Reviewer's report

Title: Conceptualizing the Impacts of Dual Practice on the Retention of Public Sector Doctors - Evidence from South Africa

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Reviewer: Giuliano Russo

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The paper explores the link between physician dual practice (DP) engagement and their retention in the public sector in South Africa (ZA), based on repeated in-depth interviews with 28 specialists. This works makes interesting contributions to the existing body of knowledge on the subject in the way of: (a) conceptualising the relationship between physicians' engagement with simultaneous private activities and their intention to stay in the public, and; (b) addressing the DP situation in ZA on the light of the recent regulatory changes.

However, the paper is affected by a number of shortcomings, as it fails to deliver a clear message from its findings and address adequately the effect of the country’s regulatory policy (RWOPS). Some apparent flaws in the study design also need to be addressed. In my opinion, the paper would need a substantial revision in order to be suitable for publication in Human Resources for Health. I hope I can offer some suggestions below.

MAJOR REVISIONS

Clarity of findings. It is unclear what conclusions the authors draw on DP’s effect on physicians’ retention. The statement from the abstract “…dual practice can impact both positively and negatively on retention in the public sector, through multiple conceptual channels including those previously identified in the literature…” is too ambiguous, and such an ambiguity seems to pervade the manuscript Results and Discussion. Unexpectedly, at the very end of the paper, it is stated that: “As such, it seems that the primary lesson from this case study is that it is questionable whether dual practice increases retention in the public sector…..”. To me the reported findings seem to suggest that DP’s supposed ability to retain physicians is somewhat overstated in the ZA case, and that at least for the people interviewed, the hypothesis of DP as a stepping-stone towards private practice may be a better interpretation of the interviewees’ transitory state of operating both in public and in private. If this is the case, the authors should be more direct and providing enough evidence to put together a convincing case.

Your Revised conceptualization of the relationship between DP and intention to stay (Figure 2) is less than straightforward, and it is unclear how this should be an improvement with respect to Figure 1. At any rate, I would advise against presenting upfront the framework that informed your research (F1), only to show at a later stage why this was not correct (F2), as it would undermine your own
approach. Probably it would be better to present the research approach (F1), and then explain in the text how you furthered your understanding of the relationship between DP and retention.

Failing to assess the RWOPS effect. As it is acknowledged in the Background section, the recent introduction of the RWOPS policy is the distinguishing feature of ZA’s DA regulatory environment (and I assume, one of the reasons that motivated the authors to write this piece). However, a description of how the RWOPS regulation works is conspicuously absent from the paper, and the specific features of this policy hardly come up in interviews and results, leaving the reader wander whether this had any impact at all. To my eyes, this is first of all a missed opportunity to analyse one of the most prominent attempts to regulate physicians’ dual practice in Africa. Secondly, the authors seem to be ignoring a key factor that could help explain some of the differences in physician responses.

Issues with the study design. If you’re planning to show that DP does not necessarily work the way policy-makers in ZA think, probably you need to talk to all those physicians who decided not to engage in DP in the country, that is, non-specialists, racial minorities and female physicians; you may discover that DP is not accessible to everyone, or that it has undesirable features for some physicians. But if you limit yourself to talking to mostly white and male specialists, I am not surprised you will get the message that DP is good and helps retain physicians in the public? I understand qualitative findings do not need to be representative, but your choice of sample reduced the external validity of your work and forces you to further qualify your findings.

You also lump together the views of those public specialists who practice private services within a public hospital (H1) and those who practice outside (P1). To my eyes, motivations across these two groups can be substantially different, and you should be able to tease them out (e.g. the hypothesis that DP reduces migration cost to the private can only be truly valid for H1 physicians). Rather than dual practice, many researchers prefer to talk about ‘multiple job-holding’ (Berman et al, 2004), and recent work on physicians’ DP in Africa shows that the traditional three-way distinction of public, private and dual practice doctors is a gross simplification (Russo, G, McPake B, et al. “Negotiating Markets for Health: An Exploration of Physicians’ Engagement in Dual Practice in Three African Capital Cities.” Health Policy and Planning, September 26, 2013. doi:10.1093/heapol/czt071). I think some of your quotes seem to support this idea – e.g., what the specialist in the quote at the end of pag.13 is really saying is that he dropped his job in the private not because he was working too much, but because he wanted to concentrate on his public clinical job AND on his academic career). This underscores the necessity to understand: (a) the multiple forms of dual practice that exist in your country; (b) how many hours physicians are willing to dedicate to any of them, and; (c) the terms of the trade-off between each of their professional activities.

Issues with the Organisational Psychology (OP) approach. The authors chose to frame their research approach from an OP approach; perhaps because of my limited knowledge of the discipline or because of the limited explanation offered
in the text, such an approach does not seem to cover aspects such as physicians’ time allocation decisions any more convincingly than the traditional approaches used to investigate dual practice. Berman and Cuizon (2004) (whom you quote in your manuscript) offer a clear overview of the existing approaches to DP and grounded in economic theory (such as the time-leisure trade-off, the hours-constraint model and physicians’ target income hypothesis) as well as in sociological theories related to the profession and to bureaucracy. If you are planning to adopt a different approach to explore DP’s impact on retention I suggest you should justify your selection against the prevailing ones.

MINOR POINTS

Abstract. I would avoid using the term ‘moonlighting’ to describe physician DP as it implies physicians taking up a ‘secret’ second job at the expenses of their primary (public) one, which does not happen to be the case at least for the case of RWOPS in ZA.

The paper’s objective needs to be stated more prominently in Abstract, Introduction and Methods

Background. An explanation of RWOPS features is needed.

Results. Organisational loyalty you say is critical to retention/intentions to stay (pag.18), but your supporting quote in page 16 is rather speaking of the ethics of public service (“My loyalty is not to the Provinces…”)

Level of interest:An article whose findings are important to those with closely related research interests

Quality of written English:Acceptable

Statistical review:No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests