care facilities in Shashemene. For instance, 4% of the total revenue is allocated for "a supervisor" in some health centers, while this doesn't exist not only in other facilities but also on the implementation guidelines of oromia health bureau, as far as the distribution of benefits is concerned.

The goal of implementing private wing within public health facilities doesn't seem to be attained in the study area. Data from both the health care professionals and managers reveal complains of dissatisfaction of income on the part of the practitioners. It has been argued that patients, especially those from the lower socio-economic status, prefer the public to the private in order to reduce expenses. An employee working in documentation office stated: After informing them that they are in private wing time and when given alternatives, many patients opt to wait the time until the public wing starts unless they are in critical situations. This is highly affecting the revenue to be collected from the private wing. Moreover, there are allegations of financial malpractices on the part of the administrative stuffs. There are individuals who earn a significant share due to the sole reason that they are members of the higher administrative stuffs, such as allocating the 4% income to 'supervisors' as noted above. Most health care professionals argue that they do not have the courage to question such unfair practices though they perceive its prevalence. This seems to reinforce the continuation of the malpractice in case of many health care facilities.

The prevalence of dissatisfaction led most health care professionals to engage in multiple jobholding practices: seeking part-time employment and working in other health care facilities owned by the private capitalists. One of the research participants said:

Following the completion of private wing time here, I will directly go to the private clinic where I work overnight instead of going to my home. My wife helps me in bringing my dinner to the clinic. There, I eat, work, and in case there are no patients, I will take a break sleeping on one of the beds reserved for patients. I earn a net salary of 6000 ETB; my wife has no job and we have 3 dependent children totally relying on my monthly income. The only way to cope-up life's struggle is through working in such a way.

Some health care professionals have reported scenarios of totally abandoning to work in the private wing of the public health facilities and resorted to other alternatives. Practitioners relatively with better socio-economic backgrounds have opened either primary level clinics alone or medium clinics in partnership with other equals. They hire nurses or beginner level health officers with low salaries to help them in keeping their clinics open throughout the day. In most cases, these employees are not in a position of treating patients; instead they are hired for the purpose of admitting patients and call the professionals. Public health professionals owning such private clinics are, therefore, on a standby mode where they move to their own clinics when receiving phone calls even by the time, they are supposed to deliver services in the public health facilities. Above all, few medical practitioners, especially generalists have also disclosed to engage in teaching medical courses at private colleges in the surrounding areas during week-end sessions.

Two major motivating variables have been found for the practitioners to engage in public-private practice: one is financial, and the other is the need to spend extra time on work. The major driving force prompting most health care professionals to engage in dual or multiple medical practices, nevertheless, has been an interest to compensate the low public sector remuneration. Many argued that the amount of salary they receive from the regular working hours is not sufficient to cover living expenses with an ever-declining purchasing power of the money. Therefore, multiple jobholding is a way out for most practitioners. Few physicians, on the other hand, revealed that they engage in dual practices because they don't want to sit idle at home; they just want to spend their spare time again at work. Such research participants were those with little or no personal and social extra-job affairs such as family responsibilities and involvement in their community.

Motivating factors for patients of the private wing are diverse and differ from the ones applied to the physicians. From the collected data, it is possible to generalize that most patients do not have a planned purpose to be treated in the private wing. For most patients, it is an incidence of the time they arrived at the health care facilities that led them to be treated in the private wing. Patients arrived at the health facilities with the prime motive of receiving private wing treatments were hardly found in the study area. The other patients in the private wing were those referred from the regular public hours for various reasons. Some patients visit private wing having personal contacts with one or more of the practitioners, especially with those working in OPD. Such patients disclosed that they prefer the private wing to the public for reasons of safety and promise of better treatment. According to some interviewees, there are cases where patients will be referred to private clinics either owned by the referring physicians or their allies.

Most patients do not have adequate awareness about the practice of private wing in the public health facilities. Data from depth interview revealed that most assume and expect that a public health facility delivers a public service throughout the day. A record and documentation officer at Abosto health center stated: *patients complain on the little amount of money we add during the private hours because they do not know about private wing practices. It is very difficult to inform each patient that they are about to be treated in private wing, and when I inform them, most resort to the public wing.* Medical directors/managers of the health facilities argue that such problem which leads to collect small amount of revenue has served as one source of dissatisfaction for most health care professionals.

Challenges and impacts of dual practice

The major purpose of this research was to find out how the newly installed public-private practice is tracking, where identifying the challenges, impacts and opportunities is the key. This helps the concerned public authorities to detect and recognize issues which in turn facilitate improvement of the project. This sub-section of the paper is therefore; devoted to presenting findings relevant to the positive and negative impacts of the practices of private wing in public health facilities in particular, and the holding of dual (often multiple) jobs among the health care professionals in the study area.

It is found out that public-private practice has always been encountering numerous challenges. These issues can be subsumed in to categories related to the behavior of physicians, unfairness in the distribution of benefits and burdens, and cream-skimming. To begin with the changing behavior of the practitioners, it has been frequently mentioned as a bottleneck for the successful accomplishment of the project. It has been revealed that late arrivals, absenteeism, and early leaving of the work place before due time are identified as problems common for most health care practitioners engaging in dual practices. Furthermore, data revealed that most physicians that engage in public-private practices commonly experience feelings of tiredness, boredom, and even sleepiness during the regular working hours. A physician at Abosto Health Center, for instance, stated: *Because I spend most hours of the day both in the public and private duties, I will not have enough time to sleep and rest. After spending a sleepless night at a private clinic where I work, I feel asleep and exhausted when I again come here for the regular duty. Often, I quarrel with patients and even my fellow colleagues. Though I recognized my situation is not fair, I have no alternative. But I always strive to control my temperaments.*

Hence, one negative impact of the public-private practice is that it contributes to the deterioration of quality health care delivery at public health care facilities.

Unequal, if not, unfair distribution of burdens and benefits have also been found to be the other problem frequently reported in the study area. It is found that the implementation of private wing in the public health facilities is not uniform among the various facilities. Many complain that distribution of revenues should not be varied based on salary scale while working hour is equally distributed for all. There is an argument, especially from nurses and drug dispensers that a capitalist mode of production prevails where practitioners who earn higher salaries in the public sector also receive the highest share of income from the private wing though they all work for equal hours: the richer gets richer and the poorer gets poorer! Managers of the health facilities, on the other hand, contend that the distribution is based on qualification which aims at retaining the highly qualified professionals in the public sector. Moreover, in some health facilities, unfair distribution of benefits between the health care professionals and the administrative stuff is said to exist. As noted above, there is informal arrangement of distribution for "supervisors" in some health facilities which is hardly found on the regional implementation guideline. It has been understood that most health care practitioners are not happy and satisfied on the distribution of income earned from the private wing.

Cream-skimming of patients to the private wing by the health care professionals has also been observed in the study area. It is difficult, however, to generalize cream-skimming either as a problem or as an opportunity given that the issue entertained both complains and appreciations from the point of view of the patients. Some patients complain that they were unwillingly referred to the private wing considering it as denial of opportunity to be treated during the public hours. Others, on the other hand gratify practitioners who referred them to the private wing considering as if it is done as a favor for better treatment. Health care practitioners that engage in such practices argue that cream-skimming depends on the nature of patients' cases. Because some cases need prolonged time and attention and given that such opportunities do not exist during public hours due to higher patient-physician ratio, we refer them to the private wing. Some other patients, on the other extreme, responded that they appreciate such practices and were thankful to the physicians who referred them. The later is applicable, especially to patients having personal relationships with the physicians treating them. And such patients do prefer to be treated in the private wing to the public for promises and expectations of better care.

The impact of public-private practice in general and implementing private wing in public health facilities in particular, is both positive and negative when treated from two perspectives: its impact in terms of achieving its primary goal and its contribution from the point of view of widening the alternatives of treatments for patients. When viewed from the second perspective, the opening of private wing in the public health care facilities has opened additional opportunities for patients to get treatments with relatively fair charges and alternative times of arrivals to the health facilities, who otherwise could have been exposed to profit maximizing private clinics. Data revealed that patients in the private wing with better awareness of the practice shown favorably positive outlooks, comparing the fee with the one charged in the health facilities owned and run by the private sector.

The implementation of dual practice, nevertheless, has failed for worse when examined from the perspective of achieving its primary goal, i.e., retaining most qualified health care professionals through

improving their remuneration. The income earned from the private wing hasn't always been in a position to balance the 'unfair' salary of the public sector, according to both physicians and facilities' managers. Most physicians are still in a state of dissatisfaction and continuously seeking employment for better payments. For instance, a doctor working in OPD said: I *don't want to continue working in a public hospital; I am waiting until I finish my cost-sharing obligations. Do you know that my salary is less than someone certified with 10+3 and working in Ethiopian Revenues and Customs Authority? That is very discouraging. We do risky tasks, but we are not ensured of risks. The government needs me only as far as I am healthy and able to serve; I know that they will throw me away once I am incapable of doing the job.*

Another physician said: *I am looking forward to joining international NGOs that pay very attractive salaries. I will be happy if I join UN agencies. However, these days, NGOs hire with personal recommendations.* I always apply when I see vacancies, but yet remained unsuccessful. Above all, the implementation of a private wing has not saved health care professionals from wondering in search of additional working hours in private health facilities. Therefore, it can be concluded that it is not interest or passion of serving the public that is somehow retaining the currently existing physicians in the public health care facilities, but a lack of opportunity for most of the case.

Discussion

The holding of more than one job among health care professionals in the study area in particular and in Ethiopia in general has always been a common scenario. This is a common practice in other parts of the world too. Manuel et al., for instance, studied dual practice of public sector health care providers in Peru and found that practitioners engage in jobs other than the public one for one or more reasons. It has been found in the present study that most physicians engage in multiple jobholding activities with the motive of supplementing the low public sector earnings. This finding is similar to studies conducted by other researchers outside Ethiopia (e.g., Roenen [6]; Manuel et al. [15]; Terence et al. [16]; Peter and Dexter [17]). Roenen [6], for example, argued that health professionals in dual practices is very common mainly due to the fact that the amount of salary earned from working in public hospitals is not sufficient for good standard of living. Terence et al. [16] further asserted that medical specialists respond to changes in earnings by reallocating working hours to the sector with relatively increased earnings, while leaving total working hours unchanged.

Dual practice has resulted in absenteeism from regular working hours, lateness, and exhaustions, the cumulative effect of which is reduced quality of health service for public patients, according to this study. This finding is consistent to the one by Manuel et al. [15]. Furthermore, unfair distribution of benefits and burdens, and cream-skimming (moonlighting) have been found to be the challenges faced by the private wing medical service in the study area. USAID's [18] report on Ethiopian health sector financing reform evaluated income-tax issue being the challenge of the private wing project. According to the report (pp, 29), the incentive to provide services in the private wing is lessened if the stuff member has to report the extra income and pay taxes. A study conducted by Gary and Ching [19] found the prevalence of moonlighting by health care professionals in the public health facilities where private wing is exercised and revealed the consequence of moonlighting in undermining the quality of health care service of the public sector. The negative impacts of dual practice have also been studied by Joseph [9]. According to his study, the implementation of private wing services resulted in specialists to spend less time with public patients. No doubt that this will have its effect on the effectiveness of diagnosis and overall treatment at large. Kiwanuka et al. [6], on their part found the prevalence of predatory behavior, conflict of interest, brain-drain, competition for time and limits to resources, absenteeism, inefficiency, lack of motivation, tardiness, and an illegal and unquantifiable outflow of resources from the public to the private sector to be the negative consequences of dual practice.

The private wing project in Ethiopia has enabled patients to get additional alternatives of treatment. Although adequate data is lacking in the present study area, reports from other researchers confirm the contribution of the project in improving the income of public health facilities. No study has been undertaken, nevertheless, regarding the aggregate impact of the project in terms of retaining qualified physicians in the public sector in Ethiopia. However, the present study generalized that the implementation of private wing project in public health facilities has failed to retain qualified health professionals in the public sector. This finding contradicts with the findings of USAID's [18] report on Ethiopian health sector financing reform midterm evaluation stating "…but it is working and helping to retain key staff, especially physician specialists with small additional income to the staff working in the private wing". Kiwanuka et al. [6] confirmed the conclusion of the present study contending that competition for time and resources resulted from the growth of the private health sector hardly made possible the attempt of the government to attract and retain qualified health professionals.

Findings both from the present study and researches outside of Ethiopia call for the need to put certain restrictions on the unregulated public-private practices in health. For González and Stadler [20], if the potential gains from private practice are low, the optimal intervention is either to limit dual practice (if the associated costs are low) or to ban it (if such costs are high). Personal compliance, adequate financing of the health sector and capacity of public health facilities would contribute to the success of the interventions, according to Kiwanuka et al. [21].

Conclusion and Recommendation

The purpose of the present study was to assess the patterns, challenges, and impacts of public-private practices among selected public health facilities of Shashemene town, West Arsi zone-oromia regional state. Ample qualitative data were collected through depth-interview and focus group discussion methods from patients, physicians, and facility managers involved in dual practice. Accordingly, the implementation of private wing in public health care facilities of the study area has become a common practice since earlier years. Most health care professionals engage in the practice for financial motives. Most physicians, nevertheless, are dissatisfied due to the insufficient money obtained from the private wing which led them to resort to a third additional alternative- engagement in multiple jobholding including the private wing.

Public-private practice in the study area is in a position of compromising quality of health care services in the public sector in the course of undermining the performance and behavioral makeup of physicians. The inability of the private wing to adequately backup the low regular income of health professionals forced them to spend restless hours in health facilities owned by the private sector.

Consequently, late arrivals to the regular working hours, absenteeism, and exhaustion seem to challenge quality health care services of the public wing.

The project of public-private practice designed and implemented by FDRE government with the big purpose of reducing inter-sector and out-boarder flow of qualified health care professionals retaining them in the public sector has failed, according to findings of the present study. Although the new practice has succeeded in terms of providing patients an additional alternative of treatment, its return doesn't seem to convince health care professionals to be stable with their public service. With qualified practitioners still in the mood of constantly searching better way outs from the public sector, it is important that the Federal Ministry of Health monitor and evaluate its project to come up with remedies.

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