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Pluralism and marketisation in the health sector: meeting health needs in contexts of social change in low and middle-income countries

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Summary

This paper is part of a broader attempt to identify the key producers of social goods and how social policy interventions can support them. In this paper, we focus on the health sector in order to:

- Examine the changing roles of health care providers and the management of health expertise in the context of pluralism and increasing marketisation of health goods and services
- Explore how pluralism of provisioning and increasing markets for health goods have affected the ways households meet their health needs
- Stimulate a reassessment of what governments should or could do to enable delivery of competent health care under conditions of pluralism and marketisation.

We argue that over the last few decades there have been profound changes in the ways health goods are being produced and consumed in low income and transitional countries. We outline the main categories of change in the health sector in terms of socio-economic changes, changes in health provision, knowledge and technologies, and political changes.

We examine the changing roles and functions of providers, asking what services health workers provide, what is the structure of rewards and incentives for health providers and how current arrangements affect transactions costs and quality of services. We go on to consider how households, particularly poor ones, manage health provisioning in a pluralistic environment where health goods and services have become increasingly marketised. We ask how the balance between different sorts of provision has changed and whether there has been an expansion of the productive and reproductive functions of households.

We then explore the roles of governments and other institutions in contexts of pluralism and marketisation. We look at the implications for financing of health services, the management of expert knowledge, and the skill needs of practitioners. We focus particularly on shifts in the location of specialised knowledge, such as the growing role of shops, pharmacies and sellers of medical techniques, and on strategies for disseminating health-related knowledge. We note the possible role of IT and expert systems for transforming chaotic markets in health care and health knowledge.

Contents

1 Introduction

There is a great deal of international interest in the relative roles of public and private health providers in low- and middle-income countries (Colclough 1997a; Bennett *et al.* 1997). This is due to an increasing acknowledgement of the very high levels of household health expenditure on private provision. It is paralleled by discussions in the field of public administration about the relative merits of institutional monopoly and institutional pluralism (Robinson and White 1997; Cohen and Peterson 1999). Analysts of both issues have drawn heavily on the experiences of advanced market economies, where initiatives to overcome specific failures of markets and governments are based on the assumption that both function reasonably well. These analyses have limited relevance where there are major failures of both kinds of institution (Moore 1999). In these circumstances it is important to move beyond debates about ideal organisational models to discussions of practical strategies for improving performance.

A number of low and middle income countries have demonstrated that a well organised and publicly financed and managed service can provide access to basic health care at an affordable cost. They illustrate what governments can achieve and provide a target towards which other countries can aim.

This paper focuses on countries undergoing social, economic and institutional transitions, particularly in Africa and the ex-command economies of Asia. Many have made more than one transition between models of social, economic and institutional organisation during the past few decades. In these countries debates about the pros and cons of pluralism in the health sector have largely been overtaken by reality. Public sector management systems exert a diminishing influence over health providers and government health budgets finance a falling proportion of their income. Health goods and services have become increasingly marketised. The health sector in many of these countries resembles a pluralistic system, without effective government oversight (Bloom 1998; Bloom and Lucas 2000; Leonard 2000). The aim of this paper is to contribute to efforts to understand how these health systems function and how their performance can be improved.

2 From dual to pluralistic health systems

2.1 Dual health systems: the mid-20th Century ideal type

It is difficult to grasp how greatly the health sector of many low and middle-income countries has changed over the past few decades. To illustrate this, we compare the characteristics of dual and pluralistic systems. The dual systems ideal type underlay health development strategies in Asian command economies and post-colonial Africa during the third quarter of the last century (Table 1). The health sector was essentially dualistic in that there was a clear division of roles between households/communities and the formal health sector. This division is expressed conceptually in opposing pairs which are characterised by difference and relatedness: lay-professional, traditional-formal/regulated, folk knowledge-expert knowledge, reciprocal relations–salaries, and so forth.

Table 1 Dual health systems of post-colonial societies and command economies

Households/traditional	Formal health sector
• Households consume health services provided mainly by public sector personnel and facilities • Household reproductive functions (using traditional knowledge and skills, mainly based on gender division of labour) • Specialised personnel (birth attendants, healers and so forth) using traditional knowledge and skills and depending on non-market forms of exchange • Reciprocal inter-household and community arrangements to support households coping with major health shocks (e.g. labour sharing, informal borrowing)	• Different categories of salaried personnel with specialised knowledge of modern health care technology • Hierarchical management system within civil service bureaucracy • Government procurement and distribution of health-related commodities and information • (In Africa) involvement of foreign NGOs/missionary societies in provision of 'Western' services • Possibly complemented by metropolitan system of regulated private sector for organisation of provision of health services and distribution of drugs

In dual systems, the government was the unchallenged leader of the construction of a formal health system. Mostly, these systems were run as a command and control government service. Reality was never as neat as this. For example, there have always been markets for a variety of drug sellers, traditional healers and quacks.

2.2 The decline and re-emergence of pluralistic health systems

During the first half of the 20th century, the health systems of most of the present low and middle-income countries were characterised by extreme segmentation and shortages of facilities, personnel and health-related goods. Members of elite social groups used services established as enclaves of the metropolitan health systems. Countries with large settler populations tended to establish private sectors, with supporting regulatory structures. In other countries these groups depended on colonial health services. The local population depended mostly on local health systems, but colonial health services became gradually involved with addressing their needs. Initially they focused on epidemic control, largely to protect the colonial elite groups. Over time, mission hospitals and/or colonial health services trained local people and provided basic health services.

Most post-colonial countries and newly established command economies were committed to substantial increases in access to health services. There was a common pattern of health sector investment that included building a large network of basic health facilities, training many health workers and strengthening health programmes. There was a dramatic increase in physical access to health facilities and trained personnel in all Asian command economies and in many countries of post-Independence Africa. This government effort was the core reality behind the rise in the vision of dualistic health systems.

Economic factors strongly influenced subsequent developments. Many African countries have experienced prolonged reductions in public sector finance since the early 1980s and the best projections suggest that resource constraints will persist (Bevan and Collier 1999). The impact of these constraints has

been magnified by the inability of governments to reduce public sector employment substantially (Barandiaran 1999). This has meant that spending on consumable items has been very low and real wages have fallen considerably (Colclough 1997b) Many countries have seen public sector provision decline in extent and quality (Agyepong 1999; Mliga 2000). Public sector health workers often earn much of their income from informal payments and an informal and unregulated market has emerged (White 1992). Drugs are available through a large array of unregulated providers. There are many players in the health care arena and it is becoming increasingly difficult to distinguish public and private forms of provision.

China, on the other hand, has experienced rapid economic growth during its transition to a market economy. However, the government lost a large source of revenue when it reformed state enterprises (Wang *et al.* 1995). Government health budgets have grown much more slowly than the salaries of public sector employees and the overall growth of total health expenditure. By 1993 Government health budgets accounted for only 14 per cent of total health expenditure. At the same time the government implemented a radical devolution of government functions that reduced the capacity of government departments to influence individual health facilities. The net result has been to introduce market relationships into the health sector (Bloom 1998).

Other developments influenced the health sector increasingly over the years. These included increases in mass education and a rise in literacy. This increased the capacity of household members to use health-related knowledge in addressing problems of family members. It also increased the ability of people to develop health-related skills for themselves. Another important development was the improvement of the transport network and the extension of systems of distribution and sale of goods. Whilst in the 1950s the government was the monopoly supplier of drugs in most countries, by the end of the century there were many channels of drug distribution.

The number of personnel with health-related skills, who are willing to offer services for payment, has increased sharply. They include a wide spectrum of areas of expertise from highly trained medical specialists to drug peddlers and a variety of quacks. Whilst some localities continue to find difficulty in attracting and keeping qualified personnel, others are oversupplied and an informal market has developed.

There have been important shifts in knowledge. Households and communities are now better regarded as eclectic consumers of many different sources of information rather than as repositories of 'traditional' knowledge or skills. 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. Both literacy and communications have improved.

Health sector reform has largely been conducted as a technical and managerial activity aimed at improving quality and efficiency. In practice, it is a highly political process of negotiation between key stakeholders. There have been struggles between different groups of providers, between providers and politicians and between different levels of government. Voices from civil society are also beginning to be heard raising governance and accountability issues on behalf of different groups of users. NGOs and other community-based organisations have become increasingly important players both in sector provision and in monitoring and accountability.

2.3 Pluralistic systems: an ideal type at the beginning of the 21st Century

Table 2 is an attempt to capture these changes in an ideal type of the pluralistic health systems that have emerged in a number of countries. Health sectors in these countries now consist of a wide variety of actors who deliver health-related goods and services.

The various actors can be categorised as part of the *organised* or *unorganised* health care economy.[1] This distinction cuts across the private/public division. 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 insuring against the financial risks of major illness, controlling costs and encouraging the provision of effective and cost effective services, and regulating the technical performance of providers (Evans 1997; Chernichovsky 1995; Hsiao 1994; Katz and Miranda 1994). The focus here is on the nation state within which a provider is based. A more complex version of this model would include the role of institutions such as international NGOs, religious missions, donor agencies and transnational corporations with governance structures based in advanced market economies. Our argument is that an increasing number of health care transactions take place outside both the organised health care economy, and the economy of reciprocal relationships in a marketised but unregulated domain of multiple providers. Yet few strategies have emerged to enable this unorganised economy to deliver more effective health care.

It is difficult to delineate the health sector clearly, since a wide range of goods and services (and other sectors) affects the health of people. However, it is possible to identify certain activities organised specifically to reduce suffering and premature death and/or provide physical support to people who are temporarily or chronically disabled. The first column of Table 2 identifies three categories of function concerned with the application of expert medical knowledge. These are specific measures to reduce exposure to health risks, the use of special knowledge and skills to treat people with health problems and the provision of medical-related goods, such as drugs. It identifies a fourth category aimed at providing physical support to people who cannot take care of themselves during an episode of illness or because they are in some way impaired. The fifth category is concerned with the specific measures societies take to help people to cope with major health-related shocks.

This way of describing health systems enables us to ask fundamental questions about how the health sector operates in pluralistic settings, and to engage with a wider range of stakeholders in weighing options for change. The following sections look at three levels of health systems: providers, households and governments/institutional structures. We conclude with a discussion of what this might mean for health sector strategies.

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[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, where a highly visible but relatively small, organised sector co-exists with a much larger unorganised economy of goods and services.

Table 2 Pluralistic health systems at the beginning of the 21st Century

Health-related function	Unorganised health care economy		Organised health care economy
	Non-marketised	Marketised	
• Public health	• Household/community hygiene		• Government public health service and regulations • 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 • Covert private practice by public health staff	• Public health services • Licensed health workers and facilities • Licensed/regulated NGOs
• 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 with disabilities	• Domestic servants • Unlicensed nursing homes	• Government hospitals • Licensed or regulated hospitals 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

3 The changing roles and functions of providers

In this section, we first examine the development of the health sector as a set of specialised functions largely regulated through professionalisation and then describe its evolution from the ideal type depicted in Table 1 to the pluralistic system depicted in Table 2. Second, we look at the associated impact of marketisation on health systems in the context of increasing pluralism.

3.1 Professionalisation and specialisation in health work

The health sector is labour intensive, depending heavily on skilled personnel to produce and deliver specialised services. The major categories of health worker (doctors, nurses, physiotherapists etc.) were defined during the establishment of 'scientific medicine' during the 19th and 20th Centuries (Porter 1999). Low and middle-income countries largely imported the structure of their health workforce from advanced

market economies, establishing training institutions to produce similar cadres themselves. Categories of health worker are remarkably similar around the world.

The health workforce is organised in job categories, which include one or more of the following functions:

- *Provision of expert advice* by assessing a problem and suggesting how people can best address it.
- *Use of special skills*, such as suturing a wound, setting a bone, delivering a baby, pulling a tooth, or carrying out a surgical operation.
- *Distribution of commodities*, such as drugs, spectacles and medical supplies.
- *Provision of nursing support* for people who are acutely or chronically unable to care for themselves (this requires special expertise but much of it replaces household labour).
- *Management of health activities* in specialised health facilities and community based preventive and public health programmes.

One principle for the division of labour in the health sector is by area of expertise. The number of specialist categories has increased as the health industry has become more complex. These categories are defined in terms of different aspects of physiology (such as reproductive health, mobility, and heart function), kinds of expertise (such as physical skills and expert advice), and use of specific equipment and commodities (such as X-ray, pharmaceuticals).

A second classification principle denotes level of managerial responsibility and/or professional autonomy. For example, many countries have a variety of people with expertise in childbirth including obstetricians, general doctors, midwives, and informal sector midwives. These differ in social status, position in public sector employment and relationship to regulatory bodies. The role of the more senior personnel, in theory, is to supervise other categories and deal with problems requiring special expertise.

A third principle for the differentiation between categories of health worker is in terms of the social groups it serves. Health workers who provide services to elite groups tend to be drawn from that social group and aspire to a lifestyle similar to their patients. On the other hand, the poor largely use lower status personnel.[2] Thus, for example, specialist physicians may see referred cases and provide routine services to high status patients.

One further function of some high status health workers is to act as a gatekeeper to expensive health services (financed by government, insurance schemes or charities).[3] The resource implications of medical decisions have grown greater as health technology has developed. This has increased the importance of

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2 Prior to the mid-19th Century in Britain, the aristocratic rich sought care from high status physicians, whilst the rest of the population, who could afford to pay, used other categories of trained personnel including drug sellers (apothecaries), graduates from vocational medical training institutions and surgeons. The poor relied on a variety of informal providers. In the mid–1800s the categories of health workers who provided services to the aristocratic and middle classes were placed on a single professional register and all other service providers were excluded from classification as doctor. The division between high status aristocrats and middle classes persists in the difference in social status between GPs and consultants.

the people who control access to them. The importance of the gatekeeper function is illustrated in a recent example from Zimbabwe, where nurses have begun to establish nursing homes. This has caused a serious dilemma for the local health insurance schemes. They need to weigh the potential impact on lowering the unit cost of care against the risks that quality will be compromised and utilisation of inpatient services will rise unnecessarily.

The development of the occupational structure of the health sector of the advanced market economies was strongly influenced during the first half of the 20th Century by the predominance of the model of individual private practice. Most governments established professional regulatory boards to control quality. These boards decide whether or not a particular category of health worker can charge for certain services. Many countries limit the right to practice to doctors who then employ support staff to work under their supervision. The relationship between these autonomous professions and other job categories has been termed professional dominance (Friedson 1970).

Status differentiation in the health sector is a complex mix that reflects the parallel development of the health care industry into large institutions, such as hospitals, and small-scale providers of expert services. Hospital staff are organised into parallel hierarchies, typified by the nursing profession, which extends from unskilled nursing aides to highly trained, high status matrons and Heads of Nursing. Within the medical profession, on the other hand, a whole range of categories has been defined, each perceived to provide expert advice and services on an independent basis.

Many countries were net importers of health workers during the colonial period. They have subsequently trained their own health workers. Much of the training took place in the advanced market economies during the immediate post-colonial period, but many countries now train more personnel than the public sector can afford to employ.

Post-colonial countries and Asian command economies employed similar strategies to expand access to health services rapidly. They constructed a network of basic health facilities and trained a variety of categories of sub-professional health workers to staff them. The underlying model was a publicly financed, command and control health economy. The emphasis until the 1970s was on the production of doctors. Subsequently, with the shift towards 'primary health care,' many countries invested heavily in other categories of personnel, on the grounds that they could produce more appropriate types of health workers at lower cost than producing doctors.

These personnel with titles such as 'medical assistants' and 'health assistants' received shorter training than full-fledged professionals, with the understanding that they would provide a basic menu of services under the supervision of qualified professionals. Countries also trained community health workers, people with relatively little formal education, who were expected to lead public health campaigns and provide simple medical care.

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[3] This role can be traced back in the UK to the 19th Century Poor Law (Hodgkinson 1967), where poor people certified as sick were entitled to health care as well as more generous government financial support.

This investment in training led to large increases in the number of health workers, relative to population. A high proportion of the world's population now lives near to some category of health worker. Where this is the case, shortfalls in access to effective and affordable health services are no longer due to a simple lack of health workers. This has led to a shift of emphasis in the analysis of health human resources from quantity to quality (Hornby 1992; Gong *et al.* 1997). Concern has increasingly focused both on the technical quality of service delivery and on the client's experience of the service provider.

Many of the countries that trained new categories of health worker did not permit private practice. In other countries, the new kinds of health workers were not registered as autonomous professionals and they could not charge for services. The dominant vision of the health sector in low and middle-income countries was thus of a highly organised, supervised and regulated publicly financed service which would cover the entire population, but with an emphasis on basic curative and preventive services. In many countries it co-existed with regulated private practitioners of Western medicine, who mostly served the affluent, and/or providers of traditional health services, who tended to serve the poorer sections of the population or to service particular problems.

3.2 Marketisation of the health sector

Reports from a number of countries suggest that the reality of health services increasingly diverges from the vision that the previous paragraph describes. Government provides a diminishing share of total health expenditure in many countries. In some cases the health sector resembles an unregulated market. There are several reasons for this.

Changes to the supply side have increased competition with government. Systems of distribution and sale of goods have expanded greatly and people can increasingly obtain most commodities, including drugs, from private suppliers. Many more formally trained health workers offer services for payment. People have greater access to health-related knowledge through short training programmes and print and electronic media. This has provided opportunities for people to gain health-related skills. Studies in many countries report the use of a wide variety of health service providers (Chernichovsky and Meesok 1986; Bloom 1998; Leonard 2000; Lucas and Nuwagaba 1999).

The inability of public health services to meet expectations has contributed to an increasing willingness of people to purchase private health services. Economic crisis and squeezes on public expenditure have created shortages of health-related commodities and dramatic falls in real wages in the public sector in much of Africa (Cornia and Mwabu 1997; Colclough 1997b). Evaluations have documented evidence of poor performance and/or popular perceptions that government health services do not meet people's needs (Alderman and Lavy 1996; Bloom and Lucas 2000). This has pushed people to seek alternative sources of health care or pay for services at government facilities.

The private health sector has grown rapidly in many countries (Bennett *et al.* 1997). The word *private* covers a broad spectrum from medical specialists to poorly trained drug peddlers and 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 licence a variety of medical

specialists (Aljunid 1995). Other providers are certified professionals without the right to practise privately. There is also a wide variety of unlicensed providers. The practice of training community health workers has been a major source of supply for the latter. Many of the former 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).

The boundary between public and private sectors has become blurred. Chinese government health facilities charge fees and use profits to augment health worker income (Bloom *et al.* 2000). Other countries tolerate a wide variety of coping strategies by public sector health workers (Ferrinho and van Lerberghe 2000). This may include permitting health facilities to generate revenue to pay for minor repairs and fringe benefits to staff (Creese and Kutzin 1996) and / or allowing health workers to practise privately in their spare time. There has been a widespread growth in informal payments to health workers, and people using government health facilities expect to pay (Assimwe *et al.* 1997; Lucas and Nuwagaba 1999). Interactions between public and private sectors can be complex. In Nigeria, for example, government nurses hire nursing auxiliaries to work in their place, while they undertake more remunerative activities elsewhere.[4] The marketisation of public services has become so ubiquitous in some countries that parts of the health system are more appropriately understood as government subsidised private services than as a publicly-funded service with minor problems with corruption.

An important factor contributing to the *de facto* marketisation of health services is the weakening of government supervisory systems. This is a reflection, in the health sector, of a problem affecting all aspects of public administration (World Bank 1997). It is common to find a greater willingness to invest in training health workers than in re-training or supervising them (Tang 1997; UNDP 1983). This has meant that health workers, who were meant to work under clinical leadership from another category of personnel, often work on their own. This has given facilities and individual health workers a great deal of scope to develop alternative livelihood strategies.

The knowledge of newly graduated doctors decays rapidly, unless reinforced by continuing education and a supportive work environment. We are not aware of systematic evaluations of the level of knowledge of isolated staff in low and middle-income countries. They should be at a considerable disadvantage compared to doctors in advanced market economies because of their shorter induction training, the virtual lack of continuing access to new knowledge and the lack of contacts with colleagues and peers.

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. In China, people buy them from health facilities, ex-community health workers, private drug stores, individual peddlers and even veterinarians.[5] A recent study in Lao People's Democratic Republic found that 80 per cent of pharmaceuticals are provided by the private sector (Stenson *et al.* 1997). The situation is similar in Nigeria (Lucas *et al.* 1996) and Vietnam (Wolffers 1995). A number of studies have highlighted problems with the quality of drug provision (Goel

[4] Personal communication from Henry Lucas.

et al. 1996). These include the supply of inappropriate courses of treatment and the over-prescription of powerful products. Calva (1996) examined antibiotic use in a peri-urban area of Mexico City. He found high rates of self-medication and non-prescription purchase of drugs. Inappropriate use and dosage were common. However, the majority of antibiotics were prescribed by physicians and poor prescribing practices were equally as common in prescription sales.

The result is that people do not get value for the money they spend and are exposed to unnecessary danger. This practice also accelerates the development of resistance to drugs, such as antibiotics. Another problem with many drug supply systems is poor quality control and the existence of counterfeit products.

One concern regarding marketisation of health services is the danger that the motivations of health workers will change (Benatar 1997; Segall 2000). A number of countries have experienced an increasing dependence on informal payments and a fall in the morale of government employees (Nunberg and Lindauer 1994). Mutizwa-Mangiza (1999) describes the high level of autonomy from regulation of the medical profession in Zimbabwe and the lack of a well internalised medical ethic. At the same time, several authors have remarked on the tenacity with which health workers retain an ethical style of practice. In China, for example, many village doctors provide preventive services, in spite of incentives to concentrate on selling drugs. Gong *et al.* (1997) suggest this is due to attitudes they acquired during the period of the command economy. Similar observations have been made about nurses in Uganda and Zambia, who have maintained high standards of professional practice in spite of long periods of severe resource constraints. It is difficult to predict how a new generation, who have only known informal markets for health services, will behave.[6]

There is a great deal of segmentation between sub-sectors of the health system used by different social groups (Bloom 2000). Those earning high incomes have access to services similar to those in the advanced market economies. However, the poor and those outside the organised economy increasingly face choices between a variety of service providers and sellers of health-related commodities. The health sector they use increasingly resembles those prevalent in the advanced market economies prior to the reforms of the late 19th and early 20th Centuries.[7] Systems of regulation are weak and inadequate to cope with the changes in the health sector in many low and middle-income countries, to the detriment of the poor.

4 The changing health roles and functions of households

In this section, we look first at the resources and services which poor households in particular use to meet their health needs in increasingly complex environments. Second, we pose the question of how the roles of households and communities in the provisioning of health goods and services have been affected by

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5 Personal communication by the Head of a County Health Bureau.

6 Kaponda (2001), for example, expresses a fear that the high levels of dissatisfaction with salaries and working conditions amongst Malawian nurses will lead to irreversible changes to the profession.

7 The descriptions of the medical market in provincial Britain in the early decades of the 19th Century in George Eliot's *Middlemarch*, for example, have many characteristics one can still find in much of Africa and Asia.

increasing pluralism in the health sector. Third, we consider what pluralism implies for understanding the relationship between household and community level actors and the formal health system.

The term household is used in this paper to refer to the basic socio-economic units within which the day-to-day and long-term reproductive activities associated with the rearing of children and nurturing of adults are conducted. Households are generally co-residential and linked to families, but they are not so in all instances. The demographic composition and social dynamics of households are extremely variable, not simply across geographical regions but often within the same micro context (see e.g. Castle 1993). Household composition and the extent of a household's links to other households and local networks are important influences on health behaviour. Hence, no particular form of household is implied in the discussion which follows.

4.1 What resources and services do poor households use?

There is a very large literature on household and individual health seeking behaviour. Broadly, this area of enquiry has been within the domain of medical anthropology. This has explored particularly the cultural meanings which people attach to illness states and the ways in which these meanings influence or determine health-seeking behaviour (Pelto and Pelto 1997). Medical anthropology has always stressed the pluralistic nature of these understandings and behaviours. For instance, there is a rich vein of writing on medical syncretism – the cultural accommodations reached between different systems of medicine – and its effects on choice of provider. This literature draws attention to the important link between knowledge and behaviour in making health care decisions.

The medical anthropology literature is much weaker on the influence of practical considerations and socio-economic variables in health seeking behaviour.[8] Despite the proliferation of studies of health seeking behaviour, we know surprisingly little about what services poor households use and how they gain access to them, or about the intersections with gender and age. 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. This methodological inadequacy is also found in many of the more policy focused studies of demand side behaviour (e.g. Winston and Patel 1995)

Some studies have looked at the relationship between socio-economic status and use of provider. No consistent pattern emerges. 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 number of factors influence 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. Leonard, K. 2000; Tembon 1996; Mariam 2000; Ndeso-Atanga 1998; Agyepong 1999; Berman and Dove 1996; Kennedy and Olsson 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 cost of their own time against direct cost (Akin 1999).

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 1996b; 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 about this. First, it does appear that self-treatment is increasing in countries where there are significant cost barriers to access and/or where quality of treatment in many facilities is perceived to be declining. In China and Indonesia, this increase is across all socio-economic groups, suggesting that quality is a key factor in the decline in utilisation of formal health facilities.

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 (Oths 1994; Tsey 1997; Ndyomugyenyi, Seema and Magnussen 1998; Ensor 1995). 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 and Lambert 1997; Calva 1996).

It is difficult to offer any firm conclusions on how patterns of household use of health goods and services have changed with the development of pluralistic systems. But certain things are clear. Households have resort to a very wide range of providers and services and cost is a key factor in decision making. At the same time, these vary greatly in quality, and households and individuals increasingly make decisions without the protection which health sector regulation provides.

4.2 The changing health roles of households

In this section, we consider the impact of marketisation and pluralism in the health sector on the health related roles of households themselves. Table 1 gives the ideal typical view of the role of households and

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[8] See Bolton (1995) for a related critique of medical anthropology's bias towards to the exotic and symbolic aspects of healing behaviour.

communities in a dual system. The assumption here is that the expansion of professionalised health care provision leads households to withdraw from the production of some health goods. Traditional knowledge (e.g. of home remedies and techniques such as manipulation) declines as households get access to health care technologies through the services of professional health workers and paramedical staff. The functions remaining at household level, are thus 'unskilled' reproductive ones associated with the care of those with minor or chronic illnesses. In this view, therefore, local level health production or health maintenance activities contracted as formal health systems developed. Households increasingly become *consumers* of health services, rather than *producers*.

Again, the reality has probably always been more complex. Households have in fact always been producers of health related services. The great majority of health care takes place in the informal rather than the formal care economy, carried out largely by women as part of family responsibilities. An important challenge to the producer/consumer dichotomy has come from feminist reassessments of the reproductive domain (Elson 1991; Folbre 1995; Young *et al.* 1981). These have argued that household level reproductive work, mainly undertaken by women, is a form of production, even though it lies outside the market.[9] The content and level of this work is thus determined to a large extent by economic and social forces lying outside the household. In particular, it is liable to expand or contract, depending on changes in the demand for different types of household labour.

For example, in relation to health, there has been a continuing debate about the impact of changes in health care provision on the extent and time intensity of women's care burdens within households (e.g. Leslie 1989; Bentley *et al.* 1995). Far from there being a withering away of these functions at household level, it can be argued that such functions have simply been disguised in language which sees production as located only in market activities. The important question, therefore, is how do changes in, for example the organisation of the health sector, affect this informal care economy?

At the same time, we would also argue that the landscape of health care provision has changed significantly over recent decades. As service provision in many poor countries has deteriorated, households and local collectivities have increasingly taken over (or taken back) roles and functions which were previously located in the formal health care sector. This is especially the case in much of sub-Saharan Africa.

The expansion of primary health care in the 1960s and 70s did professionalise some basic health care functions, particularly those associated with maternal and child health. There was also some 'reloading' of health related activities onto households and communities. Training of mothers in the use of oral rehydration therapy for diarrhoea is one example.[10] More recently, malaria control programmes have become much more household and community focused. The emphasis on the use of impregnated mosquito nets rather than on public spraying shifts the onus for ensuring protection substantially onto household members and requires associated skills in management.

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9 That is, production of use rather than exchange values.

10 ORT provides a good example of household level institutionalisation of expert knowledge (see Chowdhury *et al.* 1997).

One obvious area of expansion is that of care-giving in AIDS affected societies with limited public resources. In severely affected countries of sub-Saharan Africa, most nursing care for AIDS patients has to be provided outside the hospitals by family members. Home based care is now being actively promoted by hard pressed governments (Abrahamsen 1997; Taylor *et al.* 1996). In general, the decline in health service provision experienced in many poor countries in the 1980s has meant that households have increasingly had to fill the gap, either from their own resources or from the market.

While much of this care is conventionally regarded as 'unskilled' nursing care, not a lot is known about the skills which household members, and women in particular, bring to bear on this task. Taylor *et al.* (ibid.) report that in Uganda, female assistance includes the provision of local herbs for medicine. Where drug supplies are erratic and/or expensive, it is likely that people will turn towards or revive indigenous pharmacological knowledge (Tsey 1997).

Feminist work on household level reproduction has focused on women's unpaid labour – the non-market sphere of exchange. However, it is also important to look at the ways in which health related functions at household and community level are becoming marketised. Households engage in a complex web of non-market and market transactions in getting access to health resources. Wallman and Baker (1996) look at the treatment seeking behaviour of women in low income urban areas of Kampala in relation to management of STDs and management of crisis symptoms among children under five. They find that a range of social and cost variables influences decisions whether to seek treatment, including the expectation or otherwise of reciprocity between neighbours in managing sickness episodes.

While reciprocal, non-market mechanisms for managing illness expenditure and care remain important in many contexts, there is evidence that these are coming under strain. This is particularly so among the poorest, who have little social capital or resources with which to enter into reciprocal relationships. A number of studies record substantial borrowing from commercial sources to offset the costs of major illness (e.g. Wilkes *et al.* 1997).

Lay and 'traditional' skills are also becoming marketised. Provider pluralism coupled with relaxed regulatory regimes has resulted in many traditional practitioners borrowing practices, such as injections, from biomedicine and charging clients for them accordingly. As a number of commentators have pointed out, it is increasingly difficult to draw a boundary between traditional and modern practices and practitioners. (Barrett 1993; Geest 1991).

White (1992) describes how private clinics, medicine vendors and drug stores mushroomed in rural Uganda in the 1980s. As far back as 1985, a survey showed that 41 per cent of treatment seekers went to the private facilities, while 47 per cent went to government facilities and 10 per cent to missions. This is typical of much of Africa. By the late 1980s, there had been an exponential growth in the availability of injections outside health facilities.

She notes the strategies people use to get better treatment from hard pressed health workers and concludes that while there has been a personalisation of relations with staff in the formal system, there has been increasing contractualisation of relations with informal providers. She found health workers instructing friends and family members on how to give injections and on which medicines to buy. Those

who have learnt to treat their families often then branch out into treating others for a fee. She also notes the spread of medical practice to a wide range of agents – cleaners, technicians, drivers, storekeepers etc. who use knowledge gained in public facilities to set up their own businesses.

4.3 Households, health provisioning and the location of expert knowledge

In this section, we consider what pluralism and marketisation of health provisioning implies for understanding the relationship between local level actors and health 'systems,' drawing particularly on White's insights (ibid.).

White notes that the deterioration of public sector health services in Uganda since the early 1970s has resulted in a process of privatisation in which pharmaceuticals are readily available in the market. She argues that their popularity in many developing countries and availability from a wide range of practitioners qualifies them to be reclassified as a 'folk' remedy. Medicines are an important marker of the dynamics of health systems change. That is to say, they signify changes in the – social relations of health care through a particular type of health technology – 'the social indigenisation of pharmaceuticals.'

Her work illustrates the increasing power of consumers in deciding on treatments – and the associated need for consumer education – but she also notes that rural Ugandans do make considerable efforts to learn about pharmaceuticals. She further argues that the professionalised model of medicine has never been rooted in rural society as people are used to a more symmetrical relationship with traditional providers. She thus shows how it is impossible to contain specialised knowledge in the absence of professional monopolies or cartels or effective bureaucratic regulation.

She concludes by suggesting that 'donors and health planners should be aware that their efforts to support and expand professional biomedical institutions result in a shadow development of folk practitioners' (White 1992: 174–5).

We would go further and argue that this is not so much a parallel development of folk practitioners, as a shift in the location of 'expert' knowledge as a consequence of increasing health sector pluralism. In contexts such as poor rural areas of Africa where the formal hegemony of the health professions is poorly established and where the health sector resembles an unregulated market for services, 'expert' knowledge is increasingly mediated by this market rather than by professional gatekeepers. Such knowledge attaches decreasingly to sanctioned categories of personnel, and increasingly to a plurality of agents who are able to gain access to knowledge as a saleable commodity.

Households and other local actors simultaneously partake increasingly in this knowledge market and are its victims. With the breakdown in regulation, there are few reliable route maps for users to assess what is on offer, what is the competence of those providing goods and services, and whether the costs are justified and reasonable.

5 Regulating the health sector

We have argued that pluralism and marketisation are increasingly a reality in the health sectors of many low and middle-income countries. These trends are having far reaching effects on both the capacity of households to obtain safe, affordable goods and services, and on the ability of health workers to provide services. In this section, we consider the impact of these trends on the institutional frameworks within which health sectors operate.

Many industries produce large quantities of a small number of commodities, whose function is well defined. Individuals are able to choose between goods with reasonable skill. The market has developed strategies to deal with quality control, notably by establishing brand names and through internal forms of quality assurance. Governments may also set standards for goods that could potentially cause harm. The distribution of these goods in a largely self-regulated market is reasonably efficient.

The situation is different in the health sector, where individuals know they are unwell, but do not necessarily know what goods and services they require. In order to make effective use of health care technology, individuals need to be able to obtain good quality advice and secure competent services and high quality goods. There is a consensus amongst policy analysts that governments must play a major regulatory role in order to achieve this.

The health sector translates health care technology into useful services for the population. Its strategies for achieving this include:

- training health workers and enabling them to provide specialist services,
- producing and distributing health-related commodities,
- producing health-related capital goods, and
- establishing workplaces (hospitals) and complex management systems to combine labour, equipment and consumable inputs in the production of effective services.

Advanced market economies have established complex structures to regulate each of these aspects of the health sector. They commonly have professional councils that license health workers and monitor their performance. This assists users in choosing which health worker to consult for a particular problem. Most governments regulate the quality of health-related commodities and equipment and restrict access to drugs that can do serious harm. They also license health facilities as competent to provide specialist services. There is often an array of related controls over public sector providers, such as forbidding them to advertise their services or set their own charge rates.

There is substantial variation between countries in how they have developed a health regulatory framework. China depended almost entirely on central planning to influence provider performance. It is now constructing systems of regulation as part of its transition to a market economy. Many post-colonial economies established regulatory bodies modelled on those of the former colonial power (Aljunid 1995). In practice, they have only a limited capacity to monitor performance. Studies report poor enforcement

capacity against defaulting behaviour (Aljunid ibid.; Bhat 1996a and b; Mutizwa-Mangiza op.cit.; Ogunbekun 1999; Mills 1998). Similarly, professional associations may be more concerned with protecting their members' scope of practice from encroachment by other categories of provider, than with acting as a quality control on their behaviour (Aljunid op.cit.).

In many contexts, there are parallel systems. Formal sector services used by elite groups and in urban areas are reasonably well regulated. Formal sector services used by poorer people and in rural areas are weakly regulated, and informal services – particularly those used by the poor – are not regulated at all.[11]

Government regulatory powers are increasingly complemented by other strategies to reduce transaction costs and protect the public. For example, in the formal sector, insurance companies and insurance funds now play a role in controlling the cost of services and monitoring the performance of providers on behalf of their members (e.g. Van Lerberghe *et al.* 1997). However, this is of limited use to the majority who are uninsured.

While the most common guarantor of the quality of service provision has been the public health service, users in many countries seem to prefer other providers. In some countries, mission hospitals are believed to provide higher quality services, and people are willing to pay for them. Here, regulation works largely through an internalised ethic of service. In other countries, international or major national NGOs are well-regarded, for similar reasons. A recent development has been the establishment in South Africa of low cost commercial clinics that provide consultations and drug treatment at a fixed cost.[12] It is unclear whether management arrangements that enable these bodies to preserve quality can be scaled up to provide large-scale franchise operations, and whether the market, alone, can ensure a sufficient level of quality control on commercial providers.[13]

One of the great dilemmas concerning regulation is the trade-off between quality assurance and cost. Regulatory frameworks frequently function by limiting competition, thereby providing opportunities for favoured groups to earn rents. Laws that reserve the right to prescribe drugs to doctors, protect them from competition by other categories of health worker. Brand name drugs usually cost much more than generic equivalents.

This trade-off is especially problematic in societies with major structural inequalities. If the government establishes a regulatory framework largely to meet the needs of the better off, it leaves the rest of the population with a choice between paying large premiums to use regulated providers, going without services, or relying on unregulated informal providers.

India, is an example of this kind of arrangement. It has a highly regulated formal sector that resembles the health sector of an advanced market economy. The better off have access to very high quality medical care. The public health system extends throughout the country. However it does not adequately meet needs and the quality of services is variable (Bhatt op.cit.). India has allowed a massive

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11 There have been some attempts to regulate traditional healers, with mixed effects (Bishaw 1991; Le Grand *et al.* 1993).

12 Personal communication by N.M. Lenneiye.

13 For instance, can the market by itself provide a counter pressure to over prescription and to unnecessary investigations?

development of an unregulated health system with a wide variety of drug sellers and service providers. The legal framework with regard to these activities is poorly defined. If government were to use its legal powers to prevent the informal provision of these services, it would deprive many people of a living and it would deny the poor access to low cost services.

The existence of segmented markets for health services leads to complex struggles between provider groups. Doctors frequently have the sole right to private practice. In many countries, other categories of personnel are allowed to see patients and dispense drugs in public facilities, but they cannot do so privately. In Zimbabwe, for example, nurses provide medical services in a large proportion of rural government health facilities. Very few of these facilities have a resident doctor. Even community health workers are permitted to supply a limited list of drugs. However, nurses are not allowed to supply basic drugs or offer similar services in the private sector without a medical doctor on hand (Ndlovu *et al.* 2001).

China attempted to address these issues during the Cultural Revolution of the 1960s and 1970s, when the government identified the privileged position of doctors as a major constraint to the spread of health care benefits to the rural poor (Gong *et al.* 1997). It closed medical schools and forced doctors to move to rural health facilities. It established courses to train large numbers of peasants as 'barefoot doctors' who provided basic services in rural areas. Professional certification of health workers was discontinued. There were no promotions for many years, but in the late 1970s many people without formal qualifications were appointed as doctors. These measures resulted in a rapid spread of health-related skills.

With the transition to a market economy and the liberalisation of management of health workers, the most highly trained doctors have returned to urban health facilities. There are now concerns about the quality of services provided by health facilities in poor rural areas. There is also a perceived need to regulate the quality of professional practice in urban facilities. This is linked to the rapid rise in disposable income and the increasing demand for sophisticated medical care. The government is now drafting a bill to re-instate professional licensure for doctors. It will reserve certain interventions to registered professionals. This raises difficult problems for poor localities where non-professionals provide almost all services. It is not clear how this problem will be resolved.

Many countries have experienced the emergence of complex, segmented markets for health services. Their unitary regulatory systems do not take this into account. Poor people have little support from the regulatory system in choosing sellers of drugs and providers of medical advice. Governments face difficult choices in designing a regulatory framework that

i) ensures that participants in the organised economy obtain the benefits of modern health care technology (through use of regulated specialised providers) whilst extending access to safe and effective services to the rest of the population,
ii) establishes mechanisms to regulate the quality of providers used by social groups outside the organised economy, and
iii) protects regulatory structures against capture by interest groups.

6 Managing the health sector in contexts of rapid social change

The situation of the health sector in many medium and low-income countries represents a serious challenge and a unique opportunity. If trends continue, many more people will not have access to effective and affordable health services. However, the principal constraint is not absolute shortages of facilities or personnel. The problem is how to utilise existing resources and the potential of new technologies to provide more effective services. This may involve radical changes to present health systems.

We have noted some fundamental ways in which the production and consumption of health is being transformed in many low and middle-income countries. While the myth of a unitary, publicly financed health system remains strong, for many of these countries, the reality is that of a highly segmented sector, where the boundaries between public and private are increasingly blurred and in which the majority of users are served by a largely unregulated market. Health goods and services have become increasingly marketised. Users, particularly the poor, face a plurality of different providers often with few safeguards on competence and little information on which to base their judgements on choice.

6.1 Regulating the health sector in segmented health systems – what ways forward?

There is increasing interest in the creation of more effective regulatory frameworks for health services in low and middle-income countries. This leaves many questions open. Should countries import regulatory structures from advanced market economies or invent new ones? How should governments take the highly segmented nature of their societies and health sectors into account? In this section, we summarise and comment on current thinking in health sector regulation. We focus particularly on the problem of provision and regulation of basic health services in the context of highly segmented health systems.

It can be argued that the very minimum governments need to achieve is the following:

i) enforcement of public health regulations,
ii) assisting communities to dispose of human wastes and providing access to clean water,
iii) organisation of programmes to reduce exposure to malaria, tuberculosis, sexually transmitted infections and water-borne epidemic diseases,
iv) enforcement of regulation of health practitioners, drugs and other products, and
v) provision of information to enable people to cope with health problems more effectively and make better use of the available resources.

This minimal list does not take into account other important needs identified in Table 2, notably assisting households to manage inter-temporal health expenditure and informal care burdens. Many countries do not come near to meeting even these minimal objectives and they will be difficult to achieve unless governments are able to pay suitably skilled personnel competitive salaries and finance the other costs of providing these services. Reforms to health services, public sector employment and public finance are thus inextricably linked.

To think creatively about regulation, it is necessary to move away from a market vs. state optique and work from existing realities. There are a number of compelling arguments for the involvement of the state in the management of the health sector, which principally relate to well attested areas of market failure and the importance of externalities, such as public health goods. However, as we have indicated, the model of organising the health workforce through a centralised bureaucracy and through professions, is not the only one available. In many countries, it has largely failed to address the needs of the poor. Here, we note existing and potential strategies for improving basic service provision, which involve different combinations of government, market and community regulatory mechanisms.

Re-establishment of effective publicly funded and managed health services

The feasibility of this will depend on the national and local context. In countries with reasonably robust political structures, a relatively low degree of segmentation, a national or local tax base and a reasonably well trained and supervised health workforce, it is possible to think in terms of moving towards (or back to) a largely publicly financed and managed service. However, in many low-income countries, these conditions are simply not present. Regulation may work reasonably well in the predominantly urban formal sector, but is non-existent in the unorganised sector that the majority have to rely on. The most compelling concern is how to improve access to competent, affordable health care for this majority. There is little solid evidence regarding the best strategy for organising basic health services in poor areas. This suggests the benefits of encouraging experimentation with a variety of models involving a wider range of institutional actors.

Encouragement of branding and franchising

There is increasing interest in the use of brand names and franchising. The international pharmaceutical industry attempts to protect and increase its market share through higher priced branded drugs. These products now face competition from national producers of generic products. However, mechanisms are needed to certify their quality. This has become increasingly important because of the increasing availability of counterfeit products. Consumers are often willing to pay a premium for drugs they trust. For example, in Nigeria, consumers will pay a higher price for donor-supplied drugs.[14] Countries need to explore new strategies to ensure drug quality, by encouraging the establishment of national brands for imported high quality generics, as well as the development of franchised drug shops that guarantee the quality of their products.

Another option is to integrate drug supply into franchised service providers. In some countries these functions would be undertaken by the public health service and in others, it may be by private providers (for-profit or not-for-profit). This leaves open the question of what kinds of bodies should certify ('franchise') which types of providers. Experience from the private sector might suggest some learning from the ways in which the 'reputation' of a service becomes established and particular names become

[14] Personal communication from Henry Lucas.

synonymous with quality. However, moves to franchise existing professional cadres would almost certainly meet with strong resistance from professional bodies.

Establishment of local bodies to purchase services locally

This is happening in a number of Latin American countries, where local governments sign contracts with health service providers (Londono and Block 2000). The success of this kind of initiative depends on the ability of local purchasers to assess the quality of providers and provide them with incentives to perform well. It depends on the existence of local institutions with a high managerial ability and a degree of accountability to the local population.

Reforming human resources management

A large proportion of health workers, particularly in areas where the poor live, are nominally government employees. Although governments may be able to increase their funding of the health services used by the poor, it is likely that a substantial proportion of these health services will continue to be privately financed. There needs to be much more creative thinking about the management of human resources in the health sector and the services which government health workers can provide.

In many countries, these workers are poorly paid and frequently working on the side to make a living. It is unlikely that substantial additional financing will be found for raising salaries significantly in the public sector, unless a way can be found to reduce the overall size of the workforce. If this is politically unattainable, it may be that governments should openly acknowledge that most health workers are effectively part-time. This opens the way to more flexible contracts with different categories of health worker. These could specify more clearly the services which they are to provide, and which government is prepared to finance. Health workers could then be licensed or franchised for a range of other services for which they would be entitled to charge a fee.

Local providers also need sufficient skills and incentives to provide appropriate services. Health workers who have been isolated for years need information on modern methods for addressing common health problems. The provision of this information alone, however, is unlikely to have much impact unless the present pattern of incentives is changed. Employees of public bureaucracies tend to get paid regardless of whether they carry out their duties or not, or even whether they are present or absent. Improving the performance of the bureaucracy is an urgent concern (Moore 2000). An alternative strategy is to link performance monitoring to community based forms of regulation.

New models of accountability using community representatives and organisations

With the very obvious failures of many public bureaucracies, there is increasing interest in demand side led mechanisms for regulating and monitoring performance health sector performance. Cornwall *et al.* (1999) discuss different experiments in strengthening local accountability mechanisms in the health sector. This can involve using existing community based organisations for monitoring of facilities and providers, or appointment of representatives to decision-making bodies in local health services and individual facilities.

It can also involve making providers responsible to the community by giving local bodies supervisory powers and providing them with appropriate information to enable them to assess provider performance.

Other devolved accountability mechanisms include assisting civil society stakeholders to understand, disaggregate and monitor health and social sector expenditures to see which groups are benefiting (Loewenson 1999). The movement for women's budgets is an example of this kind of development (Budlender *et al.* 1999).

Rebuilding an ethics for the health sector

One of the strongest arguments against allowing the market to determine access to health goods and services is the impact on health system ethics. As was noted, overprescription, inappropriate and unnecessary interventions and higher costs to clients and society are all serious risks. In systems where markets are significant providers of services, and professionalisation has proved inadequate to the task, ways have to be found both to reduce or mitigate the worst effects of marketisation, and to reconstruct an ethical basis for health care practice.

This requires greater attention not only to the role of external incentives and sanctions in improving health worker performance but also to the conditions which promote an internalised ethos of good practice and how these can be encouraged in a context of increasing marketisation. In some countries this will involve changes in the expectations of both users and providers of services from a situation in which competition is largely on the basis of cost to one in which trusted health workers are paid adequately for providing expert advice.

This is an argument for looking more closely at other ways of organising goods and services which entail a significant degree of risk to the client and the wider society and where an internalised ethics is essential. There are examples of highly self-regulated industries and professions from which the health sector might have something to learn. The airline industry, civil engineering and veterinary services are all possible examples. Leonard's pioneering work on the market for veterinary services in Africa, which is largely a private one (Leonard, D. 2000) draws important parallels with the situation of health providers. This is not to argue that these are free from failures, particularly in poor countries, but they offer examples of regulatory models in largely or wholly marketised professions and industries which may have relevance for an increasingly marketised health sector.

6.2 From regulating the health sector to managing the knowledge economy

In this final section, we offer some preliminary thoughts on reconceptualising the meaning and scope of regulation in the context of the rapidly changing environment in which health goods and services are being produced. We have noted how the location of expert knowledge has been challenged by both the marketisation of health care and by growing literacy and access to mass media. Rather than focusing exclusively on regulating structures and personnel, we would argue that the need is to regulate the knowledge economy in health.

This challenge has not been sufficiently acknowledged by managers and health professionals. User information was less important when government was a monopoly supplier of goods and services. The traditional model of health education is through campaigns using the equivalent of health visitors (community health workers). These campaigns mostly focus on public health measures and preventive programmes. This will continue to be an important method for improving health. However, poor households now frequently use private providers and drug sellers. In a poorly regulated market, action should shift towards providing users with basic information to enable them to judge provider competence, purchase safe and effective drugs and know where they can get cost effective treatments.

The need to acknowledge and build up the existing knowledge base at household and community level can be linked to possibilities being opened up by new technologies. The sale and distribution of essential drugs is one area which can potentially benefit from new information technologies. The principal strategy for treating many common health problems is with drugs. Previously the major constraint was in government's ability to procure and distribute these products. They are now widely available in most countries. The problem is how to ensure that they are used well. The creation of markets for drugs has re-opened an old struggle for professional roles between providers of drugs and providers of medical advice (Gilbert 1998). Strategies are needed for reducing the cost of essential drugs (this could be achieved by subsidising them if they are going through channels that reach the poor), and for improving advice to users.

The old problem is that drug sellers have an incentive to sell more drugs. That is one reason why many countries separated the roles of drug supplier and health worker. However, new technologies may provide an opportunity to re-unify these functions. It might be possible to provide a low cost computer in which symptoms could be entered and recommended treatments could be made. The computer could track drug sales. This could lead to possibilities such as the franchising of drug shops to provide safe drugs at set prices according to agreed protocols.

Middle and low-income countries are potentially major markets for new models of health service organisation. The technology now exists to permit the organisation of simple affordable services. Thus, small clinics could be established using a range of health providers, at which treatments are prescribed according to protocols. The use of low cost computers may make it possible to ensure quality and to monitor performance. It is difficult to assess whether this will occur from the spread of drug sellers and then diversification into provision of advice, or whether health worker clinics will dispense drugs.

This kind of model is of a new kind of 'mass production' of basic health services as an alternative to total bureaucratisation and professionalisation. It would be most appropriate for addressing common problems. It is unlikely to be able to advise people coping with the complex issues related to ageing, for instance. It also could not deal with social and psychological aspects of health. But it can perhaps produce a more competent, accessible and affordable option for poor countries in managing more routine health problems. This would move us towards a new segmentation of the health sector, with an industrialisation of basic services across the population, and a continued use of professional models for complex advice and interventions.

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