

Conflict of Interest vs Conflict of Incentives: Rethinking Dual Practice in Light of Malawi's Presidential Executive Order No. 1 of 2026

Parth K. Patel^{1,2,3*}, Supriya Nair³

1. East Central and Southern Africa College of Public Health Physicians

2. School Global and Public Health, Kamuzu University of Health Sciences

3. Atlas Medical Center

* Corresponding Author: Parth K. Patel- pkpatel@kuhes.ac.mw

Abstract

Background

Dual practice—where health professionals simultaneously participate in public and private healthcare markets—is common in many health systems but presents complex governance challenges. In 2026, the Government of Malawi issued Presidential Executive Order No. 1 of 2026, prohibiting public health workers from soliciting informal payments in public facilities and restricting their ownership or financial interests in private healthcare establishments. The policy has generated significant national debate regarding its implications for health system governance and workforce incentives.

Objective

This commentary examines the policy rationale and potential implications of the Executive Order, focusing on the tension between addressing conflicts of interest and maintaining appropriate incentives for health workforce retention.

Discussion

Drawing on international literature and comparative policy experiences, the commentary situates Malawi's reform within the broader global discourse on dual practice regulation. Evidence from multiple health systems indicates that physician ownership of private facilities can introduce structural conflicts of interest that undermine public sector performance through patient diversion, reduced public sector effort, and erosion of public trust. However, outright restrictions on private sector engagement may also carry unintended consequences in settings where public sector remuneration is limited and specialist workforce shortages are acute. International experiences demonstrate that successful regulation of dual practice requires careful alignment of governance mechanisms, workforce incentives, and health system accountability.

Conclusion

Malawi's Executive Order represents a decisive attempt to strengthen the integrity of public healthcare delivery by addressing ownership-based conflicts of interest. Its long-term effectiveness will depend on balanced implementation, transparent regulatory guidance, and complementary reforms that address workforce incentives and health system capacity. The current debate offers an opportunity to move beyond polarized narratives and instead focus on building a governance framework that simultaneously protects public trust and supports a sustainable health workforce.

Introduction

In early 2026, the Government of Malawi issued Presidential Executive Order No. 1 of 2026, introducing restrictions on the solicitation of payments within public health facilities and prohibiting ownership or financial interests in private healthcare facilities by individuals employed in public hospitals. The Order has triggered significant national debate across the health sector, professional associations, policy circles, and the general public. At the centre of the discussion lies a fundamental question that extends beyond Malawi: how should governments regulate dual practice in health systems where public sector health workers simultaneously participate in private healthcare markets?

Dual practice—defined as the combination of public and private medical practice by the same health professional—is a widespread phenomenon globally. The World Health Organization notes that dual practice exists in the majority of national health systems and is particularly prevalent in

low- and middle-income countries (LMICs) where public sector salaries are relatively low and private markets are expanding¹.

However, dual practice introduces complex policy trade-offs. On one hand, it can help governments retain skilled professionals in the public sector by allowing them to supplement their income. On the other hand, it creates structural conflicts of interest that may undermine public service delivery. Malawi's recent Executive Order therefore represents an attempt to address this tension directly by prioritizing the management of conflicts of interest within the public health system.

This commentary examines the policy rationale behind the Order, explores the broader literature on dual practice, and considers international experiences with regulating private practice among public sector health professionals.

Conflict of Interest in Healthcare Systems

Conflict of interest in healthcare occurs when financial or professional incentives interfere with the primary duty of a clinician to act in the best interests of patients. The Institute of Medicine describes conflicts of interest as situations where secondary financial interests risk compromising professional judgment or institutional goals².

Ownership of healthcare facilities by physicians who also serve in public institutions represents a classic example of such conflicts. When clinicians possess financial stakes in private clinics, pharmacies, or laboratories, the potential for self-referral or preferential patient diversion emerges. In many settings, this may manifest through subtle or overt mechanisms including delays in public care, artificial scarcity of medicines, or redirection of patients to privately owned facilities where services are provided at additional cost.

A growing body of literature has documented the systemic risks associated with physician dual practice. A mapping review examining physician dual practice across multiple countries found that in 58% of country reports, dual practice was associated with detrimental effects on public health sector performance, including reduced quality of care and limited availability of staff within public facilities³.

Similarly, research has shown that dual practitioners may reduce their public sector effort in order to attract patients to their private practices, contributing to declining trust in public health services⁴.

These concerns resonate with challenges reported in several LMICs, where weak governance structures and low public sector wages amplify incentives for informal payments and private sector diversion.

Dual Practice as a Global Policy Challenge

Despite these risks, outright prohibition of dual practice remains controversial. In many countries, governments have chosen to tolerate or regulate dual practice rather than eliminate it entirely.

For example, several European health systems operate controlled forms of dual practice within public hospitals. In Italy, public hospital specialists are permitted to provide private services within public facilities under the “intra moenia” system, which allows patients to pay for faster access to care while physicians remain formally employed in the public sector. However, studies have noted that such arrangements may create inequities by allowing private patients to bypass waiting lists⁵.

In contrast, Canada historically restricted dual practice more strictly, with some provinces limiting the ability of publicly employed physicians to bill privately for services covered by public insurance. These restrictions were designed to protect the integrity of the publicly funded healthcare system and prevent queue-jumping by wealthier patients.

Several Asian countries have adopted hybrid models. In Vietnam, dual practice among public hospital physicians is widespread and often tolerated as a mechanism to retain skilled specialists in public institutions. However, studies have highlighted the challenges associated with such arrangements, including impacts on service quality and unequal access to care⁶.

In South and East Asia more broadly, policymakers have experimented with multiple regulatory approaches, including bans, restrictions on private earnings, or contractual

incentives to encourage physicians to prioritize public sector work⁷.

These international experiences demonstrate that dual practice regulation is rarely straightforward. The optimal policy response often depends on local labour markets, salary structures, and regulatory capacity.

Lessons from Attempts to Ban Dual Practice

Attempts to ban dual practice entirely have produced mixed results. In Palestine, for instance, policymakers debated imposing an outright ban on dual practice in order to reduce financial burdens on patients. However, research suggested that such a ban alone would not significantly improve access to care without broader health system reforms⁸.

Economic analyses of dual practice regulation have similarly suggested that bans are most effective when accompanied by improvements in public sector compensation and working conditions. Where private sector opportunities remain more lucrative, restrictive policies may instead push skilled professionals out of the public sector entirely.

Theoretical health economics models highlight this policy dilemma. Governments may either prohibit dual practice, tolerate it with regulation, or design incentive-based contracts that encourage physicians to prioritize public service delivery. Each approach carries different implications for workforce retention, health system performance, and equity⁹.

These insights underscore the importance of aligning incentives alongside managing conflicts of interest.

Malawi's Policy Context

Malawi's health system faces significant structural constraints, including shortages of specialized physicians, limited financial resources, and high dependence on public sector facilities for healthcare delivery. In such contexts, the balance between public and private practice becomes particularly sensitive.

The Presidential Executive Order appears to focus not on banning all private practice, but specifically on eliminating ownership-based conflicts of interest. This distinction is important. The Order restricts ownership, operation, or shareholding in private healthcare facilities by individuals employed in public hospitals, but it does not explicitly prohibit after-hours private employment.

From a policy perspective, this approach attempts to address structural incentives that may undermine public service delivery while still allowing healthcare professionals to supplement their income through labour rather than capital ownership.

Such distinctions are consistent with broader international efforts to manage conflicts of interest within health systems. For example, regulatory frameworks in several countries restrict physician ownership of diagnostic laboratories or pharmacies in order to prevent self-referral and profit-driven clinical decision-making.

The Incentive Dimension

While conflict-of-interest regulation is essential, the broader issue of incentives remains equally important. In many low and middle income countries, dual practice emerges primarily as a response to inadequate public sector remuneration. Physicians may rely on private work to achieve financial stability or support their families.

Research indicates that allowing some forms of dual practice can help governments retain skilled professionals

in public hospitals, particularly where training costs are high and migration opportunities exist⁴. However, when left unregulated, dual practice may reduce physician work supply in public facilities and increase inequalities in access to care¹⁰. Effective policy therefore requires a balance between regulating conflicts of interest and addressing workforce incentives.

Managing Transition and Implementation

One of the most sensitive aspects of Malawi's Executive Order concerns professionals who already hold investments in private healthcare facilities. Many such investments were made legally under previous regulatory frameworks. For these individuals, divestment requirements may represent significant financial disruption.

International experience suggests that policy transitions are more sustainable when accompanied by transparent guidelines and phased implementation mechanisms. Structured divestment timelines, disclosure requirements, and clear definitions of prohibited activities can help reduce uncertainty while maintaining policy objectives.

Moreover, regulatory reforms should be accompanied by broader governance improvements, including stronger monitoring systems, clearer accountability structures, and improved management of public sector working conditions.

Conclusion

Malawi's Presidential Executive Order No. 1 of 2026 has catalysed an important national discussion about the role of private practice within public healthcare systems. At its core, the debate reflects a fundamental tension between two policy objectives: preventing conflicts of interest that undermine public service delivery and ensuring that healthcare professionals operate within incentive structures that support workforce retention.

International evidence suggests that neither unrestricted dual practice nor absolute prohibition provides a universal solution. Instead, successful regulation typically requires context-sensitive policies that address both ethical governance and economic realities.

By focusing on ownership-based conflicts of interest while leaving room for regulated professional practice, Malawi's approach may represent a pragmatic attempt to navigate this complex policy landscape. However, the long-term success of the reform will depend on careful implementation, transparent communication, and complementary reforms that address workforce incentives and health system governance.

Ultimately, the debate sparked by this Executive Order should not be viewed as a conflict between government and healthcare professionals. Rather, it is an opportunity to strengthen institutional integrity, restore public trust, and align incentives in a manner that supports both health workers and the patients they serve.

References

1. World Health Organization. Governance of dual practice in the public and private health sectors [Internet]. World Health Organization; 2024. Available from: <https://www.who.int/publications/i/item/9789240096615>
2. Lo B, Field MJ. Conflicts of Interest and Medical Practice [Internet]. Nih.gov. National Academies Press (US); 2009. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK22944/>
3. Hoogland R, Hoogland L, Handayani K, Sitaresmi M, Kaspers G, Mostert S. Global Problem of Physician Dual Practices: A Literature Review. *Iranian Journal of Public Health*. 2022 Jul 17;
4. Moghri J, Rashadian A, Arab M, Sari AA. Implications of Dual Practice among Health Workers: A Systematic Review. *Iranian Journal of Public Health [Internet]*. 2017 Feb;46(2):153. Available from: <https://pmc.ncbi.nlm.nih.gov/articles/PMC5402772/>
5. Garattini L, Padula A. Dual practice of hospital staff doctors: hippocratic or hypocritic? *Journal of the Royal Society of Medicine*. 2018 Jun 15;111(8):265–9.
6. Do N, Do YK. Dual practice of public hospital physicians in Vietnam. *Health Policy and Planning*. 2018 Aug 23;33(8):898–905.
7. Hipgrave DB, Hort K. Dual practice by doctors working in South and East Asia: a review of its origins, scope and impact, and the options for regulation. *Health Policy and Planning*. 2013 Oct 21;29(6):703–16.
8. Alaref J, Awwad J, Araujo E, Lemiere C, Hillis SA, Özaltın E. To Ban or Not to Ban? Regulating Dual Practice in Palestine. *Health Systems & Reform*. 2017 Jan 2;3(1):42–55.
9. González P, Macho-Stadler I. A theoretical approach to dual practice regulations in the health sector. *Journal of Health Economics*. 2013 Jan;32(1):66–87. Feb;46(2):153. Available from: <https://pmc.ncbi.nlm.nih.gov/articles/PMC5402772/>
10. Johannessen KA, Hagen TP. Physicians' engagement in dual practices and the effects on labor supply in public hospitals: results from a register-based study. *BMC Health Services Research*. 2014 Jul 10;14(1).