DUALNA PRAKSA, FAKTORI I REŠENJA ZA ZDRAVSTVENE RADNIKE

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REVIEW ARTICLE

DUAL PRACTICE, FACTORS AND SOLUTIONS FOR HEALTHCARE PROFESSIONALS

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SAŽETAK

Dualna praksa je fenomen koji se pojavljuje u najvećem broju zemalja, ali je primetno učestalija u zemljama sa niskim dohotkom, kao što je naša, i u poslednje vreme sve više dobija na značaju zbog mogućnosti da doprinese pogoršanju nedovoljnog broja profesionalnih zdravstvenih radnika u sistemima zdravstvene zaštite. Razlozi koji dovode do dualne prakse nisu dovoljno proučeni. Rezultati uglavnom ukazuju na ekonomske faktore kao prediktore, ali osim pomenutih faktora neophodno je istraživati prevalencije, stvarne posledice, upravljanje ovim fenomenom, kao i procenu uticaja političkih mera sprovedenih u ovoj oblasti. Iako se dualna praksa smatra mogućim sistemskim rešenjem za pitanja kao što su ograničeni resursi (i prihodi) javnog sektora, niski regulatorni kapaciteti i uzajamno delovanje između tržišnih snaga i ljudskih resursa, ukoliko je loše regulisana, može dovesti do sukoba interesa, kao i odliva resursa iz javnog u privatni sektor. Optimalna regulacija situacije i mobilnosti zdravstvene radne snage zavisi od okolnosti u zemlji, sposobnosti vlade i poboljšanja zdravstvenog sistema. Na međunarodnom nivou vlade različito reaguju na fenomen dualne prakse. Da bi se prepoznala uloga dualne prakse i mobilnosti na tržištu zdravstvene radne snage, stručnjaci zagovaraju više podataka o dualnoj praksi zdravstvenih radnika i potrebu integrisanja ovih podataka u nacionalne račune zdravstvene radne snage. Istaknuta je potreba izrade nacionalne zdravstvene politike za praćenje dualne prakse i u našoj zemlji, kao i razvoj strategija za ublažavanje negativnih efekata. Ovaj rad analizira dostupnu literaturu o dualnoj praksi, faktore koji utiču na pojavu ovog fenomena, kao i o moguća rešenja za zdravstvene radnike.

Ključne reči: dualna praksa, zdravstveni sektor

ABSTRACT

Dual practice is a phenomenon found in most countries, but it is noticeably more frequent in low-income countries, such as ours. It has been gaining more and more importance lately due to the fact that it may contribute to reducing the already insufficient number of professional health workers in healthcare systems. The reasons that lead to dual practice have not been sufficiently studied. Research results mainly point to economic factors as predictors, but apart from these factors, it is necessary to investigate the prevalence, real consequences, managing this phenomenon, as well as the assessment of the impact of policy measures implemented in this area. Although dual practice is seen as a possible systemic solution to issues such as limited resources (and revenues) in the public sector, low regulatory capacity and the interaction between market forces and human resources, if poorly regulated, it can lead to a conflict of interest as well as resource drain from the public to the private sector. An optimal regulation of the situation and the mobility of health workforce depends on the exceptional circumstances of the country, government capabilities, and the improvement of the health system. At the international level, governments react differently to the phenomenon of dual practice. To recognize the role of dual practice and mobility in the health workforce market, experts advocate more data on dual practice of healthcare workers and the need to integrate these data into national health workforce accounts. The need to develop a national health policy for monitoring dual practice in our country and to develop strategies for mitigating negative effects was highlighted. This paper analyzes the available literature on dual practice, the factors that influence the emergence of this phenomenon, and possible solutions for health workers.

Keywords: dual practice, health sector

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UVOD

Dualna praksa je prisutna u većini zemalja, ako ne i u svim, ima različite oblike i učestalost. Na primer, prekovremeni rad se može smatrati oblikom dvojnog zapošljavanja. U literaturi, dualna praksa se opisuje na različite načine. Ona može ukazati na lekare sa višestrukim specijalizacijama, kao što je slučaj sa egipatskim lekarima, gde su najpopularnije oblasti višestrukih specijalizacija kardiologija i interna medicina npr. [1]. Takođe, može značiti zdravstvene radnike koji rade u različitim disciplinama (osteopatija, homeopatija, alopatska medicina u kombinaciji sa tradicionalnom medicinom - kineskom, afričkom, i sl) [2]. Dualna praksa je kombinovanje različitih oblika zdravstvene prakse - kliničke sa istraživačkim, podučavanjem ili sa menadžmentom, ili čak kombinacija profesionalne zdravstvene prakse sa ekonomskom aktivnošću koja nije u vezi zdravlja (poput poljoprivrede) [2]. U okviru istraživanja dualne prakse je posebno interesantan paralelni rad zaposlenih u javnom zdravstvenom sektoru i privatnoj praksi. Razlozi koji dovode do dualne prakse nisu dovoljno proučeni. Uglavnom, rezultati ukazuju na nezadovoljstvo od strane zaposlenih u državnim ustanovama koje je vezano za materijalnu nadoknadu, radne uslove, profesionalno nezadovoljstvo, nedovoljnu motivaciju i sl. Pojedine studije pokazuju da su razlozi kontekstualni, i da se razlikuju u zavisnosti od profesionalnih grupa i mesta zaposlenja [3-5], a da je dualna praksa učestalija kod lekara specijalista koji su zaposleni u bolnicama, u odnosu na druge profesionalne grupe, i one koji rade u domovima zdravlja. Prema Feringu i saradnicima [2] dualna praksa se može očekivati i kao rezultat reforme zdravstvene zaštite, kao što je slučaj u Kanadi [6], gde je restruktuiranje hirurškog rada dovelo do 3,5 puta većeg broja hirurga, koji rade u više okruženja u odnosu na period pre reforme. U literaturi ne postoji dovoljno čvrstih dokaza o tome u kojoj meri zdravstveni radnici koriste dualnu praksu, o ravnoteži ekonomskih i drugih motiva za to, ili o konsekvencama u smislu pravilnog korišćenja oskudnih javnih resursa posvećenih zdravlju [2]. Iako se dualna praksa smatra mogućim sistemskim rešenjem za pitanja kao što su ograničeni resursi (i prihodi) javnog sektora, niski regulatorni kapaciteti i uzajamno delovanje između tržišnih snaga i ljudskih resursa [7], ukoliko je loše regulisana, u smislu nedostatka propisa ili njihove slabe implementacije, može dovesti do sukoba interesa, grabežljivog ponašanja zdravstvenih radnika, ograničenja pristupa uslugama, niskog kvaliteta usluga korisnicima u javnom sektoru, kao i odliva resursa iz javnog u privatni sektor [2].

Osim istraživanja ekonomskih faktora kao prediktora dualne prakse [3,7,8], neophodno je istraživati prevalencije, stvarne posledice, upravljanje ovim feno-

INTRODUCTION

Dual practice is present in most countries (if not in all), where its prevalence and forms vary considerably. For example, working overtime can be considered a form of dual employment. Literature describes dual practice in various ways. It may refer to physicians with multiple specialties as is the case in Egypt, where the most popular areas of multispecialty are cardiology and internal medicine [1]. Apart from this, dual practice may include healthcare professionals who are involved in different disciplines (e.g., osteopathy, homeopathy, allopathy, in combination with traditional medicine – Chinese, African, etc.) [2]. Dual practice means combining different forms of healthcare practice – it may be clinical practice combined with research, teaching or management, or even professional healthcare practice combined with an economic activity unrelated to health (e.g., agriculture) [2]. When researching dual practice, it is particularly interesting to investigate employees who simultaneously work in the public health sector and in private practice. The reasons that lead to dual practice have not been sufficiently studied. The available results mainly indicate that employees who work in public institutions are dissatisfied with their income and working conditions, and that they also show professional dissatisfaction, insufficient motivation, etc. Some studies indicate that the results are related to context, that they differ depending on the professional group and place of employment [3-5], and that dual practice is more common among specialist doctors who work in hospitals than in other professional groups or among doctors who work in health centers. According to Ferrinho et al. [2], dual practice can also be expected as a result of health care reform like in Canada [6], where restructuring of the surgical service resulted in 3.5 times more surgeons working in more environments than before the reform. Literature does not provide enough facts on to what extent healthcare professionals use dual practice, the balance between economic and other motives for using this practice, or the consequences concerning the proper use of scarce public resources intended for health care [2]. Although dual practice is considered a possible systemic solution to issues such as limited resources (and revenues) in the public sector, low regulatory capacity and interaction between market forces and human resources [7], if poorly regulated (i.e., there is a lack of regulations or they are insufficiently applied), it may lead to a conflict of interest, predatory behavior of healthcare workers, limitations in accessing services, poor quality of services provided to the users in the public sector, as well as resource drain from the public sector to the private sector [2].

menom, kao i procenu uticaja političkih mera sprovedenih u ovoj oblasti.

DUALNA PRAKSA U SRBIJI I SVETU

Dualna praksa je fenomen koji se pojavljuje u najvećem broju zemalja, ali je primetno učestalija u zemljama sa niskim dohotkom, kao što je naša [9-13], i u poslednje vreme sve više dobija na značaju zbog mogućnosti da doprinese pogoršanju nedovoljnog broja profesionalnih zdravstvenih radnika u sistemima zdravstvene zaštite [14]. U literaturi je uočeno da zdravstveni radnici sa niskom platom, kao što je to slučaj u Srbiji [10,11], rade na više poslova kako bi sastavili kraj s krajem [12,13,15,16]. U Mreži javnih zdravstvenih ustanova Srbije [17], zdravstveni radnici su nezadovoljni uglavnom platama i beneficijama, opremom i preopterećenjem poslom [18], jer su ispod republičkog proseka već nekoliko godina [10-12] tako da dualna praksa predstavlja strategiju preživljavanja, slično kao u zemljama u svetu [7].Optimalna regulacija situacije i mobilnosti zdravstvene radne snage zavisi od okolnosti u zemlji, sposobnosti vlade i poboljšanja zdravstvenog sistema [8,19]. U Republici Srbiji, aktuelni Zakon o zdravstvenoj zaštiti (član 199) [20] i Zakon o radu (član 202) [21] daju mogućnost zaposlenima sa punim radnim vremenom (u državnim ili privatnim sektorima), da uz primarno radno mesto imaju dodatni posao do 30% ukupnog radnog vremena. Noviji podaci ispitivanja zadovoljstva zaposlenih u državnim ustanovama Republike Srbije iz 2018. godine [22] naglašavaju da od 2014. godine raste broj onih koji planiraju da odu u privatni sektor zdravstva, i da skoro 1/2 lekara i 1/3 medicinskih sestara imaju neki oblik dualne prakse [22] (318). Brojne studije su potvrdile da je i u svetu uobičajena dualna praksa: 43% u Velikoj Britaniji [23]; 20% lekara u Španiji [24]; 79% u Australiji [2]; 80% lekara iz javnog sektora Egipta, Indonezije i Kenije [25]; i gotovo 100% lekara u Austriji nosioci su dualne prakse [26]. Slično istraživanju u Srbiji [27] pokazalo je da su zaposleni na tercijarnom i sekundarnom nivou zdravstvene zaštite češće nosioci dualne prakse, kao i lekari zaposleni u bolnicama u odnosu na druge kategorije zanimanja: prevalenca je otprilike 90% lekara iz državnog sektora u Irskoj [26], 60% lekara u Velikoj Britaniji i Severnoj Irskoj [2] i 25% bolničkih lekara u Norveškoj [28]. Novije istraživanje iz Srbije [27] ističe da su nosioci dualne prakse u većoj meri stariji od 55 godina, dok druge studije u svetu potvrđuju da su stariji kadrovi [26] i specijalisti [28] u većoj meri nosioci dualne prakse nego njihove kolege, na primer, u Austriji gotovo 100% starijih lekara specijalista imaju dualnu praksu [26]. Na rasprostranjenost dualne prakse ukazuju i studije na drugim kontinentima. U Australiji medicinske sestre pokazuju sklonost

Apart from economic factors as predictors of dual practice [3,7,8], it is also necessary to research its prevalence, real consequences, managing this phenomenon, as well as the assessment of the impact of policy measures implemented in this field.

DUAL PRACTICE IN SERBIA AND WORLDWIDE

Dual practice is a phenomenon found in most countries, but it is significantly more frequent in low-income countries, such as ours [9-13] and it has been gaining more and more importance lately due to the fact that it may contribute to reducing the already insufficient number of professional health workers in healthcare systems [14]. It has been noted in literature that healthcare professionals with low salaries, as is the case in Serbia [10,11], do multiple jobs to make the ends meet [12,13,15,16]. When it comes to the public healthcare network in Serbia [17], healthcare professionals are generally dissatisfied with salaries, benefits, equipment and workload [18] as their salaries have been below the national average income for several years now [10-12], so dual practice is a survival strategy like in multiple countries worldwide [7]. An optimal regulation of the situation and the mobility of health workforce depends on the exceptional circumstances of the country, government capabilities, and the improvement of the health system [8,19]. In the Republic of Serbia, the current Law on Health Care (Article 199) and the Employment Act (Article 202) [21] enable full-time employees (both in the public and the private sector) to have an additional job up to 30% of the total working time in addition to their primary job. Recent data from a survey of employee satisfaction in public institutions of the Republic of Serbia conducted in 2018 [22] indicate that since 2014 the number of those who are planning to go to the private healthcare sector has been on the rise, and that almost half of all doctors and one-third of nurses use some form of dual practice [22] (318). Various studies have shown that dual practice is common worldwide – 43% in Great Britain [23], 20% of all doctors in Spain [24], 79% in Australia [2], 80% of doctors from the public sector in Egypt, Indonesia and Kenya [25], and almost 100% of doctors in Austria are holders of dual practice [26]. A similar study in Serbia [27] showed that the employees at the tertiary and the secondary level of healthcare are more often holders of dual practice, as well as the doctors employed in hospitals, in comparison with other professional groups: the approximate prevalence is 90% of doctors in the public sector in Ireland [26], 60% of doctors in Great Britain and Northern Ireland [2], and 25% of clinical doctors in Norway [28]. A recent study from Serbia [27] points out that holders of dual practice are

povremenim poslovnim angažmanima [29] i nepoznata je demografska slika radne snage za sestrinsku negu koja je privremeno ili povremeno angažovana, kao i kako su te grupe raspoređene u odnosu na drugi kadar i koliko ugovora o radu imaju preko zdravstvene službe - bilo kroz privatne agencije za negu ili povremene bolničke angažmane [30]. Prethodno navedno ukazuje da dualna praksa kao fenomen, nije isključivo prisutna u kategoriji lekara, već se često pronalazi i kod drugih zdravstvenih profesionalaca. U Južnoj Africi [31] 80 bolnica daje podatke da je 40,7% medicinskih sestara prijavilo rad van posla, ili radilo za agenciju u prethodnoj godini. Među onima koji rade na više mesta, 11,9% je otišlo na odmor da rade preko agencije, a 9,8% je prijavilo konfliktne rasporede između svojih primarnih i sekundarnih poslova, dok su medicinske sestre koje rade dualno bile znatno češće na bolovanju i manje pažnje posvetile svom radu na redovnom poslu [31]. Pojedine studije ukazuju da rukovodioci zdravstvenog sistema imaju manje mogućnosti za dualnu praksu nego klinički [2], dok rezultati studije koja je ispitivala prisutnost dualne prakse u zemljama u razvoju, na uzorku od 138 lekara sa diplomom menadžera u javnom zdravstvu, ističu rezultate da impresivnih 87% ispitanika dopunjuje svoje plate najmanje jednim od sledećih načina: rade za nevladine organizacije ili razvojne agencije, privatnu praksu ili imaju druge aktivnosti koje stvaraju dohodak, tako da dodatnim radom doprinose povećanju od 50 do 80% na plate u javnom sektoru što izaziva posledice kao što su odliv resursa iz javnog sektora i sukob interesa [13]. Prethodno pomenuto istraživanje iz Srbije [27] ukazuje na rezultate da osobe koje rade u ustanovama na tercijarnom nivou zdravstvene zaštite imaju 1.97 puta veću verovatnoću da će imati dualnu praksu, u poređenju sa zaposlenima u ustanovama primarne zdravstvene zaštite. Takođe, prema ovoj studiji, veću verovatnoću za dualnu praksu imaju osobe koje su nezadovoljne poslom, osobe muškog pola, dok medicinsko osoblje ima skoro dva puta veću verovatnoću da će imati dualnu praksu, od nemedicinskog osoblja, i to u najvećoj meri lekari i medicinske sestre [27]. Pomenuta studija [27] daje podatak da osobe koje nemaju rukovodeću poziciju imaju veću verovatnoću da će imati dualnu praksu, u poređenju sa osobama na rukovodećim funkcijama. Smatra se da dualna praksa raste zbog mera ograničavanja troškova ili nedostatka osoblja [2], dok pojedini istraživači ističu da su bolja oprema, vrednovanje rada zaposlenih i raspoloživo radno vreme važni za visoko obrazovane radnike i starije osobe koji smatraju da dualna praksa povećava njihovu kliničku autonomiju i omogućava potpunu upotrebu njihovih veština [32,33].

REGULATORNA REŠENJA DUALNE PRAKSE U

mostly older than 55 years, while other studies worldwide have also confirmed that senior staff [26] and specialist doctors [28] are more often holders of dual practice than their colleagues; for example, almost 100% of senior specialist doctors in Austria are engaged in dual practice [26]. Studies conducted on other continents also point to the prevalence of dual practice. Nurses in Australia show a preference for casual employment [29], while the demographics of the nursing workforce who are employed temporarily or casually is unknown, as well as how these groups are distributed in relation to other staff and how many contracts of employment they have achieved through health services, either through private health agencies or occasional hospital engagements [30]. The aforementioned indicates that the phenomenon of dual practice is not only present in the category of doctors but is also common among other health professionals. According to data from 80 hospitals in South Africa [31], 40.7% of nurses reported working outside the institution where they were officially employed or working for an agency in the previous year. Among those who had multiple jobs, 11.9% took a holiday so that they could work for an agency, 9.8% reported conflicting schedules between their primary and secondary jobs, while nurses who had dual practice were significantly more often on sick leave and paid less attention to their primary job [31]. Some studies indicate that health system managers have fewer opportunities for dual practice than clinicians [2], while the results of a study that researched the presence of dual practice in developing countries on a sample of 138 doctors with a degree in public health management indicate that 87% of participants earned extra income in at least one of the following ways: by working for non-governmental organizations or development agencies, by having private practice or doing another activity that supplemented their income; so, with an additional job they increase their income in the public sector by 50% to 80% which results in resource drain from the public sector and a conflict of interest [13]. The previously mentioned research from Serbia [27] indicates that individuals who work at tertiary health care institutions are 1.97 times more likely to be engaged in dual practice compared to the employees of primary health care institutions. In addition, according to this study, individuals who are dissatisfied with their jobs and male individuals are more likely to have dual practice, whereas medical staff (especially doctors and nurses) are almost twice as likely to be engaged in dual practice than non-medical personnel [27]. In this study [27] it is also stated that individuals who do not have a managerial position are more likely to have dual practice in comparison with individuals appointed to

SRBIJI I SVETU

Na međunarodnom nivou vlade različito reaguju na fenomen dualne prakse [26]. Pojedina istraživanja ukazuju da se dualna praksa navodi kao modus u regulisanju ograničenih resursa u javnom sektoru zdravstvene zaštite [7], ali pod uslovom da je regulisana ugovornim aranžmanom [16]. Najčešći regulatorni propisi kojima se fenomen dualne prakse kontroliše odnosi se na tri vrste intervencija: prvo je ponuda regulatornih ugovora zaposlenima u javnom sektoru, drugo je zabrana dualne prakse, i treće je ograničavanje stepena učešća u primanjima i participaciji u privatnim aktivnostima [26]. Rezultati istog istraživanja ukazuju na potrebu prilagođavanja propisa različitim ekonomskim okruženjima [26]. Dualna praksa se preporučuje u obliku ugovornog aranžmana [33], i redovno se kontroliše kako bi zdravstvene radnike sprečila da veću pažnju i napore u radu usmere prema njihovim privatnim praksama [2,3,34,35], ili da koriste svoj položaj i resurse u javnom sektoru kako bi povećali svoju reputaciju [2,12,15,29,35], i preusmerili profitabilne pacijente u svoju privatnu praksu [15,29,36-38]. Studija iz Bangladeša [15] istraživala je lekare zaposlene u javnom sektoru na različitim institucionalnim nivoima, a koji su ujedno nosioci i dulne prakse, ukazuje na rezultate da je većina ispitanika izjavila da je najmanje udvostručila prihode uključivanjem u privatnu praksu. U Republici Srbiji, aktuelni Zakon o zdravstvenoj zaštiti (član 199) [20] i Zakon o radu (član 202) [21] omogućavaju zaposlenima sa punim radnim vremenom (u državnim ili privatnim sektorima), da uz primarno radno mesto imaju dodatni posao do 30% ukupnog radnog vremena. Zaposleni su zakonski obavezni da obaveste svoje direktore i Ministarstvo zdravlja o korišćenju dualne prakse i da plaćaju porez, ali nisu zakonski ograničeni u vezi sa sektorima u kojima mogu da primenjuju dualnu praksu (na primer, u privatnoj praksi, obrazovanju, ili drugim sektorima), i nema zvaničnih procena o prevalenciji dualne prakse. U odsustvu strateških rešenja, neki koraci su preduzeti da bi se ublažio odliv zdravstvenih radnika iz državnih zdravstvenih ustanova, kao što su mogućnost rada za dva ili više poslodavaca (dualna praksa) ili prekovremeni rad za jednog poslodavca [20], volonterske specijalizacije, stipendiranje i zapošljavanje najboljih studenata. U Hrvatskoj, zemlji EU, ako institucija ima zajednički ugovor za dualnu praksu, svi zaposleni, osim direktora, zamenika i pomoćnika direktora, mogu raditi u ovim institucijama godinu dana [39], dok su pojedini istraživači jasno ukazali da u Hrvatskoj postoji svest o posledicama neregulisane dualne prakse, jer ovakav rad bez preciznih propisa može dovesti do ozbiljnog sukoba inte-

a managerial position. Dual practice is thought to be more common due to cost containment strategies or staff shortages [2], while some researchers point out that better equipment, employee performance evaluation, and available working hours are important for highly educated employees and senior employees who believe that dual practice increases their clinical autonomy and enables their skills to be used to their full potential. [32,33].

REGULATORY RESPONSES TO DUAL PRACTICE IN SERBIA AND WORLDWIDE

At the international level, governments have different reactions to the phenomenon of dual practice [26]. Certain studies indicate that dual practice is a mechanism in regulating limited resources in the public health sector [7], but on condition that it is regulated by a contractual agreement [16]. The most common regulations that control the phenomenon of dual practice refer to three types of interventions: (1) offering regulatory contracts to employees in the public sector, (2) banning dual practice, and (3) limiting the level of participation in income and private activities [26]. The results of this research point to the need for adapting the regulations to different economic systems [26]. Dual practice is recommended in the form of contractual arrangement [33] and is constantly monitored so as to prevent healthcare professionals from paying more attention and putting more effort into their private practice [2,3,34,35] or from using their position or resources in the public sector to improve their own reputation [2,12,15,29,35] and direct profitable patients to their private practice [15,29,36-38]. In a study conducted in Bangladesh [15], which surveyed physicians employed in the public sector at different institutional levels who were also engaged in dual practice, most participants reported at least doubling their income by entering private practice. In the Republic of Serbia, the current Law on Health Care (Article 199) and the Employment Act (Article 202) [21] enable full-time employees (in either public or private sector) to have an additional job up to 30% of the total working time in addition to their primary position. Employees are legally obliged to inform their directors and the Ministry of Health of the Republic of Serbia of holding dual practice and to pay tax, but they are not legally limited in relation to the sectors where they can apply dual practice (e.g., in private practice, in education, or in other sectors), and there are no official estimates on the prevalence of dual practice. As there are no strategic solutions, some steps have been taken to mitigate the outflow of healthcare professionals from state healthcare in-

resa [40,41]. U Federaciji Bosne i Hercegovine, dualna praksa može biti u obimu do jedne trećine redovnog radnog vremena, i uz odobrenje odgovorne komore i poslodavaca [42]. U Federaciji Bosne i Hercegovine građani dobijaju zdravstvenu zaštitu od javnih i privatnih pružalaca usluga, a istraživanje koje je ispitivalo način pružanja zdravstvenih usluga, posebno u pogledu odnosa između javnih i privatnih pružalaca usluga napominje da javni sektor trpi brojne slabosti u pogledu neefikasnosti pružanja usluga, slabo motivisanog osoblja, rasprostranjenost dualne prakse zaposlenih u javnom sektoru, loših uslova rada i geografskih neravnoteža [43]. Glavni metod koji su koristili autori bio je pregled i analiza glavnih pravnih, političkih i strateških dokumenata o zdravstvenom sistemu, relevantnih za utvrđivanje javnog i privatnog sektora u sistemu zdravstvene zaštite Federacije BiH. Autori su takođe analizirali tehničke dokumente, izveštaje o projektima i publikacije, koje su izradile agencije koje su bile, ili su vodile projekte u BiH. Malo ili nimalo integrisanih podataka o sastavu i aktivnostima privatnog zdravstvenog sektora u Federaciji BiH otežalo je analize i poređenje. U Crnoj Gori samo radnici sa pismenim odobrenjem od direktora mogu imati dualnu praksu [44]. U Severnoj Makedoniji uslovi i naknade za dualnu praksu unapred su regulisani pismenim sporazumom / ugovorom i odnose se na učešće na sastancima, konsultantske ili savetodavne radove, istraživanje tržišta, medicinske, naučne studije, klinička ispitivanja ili obuke [45]. Pregledom literature o dualnoj praksi uočeno je da samo ograničenje dualne prakse bez podsticajnih radnih uslova može dovesti do „odliva mozgova“ zdravstvenih radnika [24,32]. Ograničena dualna praksa, nezadovoljstvo uslovljeno individualnim i organizacionim faktorima veoma često usmeravaju zdravstvene profesionalce i na prekograničnu mobilnost [24,32,33].

ZAKLJUČAK

Pregled literature je ukazao da se u Srbiji, zemljama u okruženju, kao i u većini zemalja u svetu održava nepovoljan trend, u oblasti ljudskih resursa za zdravlje, gde nezadovoljni profesionalci rade poslove van ustanova u kojima su zaposleni ili imaju u planu da napuste zemlju u potrazi za boljim mogućnostima. Nezadovoljstvo zdravstvenog kadra i sklonost ka mobilnosti može imati nepovoljan uticaj na efikasno funkcionisanje zdravstvenog sistema u celini. Da bi se prepoznala uloga dualne prakse i drugih vidova mobilnosti na tržištu zdravstvene radne snage, neophodno je naglasiti važnost sistematskog praćenja, prikupljanja podataka, izveštavanja i procene radne snage, distribucije i aktuelne situacije u Srbiji i u drugim zemljama. Jačanje

stitutions, such as the possibility of working for two or more employers (dual practice) or working overtime for one employer [20], voluntary residency, scholarships, and employing the best students. In Croatia, an EU country, if the institution has a joint contract for dual practice, all employees except for the director, deputy director and assistant director can work at these institutions for a year [39], while some researchers clearly stated that Croatians were well aware of the consequences of unregulated dual practice, because holding dual practice without clear regulations could result in a serious conflict of interest [40,41]. In the Federation of Bosnia and Herzegovina, dual practice is allowed in the scope of up to one third of regular working time, and with the approval of the responsible chamber and employers [42]. In this country, citizens receive health care from public and private healthcare providers, and a study that examined the way of providing healthcare services, especially with regard to the relationship between public and private service providers, indicates that the public sector has numerous weak points such as ineffective service providing, poorly motivated staff, high prevalence of dual practice among employees in the public sector, poor working conditions, and geographical imbalance [43]. The main method used by the authors was to review and analyze the main legal, political, and strategic documents on healthcare system that are relevant for determining the public sector and the private sector in the healthcare system of the Federation of Bosnia and Herzegovina. The authors also analyzed technical documents, project reports and publications produced by agencies that had operated in the federation of Bosnia and Herzegovina or managed projects in that country. Very scarce integrated data on the composition and activities of the private health sector in the Federation of Bosnia and Herzegovina made the analysis and comparison more difficult. In Montenegro only employees with a written approval signed by the director can be engaged in dual practice [44]. In the Republic of North Macedonia, the terms and fees for dual practice are regulated in advance by a written agreement/contract and they relate to participation in meetings, consulting, market research, medical and scientific studies, clinical trials or trainings [45]. Reviewing the literature on dual practice shows that limiting dual practice without offering better working conditions can result in brain-drain among healthcare professionals [24,32]. Limited dual practice, dissatisfaction caused by personal and organizational factors very often make healthcare professionals opt for cross-border mobility [24,32,33].

podataka i dokaza o zdravstvenoj radnoj snazi je preduslov za efikasno poboljšanje zdravlja stanovništva i plodnu međunarodnu javno-zdravstvenu saradnju. Postoji potreba proširivanja istraživanja u vezi razloga koji dovode do dualne prakse kojim bi se dopunili nedostaci naučne literature u nekim oblastima koji su u vezi sa ovim fenomenom u smislu prevalencije, stvarnih posledica, upravljanja ovim fenomenom. Posebno je značajno istražiti procenu uticaja sprovedenih mera politike, u zemljama u okruženju, ali i svetu, oslanjajući se na iskustva prethodnih tranzicionih zemalja. Uticaj trenutne regulacije dualne prakse u Srbiji zahteva adekvatnu procenu kako bi se utvrdilo u kojoj meri utiče na efikasno raspoređivanje zdravstvene radne snage u ustanovama javno-zdravstvenog sektora npr. efikasnost radnog vremena, produktivnost, naknade i troškove zamene i povećanje vremena čekanja pacijenta, troškove pacijenata ili smanjenje kvaliteta pristupačnosti usluga. Takođe, treba utvrditi u kojoj meri omogućava međunarodna poređenja (npr. sa evropskim zakonodavstvom ili politikama u drugim zemljama) i treba ga nadograditi u skladu s tim. Međunarodni eksperti zagovaraju više podataka o dualnoj praksi radne snage i potrebu integrisanja ovih podataka u nacionalne račune zdravstvene radne snage [46], kako bi se menadžerima pomoglo u kreiranju i korišćenju potrebnih kapaciteta zdravstvene radne snage za postizanje univerzalne zdravstvene pokrivenosti. Dopunjavanje indikatora o zdravstvenim kadrovima, za koje SZO smatra [47] da doprinose dobrom upravljanju i donošenju odluka u zdravstvenom sistemu, kao i kreiranje informacionog sistema i kvalitetne baze podataka omogućili bi međunarodnu uporedivost. Istaknuta je potreba izrade nacionalne zdravstvene politike za praćenje dualne prakse u Srbiji, kao i razvoj strategija za ublažavanje negativnih efekata [48].

NAPOMENA

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CONCLUSION

The review of literature indicates that in Serbia, its neighboring countries and in most countries in the world there is an unfavorable trend in the field of human resources for healthcare where unsatisfied professionals do jobs outside the institutions where they are employed or plan to leave the country in search of better opportunities. Dissatisfaction of healthcare professionals and the tendency to mobility can have an influence on the efficient functioning of a healthcare system in general. In order to recognize the role of dual practice and other types of mobility on health workforce market, it is necessary to emphasize the importance of systemic monitoring, data collection, reporting and evaluation of workforce, distribution and current situation in Serbia and other countries. Supplementing data and strengthening evidence on the healthcare workforce are preconditions for effective improvement of population health and fruitful international cooperation in the field of public health. There is a need to expand research by examining the reasons for dual practice which would fill the gaps in the scientific literature in some areas related to this phenomenon in terms of prevalence, real consequences, and its management. Researching the assessment of the impact of implemented policy measures in the neighboring countries and worldwide, relying on the experiences of other countries that have previously gone through the period of transition, is of great importance. The impact of the current regulation of dual practice in Serbia requires an adequate assessment so as to determine to what extent this practice affects the efficient deployment of health workforce to public healthcare institutions, e.g., the efficiency of working hours, productivity, salaries and replacement costs, an increase in patient waiting time, patient costs, and reduced quality of service. In addition, it should be determined to what extent it is possible to make international comparisons (e.g., making comparisons with European legislation or policies of other countries) and it is necessary to upgrade accordingly. International experts advocate the existence of more data on dual practice among workforce and the need for integrating these data into national health workforce accounts [46] in order to help managers to create and use the necessary capacities of health workforce so as to achieve universal health coverage. Complementing the indicators on health personnel, which according to the WHO [47] contribute to good management and decision making in a healthcare system, as well as creating an information system and a quality database, would enable international comparability. The need to create a national health policy for monitoring dual

practice in Serbia and to develop strategies for mitigating negative effects has been highlighted [48].

NOTE

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