BEYOND PUBLIC AND PRIVATE? UNORGANISED MARKETS IN HEALTH CARE DELIVERY

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October 2002

Prepared and Presented at the

'Making Services Work for Poor People'
World Development Report (WDR) 2003/04 Workshop
held at Eynsham Hall, Oxford

4-5 November 2002

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This paper puts forward three arguments. First our understanding of the health sector is handicapped by trying to fit it into language and concepts which do not adequately capture its changing realities and the political economies within which health sectors are embedded. Second, this has disposed to putting forward decontextualised, and thus largely normative solutions, such as "regulation," to the problem of improving service delivery in poorly performing environments. Third, approaches need to move beyond the dualism of public versus private and work creatively with messy and sometimes contradictory realities.[1] It concludes with a discussion of how this analysis can be applied to a major international intervention set up to benefit the poor – the Global Fund for HIV/AIDS, TB and Malaria

Provider pluralism - the inadequacy of the public/private distinction

Rather to its credit, international health policy has acknowledged for some time that large numbers of health transactions in both low and middle income countries take place outside the publicly provided health care delivery system and this cannot be ignored in the planning and financing of the health sector (Berman and Rose 1996, Cassels 1995). In many countries, the public system is now a minority provider of services, including to the poor.[2] Responses to this have ranged along a spectrum from an enthusiastic endorsement of the potential for increasing private sector involvement in health provision to a strong rejection of its role and a reinstatement of the need to rebuild universal public sector provision. Proponents of the former generally stress this as the route to improving efficiency and quality through competitiveness. Proponents of the latter see universal public provision as the only guarantor of equitable access.

The problem is not whether these views are right or wrong. It is that they are often beside the point in the increasingly pluralistic environment of health service provision in many countries. An increasing number of health care transactions take place outside the organised health care economy in a marketised but unregulated domain of multiple providers of goods and services (Bloom and Lucas 2000; Leonard 2000, Bloom and Standing op.cit.). Few strategies have yet emerged to manage the consequences of this unorganised economy for the delivery of more effective health services and products.

The term *private* has thus become something of a black box carrying with it the conceptual baggage of highly regulated advanced market economies. It is used to cover a very broad spectrum from professionally certified medical specialists to drug pedlars and traditional providers of health-related services. Some providers have a legal status analogous to practitioners in advanced market economies. Many countries have medical professional councils, which license a variety of medical specialists (Aljunid 1995). Other providers are certified professionals without the right to practise privately, . Public sector health staff frequently work privately, often unregistered and unsupervised. Public sector facilities are often chronically underfunded and staff have to market skills and services in order to make a living. (Nabarro and Cassels 1994, Zwi and Mills 1995)

There is a wide variety of unlicensed providers and the practice of training community health workers has been a major source of supply for the latter. Many of the former

[1] The arguments in this paper rest heavily on empirical and conceptual work by Gerald Bloom, Henry Lucas and Hilary Standing of the IDS health and social change team (see Bloom and Standing 2001, Lucas)
[2] Estimates for household private health care expenditure range up to 80% for some countries, e.g. India. However, for both methodological and conceptual reasons, these should be regarded as a rough guide rather than taken at face value.

barefoot doctors of China are now private practitioners (de Geyndt et al 1992) and community health workers elsewhere have developed livelihood strategies to compensate for inadequate funding from governments or community organisations (Walt 1988). In rural Nepal, it is not uncommon for the first line provider at the health post to be the guard or caretaker who has picked up basic medical knowledge "on the job." The combination of the rise in the number of people with basic literacy skills, the growing availability of drugs and other medical commodities and the increasing availability of basic medical knowledge has also contributed to this expansion. Overall, the number of personnel with health-related skills who are willing to offer services for payment, has increased sharply in most developing countries.

One of the most striking features of marketisation in the health sector is the rapid increase in the number and variety of sources of supply of drugs. Whilst both users and providers complain consistently about the lack of drugs coming through the public distribution system, commercial availability is now widespread (some of it "leakage" from the public system). In China, people buy them from health facilities, ex-community health workers, private drug stores, individual sellers and even veterinarians. A study in Lao People's Democratic Republic found that 80% of pharmaceuticals are provided by the private sector (Stenson et.al. 1997). The situation is similar in Nigeria (Lucas et al 1996), Uganda (Reynolds Whyte and Birungi 2000) and Vietnam (Wolffers 1995). Quality problems abound, with counterfeiting and out of date sales accounting for a variable proportion of purchases.

The first problem is how to characterise pluralistic health sectors where governments are no longer monopoly suppliers of services. This is attempted in table 1. The terms organised and unorganised are used in preference to the more usual formal/informal distinction. We would argue that the health system is analogous to other labour markets and systems of production in countries where a highly visible but relatively small organised sector co-exists with a much larger unorganised economy of goods and services.

Table 1: Pluralistic health systems

Health-related function	**Unorganised health care economy**		**Organised health care economy**
	Non-marketised	**Marketised**	
Public health	• Household/community environmental hygiene		• Government public health service and regulations • Public or private supply of water and other health-related goods
Skilled consultation and treatment	• Use of health related knowledge by household members • Some specialised services such as traditional midwifery provided outside market	• Traditional healers • Unlicensed and/or unregulated health workers and facilities • Covert private practice by public health staff	• Public health services • Licensed for-profit health workers and facilities • Licensed/regulated NGOs, faith based organisations etc.
Medical-related goods	• Household/community production of traditional medicines	• Sellers of traditional and western drugs	• Government pharmacies • Licensed pharmacies
Physical support of acutely ill, chronically ill and disabled.	• Household care of sick and disabled • Community support for AIDS patients, people	• Domestic servants • Unlicensed nursing homes	• Government hospitals • Licensed or regulated hospitals

	with disabilities		and nursing homes
Management of inter-temporal expenditure	• Inter-household/inter-community reciprocal arrangements to cope with health shocks	• Money lending • Funeral societies /informal credit systems • Local health insurance schemes	Organised systems of health finance: • Government budgets • Compulsory insurance • private insurance • bank loans • micro-credit

(modified from Bloom and Standing 2001)

The first column identifies the basic functions of health systems. This covers application of expert knowledge to health problems, the economy of care at household, community and organised facility level and the specific measures societies take to help people to cope with major health-related shocks.

The various actors can be categorised as part of the *organised* or *unorganised* health care economy. The concept of the organised health care economy captures the idea of regulatory influence in both the public and private sectors. It also reflects the consensus view that health systems require government intervention in controlling costs and encouraging the provision of effective and cost effective services, regulating the technical performance of providers and enabling people to manage the financial risks of major illness, (Evans 1997; Chernichovsky 1995; Katz and Miranda 1994). By definition, the larger and more complex the unorganised market in health, the weaker the extent of government influence in these areas.

The health sector tends to be seen as a hierarchically organised system of provision of specialised services and goods. But it is more appropriately conceptualised as a knowledge economy in which fundamental changes are taking place in the location and possession of expert knowledge. A key feature of the development of pluralistic health systems is that expert knowledge attaches increasingly to a plurality of agents who are able to gain access to knowledge as a saleable commodity. There have been major shifts in the location of specialised knowledge, such as the growing role of shops, pharmacies and sellers of medical techniques, and in strategies for disseminating health-related knowledge.

This is paralleled at household and community level. Knowledge is no longer just located in health "experts," if it ever was. People get information from pharmacies, personal links to providers, social networks and the media. Users of health services are now better regarded as eclectic consumers of many different sources of information rather than as repositories of "traditional" knowledge or skills. From the point of view of reaching the poor, this raises issues of how their access to reliable information can be improved, and how they can distinguish between good and bad information and between competent and incompetent providers of services.

How do poor people use unorganised health care markets?

Reasons for the drift from public provision are not entirely understood but thought to relate mainly to problems of service quality (restricted opening times, rude staff, lack of drugs and equipment, poor facilities, illegal charging), and lack of accessibility, particularly in rural areas where facilities are spread thinly. As noted, it is now part of the orthodoxy that poor people make extensive use of the private sector. However, in the light of the complexities of what constitutes the private sector, this is not very illuminating for policy purposes. Despite a large number of studies of health seeking behaviour, there are limited data on exactly what services poor households use for what purposes, and how patterns of use intersect with gender, age and other socio-economic markers. This is because, whilst many studies come up with the finding that cost is significant in health seeking behaviour, few focus specifically on the poor or stratify their samples.

No consistent pattern emerges from the studies that have looked at the relationship between socio-economic status and use of provider. In Nepal, Hotchkiss et.al. (1998) found that both wealthy and poor households rely heavily on services provided by the public sector. In Papua New Guinea, Mulou et.al. (1992) found a "sizeable" proportion of patients in a survey of users of private clinics were from low to moderate income groups. In Tanzania, on the other hand, following the liberalisation of private practice and the introduction of user fees, Wyss et.al. (1996) found that the wealthy and/or highly educated were using private facilities more often.

One of the reasons for the lack of any consistency is that a large number of factors influences choice of provider. Historical patterns of use, convenience, opportunity costs, availability, severity of illness, perceived quality of service, staff attitudes, gender, age and status of the sick person, as well as more context specific cultural and intra-household factors are implicated to different degrees in such decisions (e.g. K. Leonard 1998, Agyepong 1999, Berman 1996, Tipping and Segall 1995).

The significance of direct cost in health care decision making amongst the poor is therefore variable. A study of facility use in Sri Lanka illustrates the complexity of household decision making processes. This found that the severely ill poor may bypass free facilities and travel longer and further for treatment. This is because, on the one hand they are seeking a balance between quality of care and affordability, and on the other they are trading off the opportunity costs of their own time against direct costs (Akin 1999).

In many contexts, the public sector continues to be extremely important for the poor, especially for the delivery of basic services such as MCH. Indeed, observations in some countries suggest there is often a division of labour between "public" and "private." For example, in India, rural health facilities are mainly used for family planning and MCH care, much less often for curative services.

The evidence we have suggests that in all contexts where there are substantial indirect as well as direct costs associated with consulting a provider, much illness is self-treated (e.g. Le Grand 1993, Castle 1993, Sauerborn 1996, Taylor et.al. 1996). This is particularly the case where it is perceived as minor. In different studies, self-treatment covers a spectrum from no treatment to purchasing of drugs or other remedies from a range of outlets. Two observations can be made. First, it seems that self-treatment is increasing in countries where there are significant cost barriers to access and/or where quality of treatment in many organised/formal health facilities, public or private, is perceived to be declining. In China and Indonesia, this increase is found across all socio-economic groups.

Second, the poor generally have lower rates of recourse to treatment of any kind. This is despite the fact that the poor bear a greater burden of sickness than the better off. They are also the least likely to have access to any kind of insurance or cover for sickness. Case studies suggest that the poor commonly "manage" the costs of sickness by extending the threshold of seriousness at which they seek treatment (Tsey 1997, Ndyomugyenyi 1998, Ensor et.al. 1998). Where self-treatment is through drug purchases at private drug retailers and pharmacists, the poor are more likely to purchase inadequate doses or cheaper, but inappropriate therapies (Kloos et.al. 1986, Evans et.al.op.cit., Calvi 1996).

A recent conversation in Nigeria with a director of an NGO involved in reproductive health in rural communities exemplified this latter point. She noted that women's use of the "private sector" was largely through over the counter purchase from patent medicine shops for small amounts of money. These sell "packages" consisting of four or five basic drugs – chloroquine, aspirin, antibiotic, vitamins etc. N100 (about 50 pence) will buy the whole package. Smaller amounts of money, will purchase lower doses or fewer items. The finding of widespread use by the poor of the private sector is probably better characterised as widespread use of unorganised markets, both "traditional" and commercial.

The policy challenge of unorganised markets

Responses to chaotic markets in health have generally been timid. This is partly due to a failure of conceptualisation. Most health planning frameworks focus on the public sector and are derived from the experiences and political economies of the relevant metropolitan countries. Most health planners understandably come from a public sector background. The extent and significance of the unorganised health care market in many countries, especially as a resort of the poor, is yet to register in health policy and planning. Measures to re-establish coherent institutional arrangements will necessarily go well beyond the health sector and be long-term. They require a better understanding of the complex issues involved. Approaches have been developing, however, and they can be seen to fall into three main types – those working through bureaucratic, government led measures, those working through "civil society" and those working through market mechanisms.

Some of the main ones are as follows:

- Contracting with different types of providers (which can include public sector ones) against specific service outputs
- Developing regulatory frameworks, changing service delivery models, restructuring human resources and employee contracts
- Using demand side measures, e.g. civil society monitoring, community based management of facilities, NGO facilitation and mediation, consumers associations
- Working with commercial and informal providers, e.g. pharmacies, traditional practitioners in defined areas of delivery/distribution
- Expanding the use of the market in some areas of health goods such as contraceptive delivery, malaria protection and basic test kits
- Increasing access by the population to health-related knowledge and information on providers

All of these may have potential to improve basic services or may be working well in specific places. However, they cannot work as decontextualised solutions. Health planning therefore also needs to get a much better grip on context and political economy. There has been a strong focus on regulation by governments. But lack of regulation is a symptom of a larger political economy problem, not an answer to it. In particular, chaotic markets thrive where governance is failing. Unorganised markets have their own histories and political economies. We may consider, for instance, the examples of China and Nigeria Both have highly privatised health care delivery systems but they got there by very different routes and regulatory transformation is likely to take place through very different mechanisms.

China had a highly organised basic health system embedded in a command economy with strong political involvement at all levels. As it has made the transition to a market economy, many of the institutional arrangements that established and enforced an implicit contract with health workers to provide competent and low cost services in exchange for an adequate income and social status have disappeared. It is now very difficult to draw the boundary between public and private providers; they all depend largely on earnings from user charges. There is considerable evidence of the weakening of preventive programmes in poor localities and of unnecessary cost increases, due to overuse of drugs. It is now recognised that efforts to re-establish effective and affordable health services will have to link increases in public health finance to the creation of an institutional environment that encourages service providers to act in the interests of patients (Bloom 2002).

Nigeria is an example of a country which constructed a functioning primary health care system in the immediate post colonial era. That system is now in serious decay, characterised by mass exit of users to the unorganised market in the face of decayed infrastructure, absence of staff from posts, lack of equipment and drugs, breakdown of supervision and rent seeking behaviour by providers. The crisis in the health sector is paralleled by a governance crisis in most areas of the bureaucracy. The recent participatory poverty appraisal for the Nigeria PRSP noted the total lack of trust by poor people in any institutions of the state and little trust in formal non-state organisations such as NGOs (Ayoola, et.al. 2000/2001). The poor trusted only traditional associations. Researchers evaluating the Benue Health Fund (an innovative DFID funded initiative to improve drug distribution) reported informants telling them that they had long given up

on public sector health facilities. All they wanted was to be sure that the drugs they were purchasing in the market were safe and effective (Lucas et.al. op.cit.).

These two countries clearly face very different tasks in improving health care delivery to the poor. To say that they need to improve regulation begs a whole set of contextual questions about the history and nature of governance and the type and extent of marketisation. The private sector is extremely diverse, both in its contractual arrangements and its capacity to deliver appropriate, competent services. Many governments simply lack the capacity to regulate and supervise private providers. Much of the unorganised market is not susceptible to bureaucratic regulation and it is probably better not to try but to focus on other potential entry points for improving service delivery.

Against this background, it is not easy to spell out clear policy prescriptions on engagement with the private sector as against more intensive efforts to strengthen public sector services. This will depend on an analysis of existing utilisation patterns, the relative strength and quality of different kinds of providers and the capacity of the government to develop and implement effective regulatory and contracting mechanisms.

However, some clearer contextual distinctions may assist in pointing towards more or less potentially effective forms of intervention. The following bullet points are the beginnings of a typology which may have some predictive power in terms of which strategies are most appropriate for managing unorganised markets in health care.

- Low income countries under stress – poor economic growth, high proportion of the population in poverty, conflict, poor governance and decayed public health systems, high levels of resort to disorganised health care markets (e.g. countries in sub-Saharan Africa, parts of Asia)

- Low income countries with stronger economic prospects and functioning governments/bureaucracies but endemic problems of poverty and inequality, under performing public health systems, substantial to some resort to disorganised or semi-regulated markets (e.g. some sub-Saharan African countries, countries in South Asia

- Transition countries moving from socialist planning systems to a market economy and pluralistic health systems associated with high levels of privatisation (e.g. China, countries of the FSU)

- Middle income countries with established or transitional systems of public or private social security and health care, strong governments but uneven health systems performance and areas of high deprivation and unmet health need (e.g. countries in Latin America, South East Asia)

- Collapsed states with few or no functioning institutions or markets, little or no organised health care provision

At one end of the spectrum, there will be countries with reasonable capability to implement and enforce regulatory frameworks, drive public sector reform and negotiate more appropriate health human resources strategies with often powerful provider interests. Some countries may be able to make headway in defined areas, perhaps through "soft" reform of service delivery models – changing scope of practice, training and curricula, non-monetary incentives, revision of contracts etc. Others will have little capacity or political impetus to intervene in unorganised markets for the foreseeable future. Mechanisms which directly address markets, such as branding and franchising and certain types of consumer action (Smith et.al. 2001, Druce and Standing 2001) may therefore be more effective. In collapsed states or regions, the initial answer is probably direct interventions through categorical basic health programmes, delivered by whatever capacity can be mobilised, along with restoring infrastructure in water and sanitation.

More generally, in the context of the massive marketisation we have seen in the health knowledge economy, it is important to open up the issue of regulation in a way which moves beyond purely bureaucratic solutions. The health sector is a complex one in terms of degrees of specialisation of knowledge and of types of goods and services used. But it is no longer clear where it is appropriate now to draw the boundary between unmediated transactions in health related goods and services which people

either purchase in the market or through social marketing/community based distribution systems, and ones mediated by professional/ bureaucratic gatekeepers. There has already been considerable expansion of the market in the distribution of basic health goods. Some of this is sanctioned – for instance the social marketing of malaria protection, test kits, treatment packages. Much of it is not sanctioned but happening anyway – the sale of all kinds of officially restricted drugs, laboratory tests etc.

Unorganised markets are not only used by the poor but do their greatest harm to the poor. They suffer the greatest information assymmetries and are much more likely to be at the purchasing end of shoddy or dangerous goods and services. Redrawing the boundaries between mediated and unmediated goods and services in certain areas, such as treatments for malaria opens up other potential strategies such as improving user information, encouraging consumer action etc.

Living with the new realities – the case of the Global Fund

Our principal conclusions concern the long-term nature of the institutional effort that is required to reconstruct coherent health systems. Here, we note the implications of this analysis of unorganised health markets for the design of a major international initiative to tackle the diseases most affecting the poor. This section looks at the recently instituted Global Fund for HIV/AIDS, TB and Malaria

A major purpose of the Global Fund is to make effective drug treatments for malaria, tuberculosis and AIDS more widely available in countries that cannot currently afford them. A number of problems are likely to arise in countries with unorganised health markets, including leakage through the sale of these drugs by public and private sector providers, and use by unlicensed providers.[3] People will be able to purchase antiretroviral drugs (ARVs) for a variety of conditions. This will result in poor people wasting money on inappropriate treatments, the rapid emergence of drug resistant organisms and the creation of a market for counterfeit products.

One response would be to say that the global fund should not finance drug imports by countries with large unorganised health care markets. Or, the supply of drugs could be made conditional on evidence that stringent regulations will be enforced to keep these drugs within the public sector. If these conditions were taken seriously, many countries where poor people live, would be ineligible for support. The alternative approach is to implement measures that limit the most adverse effects of the leakage of drugs into unorganised markets.

One approach is to provide specific information to the population on when and how to use these drugs. If we introduce expensive and dangerous drugs into an unorganised market, we need to ensure that people are knowledgeable consumers. We also need to train potential sellers of these commodities. There is a danger that this will encourage unskilled providers to supply more of these drugs. The appropriate strategy will depend on the importance of existing markets. Different strategies may be employed for different drugs, depending on patterns of supply and possible consequences of misuse of it.

A second approach is to define particularly bad practices and establish mechanisms to reduce them. These mechanisms may involve community groups, government health officials and/or specially established drug regulatory bodies. The combination that works best will depend on existing institutional arrangements. It may also be possible to involve international drug companies in partnerships to improve the regulatory environment within which their products are used. They have an interest in this because of the need to maintain their good name and the danger of counterfeiting. They also need to maintain the integrity of the newly agreed two-tier drug pricing structure and avoid the re-export of products to high-income countries.

A third approach is to develop strategies for the supply of subsidised products by the organised health sector. This involves decisions about the roles of different kinds of public and private provider. Depending on the product, these could involve all providers (in the case of anti-malarials) or those specifically identified as competent and ethical. The latter could include certain NGOs or new types of franchised providers (either commercial or not-for-profit). The provision of subsidised drugs to public and private

[3] According to a senior health official in Mozambique, some traditional healers are already incorporating them into herbal treatments for AIDS, but at inappropriate dosages.

providers would have to be linked to measures to encourage them to behave in an ethical manner. This might include new kinds of contracts that provide more appropriate financial incentives. It might also include measures to monitor and regulate bad behaviour. There is a danger that linking these measures to the delivery of a few specific drugs could encourage further fragmentation of services.

The Global Fund is one of several major initiatives aimed at making a substantial impact on the health of the poor in a relatively short time. We argue that interventions which do not take the reality of unorganised health markets into account will have a limited impact and may cause harm. Measures can be taken to limit this harm. However, they require a clearer understanding of the institutional and political context of such markets in order to determine what is going to be implementable.

More generally these will need to be part of long-term efforts to create a coherent environment for the health sector. We anticipate that in some countries at least, new institutional arrangements will emerge, engaging new models of health care providers and taking greater advantage of the possibilities of information technology in both clinical and logistics aspects of service delivery.

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