Original Article

Managing Health Services in Developing Countries: Between the Ethics of the Civil Servant and the Need for Moonlighting: Managing and Moonlighting

Jean Macq, MD, MPH [1], Paulo Ferrinho, PhD [2], Vincent De Brouwere, MD, MPH, PhD [3], Wim Van Lerberghe, MD, PhD [3]

1) ULB Free University Brussels, Belgium; 2) Garcia de Orta Development and Cooperation Association, Portugal; 3) Institute for Tropical Medicine, Antwerp, Belgium

Abstract

We report on income generation and work mix among 100 civil servants who manage public health services in developing countries. Corrected for purchasing power parity, the government pays the respondents a median salary of 3,800 US$PPP per annum. This salary puts these managers among the better-off in their countries. However, it definitely remains below what they could expect from alternative occupations as medical doctors in their own countries. An impressive 87% of the respondents complement their salaries with at least one of the following: working for NGOs or development agencies, private practice, or other income-generating activities. All in all moonlighting adds an extra 50 to 80% to their public sector salaries. There are three possible consequences: competition for time, outflow of resources from the public sector, and conflicts of interest. The problem of moonlighting needs to be addressed openly so as to protect public sector values while meeting both professional needs and user demands for quality.

Key words: Civil Servant, Ethics, Developing Countries, Public, Private, Human Resources

Introduction

In many countries public sector doctors and nurses get a large share of the blame for their public sector's failure to deliver efficient quality care: they are said to be 'unproductive', 'poorly motivated', 'inefficient', 'client unfriendly', 'simply not there' or 'corrupt'. The moralistic connotations of these simplistic characterizations do not help. Most would agree that public sector salaries are most often 'unfair'. For example, in 1999 a Mozambican nurses salary was only 10-15% of what it had been 15 years before.[1] In many countries health staff is going through similar experiences. In such a context, 'demotivation', and overall 'lack of commitment' are to be expected.

To compensate for unrealistically low salaries, health workers rely on individual coping strategies.[2,3] Many clinicians combine salaried public sector clinical work with a fee for service private clientele. Others resort to predatory behaviour, asking under-the-counter payments for access to 'free' services or goods and/or misappropriating drugs or other supplies.[4-7] The problems this creates are increasingly recognised.[8-14] although the subject remains taboo in many ministries of health and development agencies.

Managers of public health services also often work under circumstances that can hardly be called adequate, professionally and economically. They have fewer opportunities for predatory behaviour than clinicians. Some may abuse their position for corruption or misappropriation of public goods, but most try to cope in other ways.[2,3] They take up a second, third or fourth job, teaching, doing consultancies for non-governmental or development agencies, moonlight-

ing in private practice or non-medical work to provide extra income. Secondment to not-for-profit NGOs or health development projects and activities that benefit from donor-funded per diems or allowances are other means for topping-up salaries.[1]

There is surprisingly little hard evidence about the extent to which health staff resorts to such coping strategies, about the balance of economic and other motives for doing so, or about the consequences for the proper use of the scarce public resources dedicated to health in developing countries.[7,15] This paper reports on income generation and work mix among civil servants who manage public health services in developing countries. Although the civil servants from whom information has been obtained can hardly be called representative, it makes it possible to bring some concrete elements to a subject that is particularly poor on hard evidence.

Population and methods

The information was obtained through a semi-structured mail-survey of 401 medical doctors with an MPH degree obtained in Europe between 1976 and 1996. The survey asked for detailed information on time spent on various professional activities, the income generated, motivation to do so, perceived consequences and professional and legal context.

There were 138 respondents - non respondents include a large number of faulty addresses, and probably many who were ill at ease with the subject, for reasons of privacy or out of fear for personal consequences. The response rate was highest among the more recent graduates: 50% of those graduates in the last ten years replied. One hundred of 138 respondents were working as civil servants in their own country in a managerial or in a mixed managerial-clinical position, and considered eligible for analysis. At an average age of 45 they can be considered as fairly well advanced and stable in their careers. Although primarily managers, about one in two also had clinical and teaching duties as part of their public sector terms of reference. Only four work in situations where the civil service does not restrict civil servants from engaging in private practice.

Comparing nominal salaries at current exchange rates may give a misleading picture. Since non-tradable services may be cheaper in poor countries, the gap in living standards is often smaller than suggested by the exchange rates. Purchasing-power-parity (PPP) exchange rates adjust for these differences, narrowing the gap and stripping out the effect of exchange-rate fluctuations. For each country the respondents supplied information on going rates for consultancy work and for private practice. This provides a local yardstick for comparison of the income of the respondents with what they could earn through an alternative occupation.

The data are presented separately for low- and middle-income countries[1].

Results

Privileged, but not up to expectations

Corrected for purchasing power parity the respondents to this survey have a median salary of 3,800 US$ PPP per annum. This is equivalent to a median 10 times (range: 2-57) the GDP/ PPP per capita of their country in low-income and 6 times (range: 0.8-24) in middle-income countries. On top of their salaries more than half of the respondents also have fringe benefits such as free housing (9), the use of an office-car (28) or both (17).

This puts doctors-managers definitely

1 Low-income countries in the sample: Burkina-Faso; Burundi; Cameroon; Cape Verde, China; Congo; Ivory Coast; Erythrea; Ethiopia; Ghana; Guinea; Haiti; India; RDP Laos; RD of Congo; Togo; Viet Nam; Madagascar; Mauritania; Mali; Nicaragua, Niger; Uganda; Senegal; Tanzania. Middle-income countries: Argentina, Bolivia; Brazil; Ecuador; Indonesia; Mexico; Morocco; Peru; Philippines; El Salvador; Surinam; Thailand and Tunisia. Classification according to the World Bank.

among the privileged in their societies. In low-income countries all but two have salaries that are higher than the average GDP(PPP) per capita of the richest quintile in their country.[16] In purchasing parity terms respondents from middle-income countries earn twice as much as those from low-income countries.

More appropriate to what the managers themselves perceive as a 'fair' income is a comparison with what their peers earn in alternative occupations. Two attractive possibilities for people who can boast of a medical degree and an international MPH diploma are private practice and expert-consultancy work for development agencies or NGOs. A manager's monthly public salary corresponds to about 6 days of consultancy work at going rates in low-income countries, and to 17 days in middle-income countries. It is equivalent to less than one quarter (median 22%) of the proceeds of a small private practice of 15 patients per day (Table 1). The gap with private practice work is most pronounced in low-income countries.

Their public sector salary may thus put these managers among the better-off compared to the distribution of GDP in their countries. However, measured by the yardstick of consultancy work, or of a small private practice, it definitely remains below what they could expect from alternative occupations in their own field and in their own country.

Extra work, and extra income

An impressive 87% of the respondents have at least one other job. Figure 1 shows how working time is distributed between what, in their terms of reference, is seen as civil service and other activities. Less than one third of the respondents spend 90% or more of their time working for their public sector assignment. Forty-nine respondents do work for NGOs or development agencies: 22 through stable secondments to projects and 40 through ad hoc consultancies or other occasional activities such as seminars. Almost two out of three teach. One in four have an income from business or agriculture - which takes up an average of 13% (but up to 40%) of their working time.

Private patients take between 2 and 63% (median 18%) of the time of 29 respondents. Four of these work in countries where private practice for civil servants is not restricted. Legislation is restrictive in all other countries, although many are either confused about what the regulation actually entails (n = 17) or comment that legislation is not controlled or enforced (n = 37). Only four respondents report that legislation is restrictive and enforced.

Eventually, out of the total working time these doctors were supposed to spend in government employ, 10.3% goes to an extra job teaching, 7.3% to working for not-for-profit NGOs or donor agencies, 5.9% to private practice, and 3.1% to farming or small businesses. This leaves 73% of the theoretically available person-time for public service. Half of the respondents are

Table 1 Median and inter-quartile range of take-home salaries of civil servant health service managers.

	Low-income countries (61 respondents)	Middle-income countries (39 respondents)
• In US$ at official exchange rate	3,802 (2,137-5,249)	11,253 (6,704-18,900)
• In US$ corrected for purchasing power parity (18)	13,890 (9,411-20,956)	26,376 (18,416-38,931)
• As % of the income of a 15 patients per day private practice	14% (10%-33%)	29% (22%-41%)
• As % of the income of full-time consultancy work (250 days/year)	31% (23%-44%)	81% (45%-108%)

available less than 75% of the expected working time, and for 15% the public sector employment is, in practice, less than a half-time job.

On the whole these side-activities generate a substantial extra income. However, 32% of those working with NGOs and 51% of those teaching report doing this as unpaid volunteer work. The other side-activities provide an extra income on top of the public sector salary. Private practice, *ad hoc* consultancy work and business or agriculture provide 2.4 times more income per time unit spent on the activity than the civil servant salary for an equivalent amount of time (ranges 0.6-10 for private practice, 0.3-54

Figure 1 Distribution of working time of 100 public health services managers: distribution over public sector work, teaching, work with NGOs, consultancies, private practice and other income generating activities. Each line represents the total time available for a full-time job for one individual.

for consultancy work, and 0.6-9.1 for business or agriculture). Secondment to NGOs pays a median of 1.3 (range 0-26) times the public sector salary for an equivalent amount of time. Teaching, however, pays less on the average: 0.13 time for an equivalent amount of time (range 0-26).

All in all, however, extra jobs add an extra 50 to 80% to the public salary (Figure 2, Table 2). The end result is a net total income that is equivalent to the fees these same doctors could earn by doing 15 days a month of consultancy work; it is equivalent to one third of what they would take home from a small private practice of 15 patients per day.

Figure 2 Distribution of income in US$PPP, with the increase from extra jobs, and compared to the distribution of potential income through consultancy work or private practice.

The box-plot chart represent for each variables, the maximum, percentile 75, percentile 25 and the minimum.

Table 2 Median and inter-quartile range of total income (salary plus extra activities) of civil servant health service managers.

	Low-income countries (61 respondents)	Middle-income countries (39 respondents)
• In US$ at official exchange rate	5,899 (2,712-8,137)	11,372 (6,000-23,040)
• In US$ corrected for purchasing power parity (18)	21,438 (4,081-84,640)	39,377 (26,149-64,338)
• As % of the income of a 15 patients a day private practice	26% (17%-52%)	42% (29%-64%)
• As % of the income of full-time consultancy work (250 days/year)	49% (30%-96%)	115% (74%-172%)

Discussion

Money, Time and Conflicts of Interest

For public health services managers, such as the respondents to this survey, the impact of moonlighting on their income is considerable and cannot be ignored. It is not necessarily negative. It allows a standard of living that is closer to what doctors - still a rare resource in many situations - expect, and thus helps retain valuable elements in public service. Money is not, however, the only factor in retaining staff. Most could earn much more in private practice, at the locally going rates, but remain in office. Many spend comparatively little or no time on private practice. It is unlikely that this is only for lack of opportunities - a saturated private health care market, or too much competition from the 'real' clinicians. There must be other sources of motivation to keep on managing public services. The involvement in (relatively unrewarding) teaching, or in unpaid NGO work shows that other factors - social responsibility, self-realization, professional satisfaction, working conditions and prestige - also play a role.

Nevertheless, the gap between income and expectations makes it unavoidable that managers, as other health care workers, will seize opportunities that are rewarding, professionally and financially. The notion of the full-time civil servant exclusively dedicated to his public sector job is disappearing. Were this without consequences for the performance of the public health sector, it would not be much of a problem. But in many poor countries the situation has gotten out of hand, and there are consequences.

They are hard to assess empirically. It seems reasonable to assume that they mainly stem from competition for time and from conflicts of interest.

Competition for time is a nagging problem for many development agencies and ministries of health. At times it is blatant. In Mali, for example, regional health staff was found to spend 34% of their total working time in (income generating) workshops and supervision missions supported by international agencies, and chief medical officers 48% (El Abassi and Van Lerberghe, unpublished data, 1995). The self-reported 73% of working time spent on official duties by the respondents to this survey may well be an overly optimistic estimate. Given the selection biases in the sample it is likely that in many situations a much greater proportion of working time is spent on activities that do not fit in with the public service job descriptions. It is also likely that private clinical work is less important for managers such as the respondents to this survey than it would be for clinicians.

Competition for time automatically results in a transfer of salary-resources out of the public sector through reduced availability - at least the equivalent of 27% of the salary mass. In many cases the use of the public sector's means of transportation, office infrastructure and personnel represent additional hidden outflows of resources. At times the loss to the public sector may be compounded by the fact that diagnostic and therapeutic resources are redirected to private practice - a practice that is obviously difficult to assess.

Other effects on the system can best be understood by thinking in terms of conflicts of interest. This has to be looked at separately for each type of side-activity. Doing business or agriculture is neutral towards health services, although it constitutes a de facto internal brain drain. In the case of teaching, conflicts of interest are unlikely, on the contrary. Involvement in teaching probably benefits both the health system and the teaching institutions as it reinforces the contact of trainees with the realities of the health services. For doctors who are basically managers, moonlighting in private practice presents less of a conflict of interest than for clinicians. The latter have to compete for patients with themselves, and thus an incentive (and the opportunities) to lower the quality of the care they provide in the public services. This is not the case for managers. Involvement in NGO projects or work for donors can foster better

coordination in the provision of services, but may constitute a conflict of interest when NGO or project policies are at odds with national health policies.

The Need For an Open Discussion

What strategies, then, can public authorities and development agencies propose?

Prohibition of moonlighting without changing the salary scales is probably one of the least effective ways to tackle the problem. As an isolated measure it only drives the practice underground, which makes it difficult to avoid or correct negative effects. Enforcement is unlikely when the problems in retaining motivated staff become obvious, and the enforcers are in the same situation as those who have to be disciplined.

To close the salary gap by raising public sector salaries across the board to 'fair' levels is not an immediate realistic option in many poor countries. In the average low income country salaries would have to be multiplied by at least 5 to bring them to the level of the income from a small private practice. Doing this for all civil servants is not imaginable; doing it only for selected groups such as doctors-managers would be politically very difficult, if financially possible.

Downsizing would make it possible to divide the salary mass among a smaller workforce, thus increasing individual salaries. Experience with such attempts are disappointing: it usually provokes enough resistance among civil servants never to get to a stage of implementation, and where retrenchment becomes a reality this is not followed by substantial salary increases.

Performance linked incentives - the now fashionable new public management approaches - would in principle address the problem of competition for working time, one of the major drawbacks of moonlighting. However, these ways of working require a well functioning and transparent bureaucratic system. The countries that would benefit most from new public management are the ones where it is a priori most difficult to implement on a large scale.[17,18]

That does not mean that nothing can be done. Improvement is likely to come from a combination of small piecemeal measures that rebuild a proper working environment. Improved working conditions in public services imply the provision of a fair package of material benefits, including career prospects. This is far from being the case, particularly in low-income countries. Perhaps most important, it requires a social environment that reinforces a professional behaviour that is free from the clientelism and the arbitrary prevalent in the public sector of many countries.

A pre-requisite is to address the problem of moonlighting openly. Where it is not realistic to expect health care workers to dedicate 100 percent of their time to their public service job, this should be acknowledged. That is the only way to create the possibility of containing and discouraging income generating activities that present conflicts of interest, in favour of safety valves with less potential for negative impact on the functioning of the health services. Besides minimizing conflicts of interest, open discussion can diminish the feeling of unfairness among colleagues. It is to be hoped that once these situations become more transparent and predictable, one can start thinking about improving performance.

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