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**Factors Motivating Physicians to Undertake or Abstain from Private Practice:**

**Analysis of the Motives and the Formulation of Policies that Encourage Physicians to Remain within the Public System**

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This article brings evidence that physicians, like patients, have a great interest in improving the public health-care system. Putting health-care reforms into action is especially difficult if we do not take into account physicians' perspectives. From their point of view improving the public system is more than a discussion about reducing inequalities in the Israeli health-care system. There is an additional goal of making the public health system more efficient. Most physicians prefer to work in one place, i.e., the public system and to have only one employer. This and other preferences of physicians presented in our study should be taken into consideration by policy makers who are interested to strengthen the public health-care system.

**Introduction**

Countries that provide universal health care have long struggled to balance provision of publicly funded services with a smaller but growing sector of private services [refs]. In this context, dual practice – physicians who work in both the public and the private sectors – has been debated by physicians’ organizations, ministries of health, decision makers on health policy issues, and insurance agencies around the world. For example….

The concerns about growing private service provision weigh heavily on policy makers and healthcare providers alike. Some argue that the practice whereby physicians work in both public and private settings can challenge the entire health-care system by….

There is an innate tension emerging from the simultaneous provision of low-fee public services and costly private medical care, as these two systems represent conflicting values. Those who favor public provision prioritize the values of egalitarianism, solidarity, patient’s interests, and equal access to medical care. In contrast, those who favor the private system prioritize independence, consumer and provider freedom of choice, and the profit motive, arguing that these lead to better quality and more efficiently provided health care [ref]. Physicians who work in both systems straddle both value systems and experience this tension most acutely [ref?].

Despite their central role in providing health-care services of all kinds and their influence on the direction of any system-wide reform [ref?], beyond physicians’ revealed preferences for place of work, little is known either about the factors that influence their decisions to work in either or both systems or their perceptions of dual practice in general (Humphrey & Russell, 2004).

Understanding physician attitudes is especially timely both in Israel, and in other universal healthcare systems experiencing growing pressures towards private provision of health services. Since 1995, the Israeli government has provided universal coverage to citizens and permanent residents through one of four competing health maintenance organizations (HMO). While the health-care system in Israel is undergoing privatization in a manner similar to other publicly funded systems and in ways that contribute to a blurring the boundaries between the public and private sectors, during the last two decades Israel experienced the fastest rate of increase in private financing and supply of health services in the world (Filc et al., 2020).

Consumers fuel the expansion of private healthcare services by purchasing supplemental insurance coverage from their HMO or from private insurers. Physicians participate in the expanding private opportunities primarily by opening private clinics with afternoon hours. Currently, private practice in Israel exists in three formats, with most physicians belonging to the last two:

1. Physicians who work only in their own private clinics (XX % of physicians)
2. Salaried physicians in the public system who have a private practice, usually in afternoon clinics, outside their hospitals (XX % of physicians).
3. Salaried physicians in the public system who have been permitted to set up a private practice within specific hospitals (XX % of physicians). This arrangement, via a private health service known as Sharap[[1]](#footnote-1), enables patients at specific hospitals who pay more (directly or through their HMO) to receive additional services, including the ability to choose the doctor who will treat them, to get faster appointments and consultations for second opinions, and access to preferred services.

This qualitative study therefore aimed to directly address missing information about physician preferences by asking three overarching questions. First, we sought to uncover the range of motivations physicians report for engaging in or abstaining from dual practice. Second, we probed how physicians view the conflict surrounding the mix of public and private healthcare services, and finally, we solicited their suggestions for retaining doctors in public employment. We were especially interested in physicians’ justifications for engaging in dual practice with its conflicting responsibilities, and their views on how dual practice affects the public sector.

**Background**

In order to improve the public health-care system, it is crucial to involve physicians in decision-making and health-care reforms [ref?]. Therefore, it is important to understand how physicians perceive both systems and the relationship between them. According to the limited research on the topic, physicians, in most cases, see their private practice as a complement to their public work and not as an alternative to it (Humphrey & Russell, 2004). Despite the criticism towards the public system, very few abandon it completely. There are some key characteristics of the public health system that physicians do not wish to forego. Among these public sector characteristics are job security, credibility as a doctor, access to power centers and resources, social prestige, point of entry into international projects, and commitment to the public welfare (Ferrinho et al., 1998). Thus, most physicians enroll in both health systems and do not engage in the private sector only (Assuta Medical Centers, personal communication, May 26, 2019).

However, several studies showed the negative side of dual practice. González (2004) shows that physicians who work in both sectors have an incentive to over-provide medical services . Garcia-Prado & González (2011) list the negative effects on quality of care: misuse of public resources; less time and effort put into the public position; self-referral of patients from a doctor’s public to private clinic; unwarranted absence during public hours leading to the substitution of less qualified residents to provide public care; lower quality due to physicians’ overwork and fatigue and greater departures from the equity principle of equal treatment according to need. Similarly, Ferrinho et al., (1998) found that most physicians interviewees were conscious that enrolling in private practice impacted their public sector work in a negative way, decreasing quality health-care provision. Some even felt ashamed and revolted by having to find additional sources of income (.

Moreover, according to one of the few studies based on interviews with physicians, British National Health Service (NHS) doctors are aware of the inequity of offering private health care to those who can afford it, and they acknowledge the risk involved in the lack of separation between the two health-care systems (Humphrey & Russell, 2004). Furthermore, several of the interviewees admitted that a small dishonorable minority allow their public waiting lists to grow in order to generate private demand. Others claim that doctors try to keep their public waiting lists down to reasonable length.

In spite of this, the literature shows that, for many physicians, private practice is a normative expectation, and abstaining from it is considered eccentric [ref?]. How do physicians relate to and justify dual practice? British interviewees were “quite comfortable with their dual practice,” maintaining that private practice was a traditional right of the profession and was a necessary activity enabling them to satisfy basic personal and professional requirements (Humphrey & Russell, 2004). Private practice is seen as a fair reward for years of hard work and sacrifice, especially because working solely in the public system cannot meet personal and professional goals. Other respondents termed it meeting “survival needs” (Ferrinho et al., 2004). In these studies, physicians presented the following additional arguments:

* Unfairness exists in every sphere in life;
* The private sector does not compromise the quality of public medicine; it only provides patients with slightly more comfort and convenience;
* The private sector contributes resources to the health economy including the public sector.

Overall, the perspectives towards dual practice according to Humphrey & Russell’s findings, are mostly positive. Most importantly, doctors undertaking dual practice claim that they manage the interface to everyone’s benefit—to themselves, their private patients, and their public ones. (Humphrey & Russell, 2004)

**Methods**

***Design***This qualitative study, performed within a broader “mixed method” research, drew on 30-minute, semi-structured personal interviews with 23 physicians conducted in their offices between 2017 and 2019. Along a predefined protocol we prompted interviewees with spontaneous questions during the interviews, using clinical interview techniques (reflection, restatement, clarification, and exploration). The interviewer sought responses to specific questions while also being attentive to the dynamics and body language of the interviewees, noting not only their stated but also their understated sentiments (for example the length of time an interviewee might spend to justify a certain position). The protocol was approved by the Institutional Ethics and Human Subjects Review Committee of xxx. Participation was voluntary and participants provided informed consent; moreover, they were not provided with any incentive.

***Participants***

The goal in our selection process was to raise the range of issues and perceptions which influenced physician perception and decision making and not their prevalence. For this reason, we chose a sample of physician interviewees to ensure geographic variety, diversity in academic hierarchy, and in stages of their professional lives. A few interviewees were specifically chosen due to their outspokenness regarding the public-private mix. In addition, we sought physicians whose specialties included both those in which private practice is more common and those in which private practice is less common. At the same time, we ensured inclusion of internal medicine as opposed to only surgical specialties. We wanted representatives from the four possible combinations highlighted in the following table.

Table 1. Participants According to Specialty and Practice Type

|  |  |  |
| --- | --- | --- |
|  Practice Type Specialty | **Physicians more commonly work in the public sector** | **Physicians more likely to *also* work in the private sector** |
| **Internal** | Infectious diseases | Cardiology |
| **Surgical** | Intensive care | OrthopedicsCardio-thoracic surgery |

Among the 23 participants were 4 females and 18 males ranging from junior specialists to senior specialists; XX were department heads. Approximately half of the doctors in the sample worked either in the public sector exclusively or in both the public and private sectors. One participant worked solely in the private sector.

***Analysis***

We used the grounded theory approach which seeks patterns in the data, so the data are theoretically bounded. In this approach, codes, concepts, and categories emerge from the data without preconceived expectations (Glaser, 1967). Data coding and analysis was done using *ATLAS.ti* software and involved an iterative process of inserting each initial code into larger categories. We conducted ongoing discussions among research team members to explore the level of agreement between coding and concepts, and to challenge the initial interpretations. The quotes were translated from Hebrew by a native English speaker.

**Results**

While analyzing the interviews, three key questions emerged:

**#1** What motivates physicians to engage in or abstain from private practice?

**#2** How do physicians resolve the conflict in their professional lives that emerge from working in both the public and private health sectors?

**#3** In light of the fact that many physicians in dual practice argued that they would rather work only in the public sector, we asked what suggestions would they offer in order increase the percentage of doctors working solely in the public sector?

**Question #1 – What motivates physicians to engage in or abstain from private practice?**

Motivations to engage in private practice

A main motivation for private practice is higher income. Physicians feel they deserve higher recompense after investing many years to professional training, night/weekend shifts, and abnormal absences from family and children. Years of investment, they argue, should yield commensurate compensation (14).

*I compare my salary to the salaries of my friends in hi-tech and engineering. A person wants some kind of adjustment. I studied in medical school six years. Then a year of internship. Another six in residency. Then two years in the U.S. in a fellowship program. I invested many difficult years: sleepless nights, I didn’t see my family; I wasn’t involved in raising my kids. Now give me some compensation for all this.~ Interviewee* B9 – cardiac-surgeon (public sector exclusively)

A general surgeon who works exclusively in the public sector adds two more reasons for deserving the higher salaries afforded by private sector work. The first is their heavy responsibility for the health and sometimes the lives of their patients. The second is to remove any incentives for accepting under-the-table payments:

*The reason we should receive appropriate remuneration is because the responsibility is very heavy. Look at the salaries of pilots; a pilot has the responsibility for 300 passengers. Wake up! What about us? When it comes to judges, you remunerate them liberally so they won’t take payments under the table. Wake up! You want to put the brakes on “under-the-table” medicine, give appropriate remuneration.* ~ B22 – General surgeon (public sector exclusively)

The desire for a better life quality intensifies even more when physicians compare themselves to their neighbors, the natural tendency to "keep up with the Joneses":

*[If] a physician sees her neighbors on a ski vacation in St. Moritz, while she camps in a tent by the Sea of Galilee, she could be upset. And when her neighbor upgraded to a BMW and she’s still with the Subaru, she’s upset… And when this agitation sinks into your life, it becomes a powerful force, pressuring you to join the rat race. And then you need to make more money… and it’s never enough.* ~B5 – ICU (public sector exclusively)

Interviewees also mentioned non-pecuniary motivations to engage in private practice, including:

1. **Status and prestige.** Patients perceive private doctors as better doctors. However, physicians realize that this is only a lay perception.

*The ordinary person thinks that if he goes to a private hospital then he’ll get higher medical standards. Similarly, when it comes to asking for second opinions. it’s Israeli, it’s the Jewish mentality, you think that if you pay you’ll get better care. There’s a joke that in New York there’s a sign on the doors of physicians which says: Jewish patient-take your second opinion first. This phenomenon is even more striking on the periphery. They prefer to travel 3 hours from the north to Tel Aviv to pay for a second opinion, when they could get it right there in the periphery free.* ~B22 – General surgeon (public sector exclusively)

1. **More efficient health-care system.** Doctors, like patients, enjoy the quality of the private sector because they consider it well-organized, less stressful, more accessible, better equipped, and less “clumsy.”

*I work [in a private hospital] from time to time and it is excellent. There is no*

*comparison between the conditions there [and those in a public institution.] The efficiency is greater. In the time it takes a public hospital to do one or two operations, you can do three or four in a private one. Everyone benefits: hospitals, patients, physicians, and the waiting lists are shortened.* ~B13 – Cardio-surgeon (public & private sector)

1. **Physicians’ freedom of choice.** Doctors can choose patients who present simpler medical problems. This practice of treating straightforward cases in private clinics is known as cream skimming. If one does not align with this norm, one might even be excluded from working in private hospitals.

*You do not bring difficult cases to a private hospital because you do not want to wind up with complications that result in [monetary] losses to the hospital. If you do this too often, then the hospital will say, “My dear doctor, we’re sorry. You’re causing us losses. We’re a for-profit hospital. Don’t come here.”* ~B9 – cardio-surgeon (public sector exclusively)

The interviewees suggest that, while physicians who perform surgical interventions refer more complicated patients to the public system to avoid complications in their own private clinic, there are exceptions in certain specialties. A diagnostic cardiologist, for example, does not run risks since she does not do procedures. Then she can enjoy complex cases which have medical and intellectual challenges:

*There are several sources of satisfaction associated with private medicine. Often you are faced with complex problems. As a rule, someone who’s looking for a second opinion has a bit of a problem. Those cases are more complicated, and therefore more interesting.* ~B12 – cardiologist (public & private sector)

1. **Free market enterprise and patients’ freedom of choice.** Public system physicians mentioned their egalitarian ideology. Similarly, we encountered ideological motivations for physicians to practice privately. Physicians who work privately do have arguments in favor of enabling a parallel private health-care system to exist as an aspect of social norms and an open market. Moreover, since we are in the post-communist era, says one of the interviewees (B14), patients should have the possibility to choose a private doctor.

Motivations to minimize private practice

Even though the private system is financially enticing, there are physicians who buck the tide and choose to work exclusively in the public system.

1. **Professional status:** Until recently only public hospitals could train residents, teach medical and nursing students, operate research laboratories, and sponsor academic positions.

*An advantage of the public sector is that one can have an academic career, aim for professorship, and present research in conferences.* ~B9 – cardio-surgeon (public sector exclusively)

1. **Better service quality:** Some dual sector physicians said medically they prefer treating patients in the public system due to teamwork, variety of disciplines, and shared responsibility, for example an orthopedist working in both sectors (BX) said he feels like a guest and not a team member in private hospitals. Surprisingly, the arrangements vis-à-vis equipment tilt the scale for some in favor of public hospitals. As opposed to private hospitals, in public hospitals physicians are not held accountable for equipment they use.

*In a large, public hospital, if there are complications you have an infrastructure behind you: you have a variety of medical disciplines present, unlimited equipment, and additional medical staff. In contrast, in a private setting you don’t have this backup. If something happens and you don’t have the additional equipment, then you must manage with what you have! So working in a private hospital can be inferior medically.* ~B23 – Orthopedic surgeon (public & private sector)

1. **Preference for salaried employment:**  Salaried employment obviates the need that exists in private practice to worry about rental payments, office workers, taxes, and marketing.

*I have the mentality of a salaried public employee. For the life of me, I could never manage if I had to run my own business.* ~B17 – ICU specialist (public sector exclusively)

1. **Egalitarian ideology:**  Physicians feel that health care is a human right that should be accessible to everyone and not restricted to those with higher incomes:

*I think that everyone deserves the same health care; this is what I think, no matter what. In health care there is no difference between a rich person, and a street sweeper. They all deserve the same treatment.* ~B21 – Infectious disease specialist (public sector exclusively)

Moreover, health care is not a privilege but rather society’s duty to provide, just like the human right to education and to security:

*In my view this is the duty of society… [there are] fundamental rights to housing, security, health, and education.* ~B6 – Pediatric ICU (public sector exclusively)

1. **Good medicine requires total commitment to patients and** this **is easier when working in only one sector.** In Israel the default option is public medicine.

*Working privately, especially when you have too many patients, has a negative effect on your work the next day. When I was a resident, I saw how senior physicians looked after a day in their private clinic. They got home exhausted, and the next day they came to the Department [in the public hospital] without the usual sparkle in their eyes and without enthusiasm to return to routine work. I also would like to earn more, but I made the calculation: if I have any extra energy and time, I prefer researching or traveling abroad rather than taking on more patients in the afternoon.* ~B11 – Infectious disease specialist (public sector exclusively)

*Consider this: If I would operate on a patient in a private hospital and then go to my job in a public hospital I would feel obligated to both patients. If there’s any medical problem with my private patient, I would feel one-hundred percent obligated to take care of him. I’m not willing to sacrifice the health of my patients for an increase in my personal income. ~*B9 – Cardio-surgeon (public sector exclusively)

**Question #2 – How do physicians resolve the conflict in their professional lives, i.e. what solutions do they implement regarding their work in both health systems?**

The physicians interviewed for this study are aware of the tension and problematics in the public-private mix and note the following issues:

1. **Blurring the boundaries between the public and private sector increases inequalities in access to health-care services**. For example, they noted that waiting times are considerably longer in the public sector (Filc & Davidovitch, 2016; Brezis Mayer, Axelrod Tom, Cohen Matan, Keidar Nir, 2012)
2. **The public-private mix takes advantage of the difficulties encountered dealing with the bureaucracy of the public system in order to attract patients to private systems.** Interestingly, doctors who work solely in the public system concur that bureaucratic hassles are real, but are in some cases deliberately exacerbated by the doctors themselves in order to encourage patients’ transfer from the public to the private sector. In addition to factors like long medical queues and service bottlenecks, they point to old-fashioned facilities and crowding in the public system.

*When there’s a choice between sending a patient to a public versus private hospital, many surgeons choose, consciously or unconsciously, to ensure that the pressure in the public system will be so great that it will work in our favor, and we can suggest to the patients a private alternative.* ~B9 – cardio-surgeon (public sector exclusively)

An intensivist described the contradictory interests faced by the doctors who work in both the public and private system. It seems that in each system these doctors have interests that are polar opposites:

*Did you ever try to get an appointment from a specialist in the public system versus her private clinic? I’ll tell you how this works. You phone and say, ‘OK, I’d like an appointment with Dr. A in her clinic (in a public hospital).’ You are told it will take nine months. So you hurry and phone her private clinic and she tells you, come tonight. How do you think this works? Who’s interested in the waiting time being so long? The doctors have a stake in these long waits because this encourages patients to turn to private medicine. ~* B5 – ICU (public sector exclusively)

Not everyone agrees that the red tape and long queues are deliberately encouraged. Physicians who split their time between the public and private spheres do not ascribe the long queues necessarily to doctors' interests but rather to bottlenecks that are inherent in any big system.

*Everywhere it’s the same. In England and in Canada the queues are very long. If you pay from your pocket, the queue is suddenly shorter. ~* B2 – Orthopedic surgeon (public & private sector)

1. **Once physicians get paid per procedure or per patient, and not globally via an overall salary, there is a risk that non-medical considerations (e.g., financial) will cloud the picture.** This can lead to corruption—such as doing unnecessary procedures.

*Patients are sometimes advised to undergo treatments that are unnecessary. Take a case where the indications for a certain treatment are absent. But the minute a patient can pay for the treatment, it suddenly becomes highly recommended. At the other extreme you have patients where nothing further can help. In fact, they might be harmed by further treatment. Still, if they can pay for a treatment, there will always be someone who will explain that a certain treatment is worth trying, even if the odds are only one in a hundred that it will be efficacious.* ~ B9 – Cardio-surgeon (public sector exclusively)

An intensivist (B17) who works in a hospital that offers a private (Sharap) arrangement described her confrontation with the hospital’s management regarding when to release a patient from the ICU unit. The Sharap arrangement enables patients to choose a private doctor, usually a surgeon, who will treat them privately in a public or private nonprofit hospital, for an additional, private fee. The payment is then divided between the physician (around 80%) and the hospital (around 20%) (Achdut & Bin Nun, Gabi, 2012). Due to historical precedent, Sharap is permitted only in two Jerusalem non-profit hospitals (7). When she thinks it is time to release the patient from the ICU, she has encountered situation in which the privately selected Sharap surgeon, or even the hospital’s administration, can apply pressure against releasing the patient, and usually not for medical reasons:

*Say I want to release patient X from intensive care. The Sharap surgeon says, “No, I do not agree.” She wants the patient [to stay] another two days in the ICU because the care here is much better. So the Sharap surgeon says to me, “Leave the patient another two days. Keep her over the weekend with you in the ICU.” The real reason is that the Sharap surgeon might not be there because she’s flying to Prague for two days. “When I get back we can talk…” says the surgeon. This surgeon brings in Y amount of money via Sharap to the hospital. The hospital gets Z percent. Therefore, to paraphrase the Biblical Scroll of Esther, ‘Thus shall be done to the man whom the king desireth to honor.’ So if I want to release the surgeon’s patient, and she doesn’t want to, the Sharap surgeon phones the hospital director. Then I get a call from the director saying, “Why am I being told that you want to release patient X from ICU when her surgeon doesn’t think it advisable?” My medical autonomy in the ICU is undermined. My judgment ignored.* ~B17 – ICU specialist (public sector exclusively)

1. **Physicians cannot really devote oneself seriously to patients while working simultaneously in different institutions.** Patients in both places will be neglected.

*There’s an emotional cost when performing operations in public and in private… When there’s a complication, then you’re preoccupied and cannot completely concentrate on other matters. You want to be totally available for the patient with the complication. If I have a private patient with a complication in Assuta [a private for-profit hospital], and in the morning I am in the Ichilov public hospital, then I may not have a clear mind to function as calmly as I should. I have a colleague who is excellent, a superb physician, a first-rate surgeon, and not long ago there was a complication with a patient on whom he operated in Assuta. That morning he was scheduled to do a big operation in Ichilov. He asked for someone to come help him with the operation in Ichilov, because he was on the phone constantly with the ICU in Assuta. So his head was not in Ichilov at the time.* ~B20 – Orthopedic surgeon (public sector exclusively)

Moreover, a 2018 report from the Ministry of Finance noted that employees in the medical sector are the only public sector workers who are allowed to hold private sector jobs on the side [ref?]. In other professions not only is there a strict separation between the two, but working in both systems at the same time is severely criticized (Belinsky, et al., 2018). One suggestion in the report for addressing this situation unique to the healthcare system was to restrict department heads to working in the public system only, to prevent conflict of interests:

*It shouldn’t be this way. There’s no other area in the country where public servants work in their same profession privately. Can you imagine a justice on the Supreme Court who also gives consultations privately as an attorney? Can you consider the possibility that the director general of the Finance Ministry would also be a consultant to private industry? But in the field of health care, department heads in public hospitals have an interest in patients coming to them privately. This is an unimaginable conflict of interest. The system should insist that anyone who’s a candidate for an administrative position in a public hospital won’t work in any other position. If you don’t want to forgo private practice, no problem. Just don’t aspire to be department head. It cannot be that public hospital department heads will have as a priority their private practice.* ~B15 – Cardio-thoracic surgeon (public sector exclusively)

1. **The public-private mix causes physicians to leave public work early in the day.** As a result, in mid-afternoon there are very few senior physicians in public hospitals. The dual commitment to both private and public sectors interferes not only with medical care but also with other responsibilities, like teaching students and instructing residents. A director voices the difficulties in handling an operation schedule when physicians leave their public workplace in mid-day:

*As a result of forbidden mixture, at 2pm the doctors abandon the hospitals. If they don’t leave physically, their heads are no longer in the hospital. Then the department directors deal with various constraints: “Put me in this operation.” “Don’t put me in that operation.”* ~B22 – General surgeon (public sector exclusively)

**Balancing the public-private mix**

Physicians feel uncomfortable with their own public-private mix. One can see it in the way they talk about the tension between the two systems. They rationalize and insist on explaining why the way they navigate is reasonable. The balancing acts consist of a range of solutions.

1. **Some physicians prevent overlapping by scheduling private practice only on days they do not work or operate in the public hospitals, or by locating the private clinic in walking distance from their public hospital.**

2. **Another way to minimize discomfort is to have an intermediary between physicians and their private patients, such as hiring a secretary to deal with payment.** This way doctors can overcome the discomfort of talking about pecuniary matters with the patient. A cardiologist who works in both sectors in the same place describes how the same secretaries manage his two schedules and both "kinds" of patients.

*In the public clinic there is a separate counter where all the patients register and appointments are made for all kinds of tests. The secretaries who worked for me apparently arrange my private clinic, so the same secretary prints the documents for my private and public patients.* ~B8 – Cardiologist (public and private sector)

3. **At the other end of the spectrum are physicians who felt so uncomfortable that they either had a pro-bono clinic and see private patients free of charge; others have closed their private clinics.**

*I do not take money from the patients. They do not owe me anything. They come here the first time without any obligation, nothing. Whoever wants to come, comes. I see over a thousand patients a year in this manner. It’s called an open clinic. At night, after operations, between operations. I sit here in the evenings and I sometimes see five or six patients, even if I have to stay here until 11 at night.* ~B15 – Cardio-thoracic surgeon (public sector exclusively)

*I made a decision. It is not as if I did not have a private practice. Until eight years ago I also had a private practice. I had huge clinics. Eight years ago I decided to devote myself solely to public medicine and I’m very happy with it. If you are a physician, you have to be a physician and not run around and practice medicine in all kinds of other places…. Look I’m a pancreatic surgeon–I see patients on Saturday mornings when I have a clinic here pro-bono and I don’t charge these needy patients anything.* ~B22 – General surgeon (public sector exclusively)

**Question #3 – What suggestions do physicians offer in order to retain more doctors in the public sphere?**

We have shown that the interviewees are aware of the inherent tension between public and private health-care provision. Interestingly, physicians who were moonlighting in private practice said they would prefer to work only in the public sector: With a slight addition to their public salary and some minor accommodations they say they are willing to forgo their private practice and commit themselves to the public system. Here are their suggestions:

1. **Recruit full-time doctors who will be well paid, especially in the geographic periphery.** Two surgeons even quoted a price they believe will be satisfactory for physicians to stay within the public boundaries.

*I suggest paying a large sum to bring department heads to work full-time in peripheral public hospitals. Here’s a wild exaggeration: $40,000 for a monthly salary. How many department heads in my hospital? Twenty. I am still exaggerating. Do the numbers, what do you get? For $800,000 a month you have improved the quality of medical care by leaps and bounds by bringing in twenty department heads who are big canons. Can’t we afford this?!* ~B13 – cardio-surgeon (public & private sector)

*What is the appropriate remuneration for a senior hospital physician? I think $16,000 a month, net. That would enable a physician to truly have no worries and not have to have [private] clinic hours. That translates into $31,000 gross per month. That’s fair compensation for what I sacrificed in the past, and what I do now. Very reasonable. I don’t want to net $62,000 a month. I know guys who do make that. I don’t know what they do with so much money.* ~B22 – General surgeon (public sector exclusively)

The following doctor cites the example of the solution implemented by the head of a Tel Aviv hospital. It illustrates the willingness of physicians to forgo private clinics in exchange for slight salary raises.

 *Instead of doctors leaving the hospital [for private clinics] they will stay* ***in*** *the hospital, doing medicine in the afternoons, and this will result in shortening the queues. There is no reason not to do this, when it is not at the expense of the hospital, but in the context of an agreement with the supplementary health funds. I think that 80% of the doctors would agree. I believe most doctors would agree to a reduction of about 20% from their salary as long as they do not have to run around. Everything will be in one location.* ~B6 – Pediatric ICU (public sector exclusively)

With respect to the aforementioned full-timer model, a number of conditions would have to be met in order to join. Examples: staying in the hospital a few times a week after four o’clock; doing a night or ER shift once a week; seeing public outpatients in the evenings (thus maximizing the use of existing facilities). This way everyone benefits: doctors gain more income, residents have access to a senior physician; hospitals reduce patient wait times; and patients are more satisfied.

1. **Allow patients to choose their doctor in the health funds and public hospitals.** Several surgical wards in public hospitals have been giving this option for years and recently this spread to governmental medical centers. Physicians feel this would attract patients from the private system to the public health-care system.
2. **Bill private hospitals in cases where complications necessitate moving patients to public hospitals.** Sometimes physicians bring their private patients to a public hospital after complications developed in a private setting.

A different point of view was expounded by physicians favoring expanding the private Sharap model, yet with well-enforced restrictions:

1. **Duplicate the “Sharap” model beyond the current three private nonprofit Jerusalem hospitals, because all parties benefit from this.** Even the public patients benefit indirectly because some of the additional hospital income goes towards hospital improvements.
2. **Strictly enforce separate hours for public and private patients.**
3. **Set minimum thresholds for public procedures before a doctors can see private clients.**

**Discussion**

This study explored physicians' perspectives towards public-private arrangements by considering their 1) motivations, 2) coping mechanisms and 3) suggestions and solutions. The interviewees indicated that the main motivation to engage in private practice is economic – a way to increase their income. Nevertheless, there are key characteristics in the public health sector that physicians do not wish to forgo, which is one reason why most physicians enroll in both health systems and do not engage in the private sector only (Assuta Medical Centers, personal communication, May 26, 2019). At the time of the interviews, these physicians cited academic promotion, research labs, working as a team with shared responsibility, and mutual enrichment were elements that are mainly in public hospitals, although this may be changing.

Currently, physicians who mix public and private go on rounds, teach residents, do research, and perform procedures in the morning in public hospitals, while in the afternoon they go to private institutions where they have no commitment beyond their private patients. One of the surgeons interviewed (B22) suggests an either-or model: two parallel systems like those operating in other national health systems around the world: "In my utopic parallel system surgeons will not wander back and forth between the two sectors."

Vis-à-vis the second question many physicians feel uneasy mixing both public and private sectors and thus find solutions with which they can live comfortably. The dual practice physicians justify themselves by invoking the  need for compensation following years of sacrifice,  by comparing themselves to peers in non-medical professions, and by  pointing to their heavy responsibilities. Some physicians do not feel the need to justify their dual practice because it has become the new norm, and in some cities (e.g., Jerusalem) it is encouraged by the hospitals*.* As far as coping with the tension between public and private, some physicians choose to avoid the tension altogether, by abstaining from private practice. At the other end of the spectrum are those who are heavily engaged in private practice. However, even the latter were somewhat uncomfortable. Examples of coping mechanisms between these two extremes cited by the interviewees include restricting private practice to certain days/hours and hiring an intermediary or secretary to handle monetary issues.

We organized interviewees’ responses to the last question eliciting their suggestions and solutions for preserving the public sector into two clusters: The *egalitarians* and the *pragmatists*. Those we termed *egalitarians* prefer solutions based solely on public institutions. A minority adamantly oppose private medicine as corrupting medical practice, with many opposing even the inclusion of private practice within public institutions. According to the interviews, both groups want to improve the public system on the basis of changes in the public system only. This group advocates expanding the ‘full-timers’ model: physicians who work exclusively in the public system in return for extra pay. Note that among those who suggested this model is a physician quoted above (B13) who himself is working in both systems. Doctors wishing to join this model will be obligated to see outpatients in the evenings (in the hospital’s public outpatient clinic) and remain at the hospital for night shifts. A Norwegian experiment reduced dual practice by 30% using a similar policy. (Johannessen & Hagen, 2014)

The suggestions provided by those termed *pragmatists* do not aim to end dual practice. Instead, their suggestions are intended to eliminate the tensions of dual practice by including private medicine within the public institutions. Their suggestions are grounded either on their belief in the benefits of privatization, or in the belief that given the privatization trend in Israel in the last decades, is impossible to turn the clock back. One physician who opposed private medicine for ethical reasons, agrees that preventing private practice in public hospitals is “closing the door after the horse has bolted.” This group claims that the only way to keep physicians in public hospitals is by instituting the Sharap model in all public hospitals, but with strict regulation.

They argue that private financing within the public system “can also help improve care quality, keep top physicians committed to and practicing in public hospitals via higher pay, and provide additional revenue to improve overall hospital services” (Bowers, 2014). According to the ‘pragmatists,’ it is better to have physicians seeing private patients in the public facilities than physicians leaving the public hospitals at mid-afternoon for their private clinics. This way physicians are committed to only one workplace. However, these solutions do not really address the problems of dual practice; rather, they institutionalize dual practice within the public sector. The problems of this approach are delineated by an intensivist who withdrew from Sharap practice:

*I’m very socialist in my outlook in this sense. You pay health insurance. You pay an HMO. You deserve what is coming to you. If it isn’t coming to you, then even if you pay you should not get it. I don’t think people who pay more deserve to receive more. In my eyes, money is not the highest value. I feel that in this sense I can live comfortably with my conscience today. But I know that my views are unconventional. ~*B17 – ICU specialist (public sector exclusively)

Dual practice, as other forms of public-private mix, presents significant challenges for the public health-care systems. Facing these challenges in ways that not further weaken the public health-care sector requires recruiting physicians’ support. Hence our suggestion to engage physicians’ perspectives in the reforms aimed at supporting the public health system. Once again, we find that some physicians declare they are willing to commit themselves to the public system and to forgo their private practice in return for a slight raise their salary. Thus, it is worthwhile putting into action their ideas on how to improve the public health-care system.

**Limitations**

The views represented in this study are specific to the 23 physicians we approached and who agreed to share their opinions. Despite the limited sample, their varied and even contradictory views satisfied our goal of raising the range of issues germane to this topic. This lends credibility to our contention that the interviews reliably reflect a spectrum of opinions. We have one caveat. Among the 23 physicians interviewed, only 4 were women. Even though to date there are more male senior physicians, further research should aim to include a roughly similar number of men and women.

Further, our study focused on current health care in Israel which is dynamic and includes ongoing attempts to improve the public system. Further research would benefit from an examination of the impact on the public-private mix after implementation of some recent reforms, among them those promoted by the Ministry of Health and our research.

**Conclusion**

Health-care providers and policy strategists agree that the public health system in Israel is deteriorating [refs]. To implement reforms, physician engagement is necessary. Physicians must feel that their everyday work life and priorities are taken into account with any proposed changes. Our study is a first attempt to reveal the range of physician attitudes and concerns around the public-private mix in the Israeli health-care system. On the one hand, doctors want what is best for their patients and part of this is achieved by maintaining senior physicians in the public health-care system. On the other hand, doctors expect fair pay and respect for their investment in education, their dedication and their responsibility for patients’ lives. Our interviews suggest that physicians’ commitment to the public sector can be strengthened by listening to their preferences and implementing some of their suggestions. Perhaps such changes may might even convince physicians who moved to the private sector to return to the public health-care system.

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**References**

Achdut, L. & Bin Nun, G. (2012). [INSERT TRANSLITERATED TITLE IN ITALICS][English Translation: The Private-Public Mix in the Health System in Israel—The Case of Private Health Service in Public Hospitals.] Van Leer Institute Press.

Belinsky, A., Ben Naim, G. & Hecht, Y. (2018). [INSERT TRANSLITERATED TITLE IN ITALICS][English Translation: Physicians’ Pre-tax Pay from Public and Private Medicine in Governmental Hospitals – Findings and Trends].*.*https://www.gov.il/BlobFolder/reports/article\_29012018/he/Publishes\_Article\_29012018.pdf

Bowers, L. (2014). *Hot Issues in Israel’s Healthcare System* (Policy Brief, p. 11). Taub Center. https://www.taubcenter.org.il/wp-content/uploads/2020/12/htissues\_taubcenter.org\_.il\_tauborgilwp\_wpcontent\_uploads\_e2014healthcarepolicybrief.pdf

Ferrinho, P., Van Lerberghe, W., Fronteira, I., Hipólito, F., & Biscaia, A. (2004). Dual practice in the health sector: Review of the evidence. *Human Resources for Health*, *2*(1), 14. https://doi.org/10.1186/1478-4491-2-14

Ferrinho, P., Van Lerberghe, W., Julien, M. R., Fresta, E., Gomes, A., Dias, F., Gonçalves, A., & Bäckström, B. (1998). How and why public sector doctors engage in private practice in Portuguese-speaking African countries. *Health Policy and Planning*, *13*(3), 332–338. https://doi.org/10.1093/heapol/13.3.332

Filc, D., & Davidovitch, N. (2016). Rethinking the private–public mix in health care: Analysis of health reforms in Israel during the last three decades. *Journal of Health Services Research & Policy*, *21*(4), 249–256. https://doi.org/10.1177/1355819616650470

Filc, D., Rasooly, A., & Davidovitch, N. (2020). From public vs. private to public/private mix in healthcare: Lessons from the Israeli and the Spanish cases. *Israel Journal of Health Policy Research*, *9*(1), 31. https://doi.org/10.1186/s13584-020-00391-4

García-Prado, A., & González, P. (2011). Whom do physicians work for? An analysis of dual practice in the health sector. *Journal of Health Politics, Policy and Law*, *36*(2), 265–294. https://doi.org/10.1215/03616878-1222721

Glaser, B. G. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago : Aldine Pub. Co.

González, P. (2004). Should physicians’ dual practice be limited? An incentive approach. *Health Economics*, *13*(6), 505–524. https://doi.org/10.1002/hec.890

Humphrey, C., & Russell, J. (2004). Motivation and values of hospital consultants in south-east England who work in the national health service and do private practice. *Social Science & Medicine*, *59*(6), 1241–1250. https://doi.org/10.1016/j.socscimed.2003.12.019

Johannessen, K.-A., & Hagen, T. P. (2014). Physicians’ engagement in dual practices and the effects on labor supply in public hospitals: Results from a register-based study. *BMC Health Services Research*, *14*(1), 299. https://doi.org/10.1186/1472-6963-14-299

1. Sharap is the Hebrew acronym **Sh**erut **R**efuah **P**ratie, private health service. [↑](#footnote-ref-1)