

NGO and Public Health Systems: Comparative Trends in Transforming Health Care Systems in Kenya and Finland

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Abstract

This paper examines the transforming health systems in two countries (Kenya and Finland) through a study of the roles and significance non-governmental organizations (NGOs) exact in health services provision, health promotion/prevention and health policy making. Issues of the NGO and public health systems' organization, development and collaborations are dealt with in a comparative perspective. The study is part of a doctoral research project carried out in the last three years. It makes extensive use of primary and secondary documentary materials and data as well as field interviews with over 130 decision makers in government, NGOs as well as other experts and commentators in this area in the two countries. The analysis suggests that the contribution of NGOs to developing the countries' health systems is larger than hitherto understood, that NGOs are firmly at the centre of health policy discourses and that international health trends informs countries' health systems development greatly thus the major similarities in policy developments in the two diverse countries. The research findings have a broad relevance to health systems development in advanced welfare states and developing countries in general and in particular for the understanding of the complexities surrounding NGOs in this sub-field of social policy.

1. Introduction

Health care systems the world over have undergone a series of transformations over the past half century. In particular, the *World Health Report 2000* identifies three generations of reforms (WHO, 2000: 13-16). In Kenya and Finland, this is explained by the development of the governmental system in the 1960s, emphasis on primary health care (PHC) through the 1970s-1980s, and decentralization and marketization in the 1990s. These transformations have followed global shifts in ideas towards health, in particular, the 1978 Alma Ata Declaration on Health for All (HFA) by the Year 2000 (Owino, 1999: 269; Koivusalo and Ollila, 1996: 111-28) as the general framework. These reforms have been implemented under conditions of economic, political, structural and cultural constraints (Vogel and Stephens, 1989: 480; Koivusalo and Ollila, op. cit.: 128-137) and transformations. In line with the HFA, the current policy objectives of the Ministry of Health (MOH) in Kenya and Ministry of Social Affairs and Health (MSAH) in Finland lay increasing emphasis on preventive/promotive health while encouraging the participation of the NGO/private sectors, communities, households and individuals to play a greater role and cross-sectoral collaboration (Republic of Kenya (ROK), 1999a; Ministry of Social Affairs and Health (MSAH), 2001a). These developments have led to the emergence of a public-private partnership discourse towards the end of the century (e.g., Mwabu, 1998: 18; Palmer, 2000; Harding and Preker (Eds.), 2003).

The growth and organization of NGO health systems in both Kenya and Finland has followed the broad societal transformations in each country contexts. In both cases, extensive networks of NGOs in the health and social sectors existed in the colonial and World War periods (WHO, op. cit.: 11-13; Hélen and Jauho, 2002: 3-4). The expansion of the public system incorporated much of this voluntary system in the 1960s and 1970s. The proliferation of NGOs in the 1990s has mediated a transformation in social policy thinking (Room and 6, 1994; Mwabu, Ugaz and White (Eds.), 2001). Throughout the decade, over 2,000 NGOs were established annually in Finland (Newton, 2000: 210) while in Kenya the figure was over 100. In spite of the availability of these numbers, the growth and organization of health NGOs in both countries is largely undocumented. Hence, this study was a systematic attempt to

generate information on the role, scope and size of NGOs in the health sub-sector with regard to three key components: (1) service *provision*; (2) health *promotion*; and (3) *participation* in policy making.

In line with the component areas, three major findings can be summarized. One, health NGOs already operate 20% of all health care facilities and receive the largest share of health insurance payments from the statutory health insurance schemes in both countries. Second, the NGO system utilizes the largest single share of health promotion budgetary appropriations in both countries. And third, health NGOs are indispensable constituents of health policy-making in relevant governmental bodies. In this regard, there exists at the health Ministries level various institutional dynamics created by legislation, decree or policy where NGOs are represented. In spite of their large role as exhibited by these findings, the NGO health system is mostly under appreciated by policy makers and scholars alike, although they have had wide recognition and been accorded a place in designing the countries' health care frameworks. Indeed, the current long-term health policy and development frameworks in both countries strongly emphasize their role and the centrality of collaborative cross-sector partnerships: the 1994 *Kenya Health Policy Framework* (KHPPF 2010) (ROK, 1994) and the *Health 2015* (MSAH, 2001a) in Finland. Other medium-term frameworks are the *National Health Sector Strategic Plan (NHSSP) 1999-2004* (ROK, 1999) and the *National Project for Securing the Future of Health Care 2007* (MSAH, 2002), respectively. In addition to discussing the above findings, the paper will document an appraisal of the central elements that capture the interactive inter-organizational relations presented by these policy frameworks.

The paper will underline the centrality of NGOs in the transforming health care systems in these two countries using extensive quantitative data and illustrations from the field. The study is located in the wider theoretical discourses of the new social policy paradigm (Mullard and Spicker, 1998; Kautto et al, (Eds.) 1999; Harris, 2002; ISTR, 2002: 7) and the "paradigm of partnership" (Salamon, 1995: 203; Singh, 2002: 8; Le Grand, 2003: ix). The participation discourse is also of particular importance given the rationale it gave to the HFA PHC movement, preventive/promotive health care, and more recently also to the participation of private players in specialized health care (e.g., Harding and Preker (Eds.), op. cit.). A part of its theoretical foundation, one of the hallmarks of decentralization is the possibility it offers for citizen participation (Mohan et al, 2000: 92-93; Munishi; 2002: 78). It is evidenced in this research that overall government decentralization and health care reforms have had far-reaching implications on the development and organization of the NGO health system in the countries.

Both Kenya and Finland are democratic republics. The countries have differing socio-historical, economic and cultural realities. As a sub-Saharan African developing country, Kenya's social economic indicators are low and have overall worsened particularly during the 1990s. For example, the level of poverty reached its worst level in 2000 rising to 56% from about 44% in the early 1990s (UNDP-Kenya, 2000; for detailed data on social and human-economic indicators, see Wamai, 2004:116-119). A highly industrialized society, Finland has among the leading social-economic and health indicators. The Gross Domestic Product (GDP) per capita economic measure shows that while Kenya's is US\$ 306 in 1999 (UNDP-Kenya, op. cit.: 30), Finland's was US\$23,096 in 2001, ranked 5th in the world (UNDP, 2001). Average life expectancy in Kenya stood at 54.7 years in 1999 (UNDP, 2002:15) while Finland's was 77.4 in 2001 (UNDP, 2001). Further data on health expenditures as a percentage of the GDP indicate a favourable figure of 7.8% in Kenya and a slightly lower

6.9% for Finland during 1998 (World Bank, 2001). Again, overall health care financing differs with the share of out-of-pocket payments estimated at 49% in 1994 (ROK, 1999b: 12) in Kenya and 20% in Finland in 1999 (Järvelin, 2002: 31).

Admittedly, the wide disparities in the indicators make comparison of these two countries questionable and even difficult. In spite of this however, the case for cross-cultural studies is endearing for theoretical and practical reasons. Such studies contribute to building or developing theory as well as generating lessons for possible application in the countries (e.g., Mabbett and Bolderson, 1999: 54; Salamon et al, 1999; Øvretveit, 1998). The study also has a North-South dimension that can inform the development of the lesser developed health system (e.g., Nissinen, Berrios and Puska, 2001). Finally, because of the nature of health care, a unified thread is found for studying health system developments, reforms and transformations (WHO, 2000). In this paper, whenever appropriate, I present the data in a comparative dimension rather than separate cases in different sections. First I examine the health systems in the two countries to have a general overview then present some key features of the NGO health systems and close with a reflection of the NGO systems in the context of transforming health care systems.

2. Organization of the Health Care Systems in Kenya and Finland – A Comparative Overview

A general norm in most countries, the organizational structure of the Kenyan and Finnish health care systems is hierarchical comprising various levels of administration. Figures 1 and 2 (in the appendix) depict the complex picture in Finland and Kenya, respectively.¹ The hierarchy is embodied in the general sense that administrative decisions and policy direction flow from the top (Ministerial level) to the bottom. In addition, the hierarchy also adheres to the service structure whereby clients access the system by starting at the bottom and move upwards as the health need gets more complex, by a referral procedure. The service system structures are also pyramidal in the sense that they are bulky at the bottom and thin out towards the top; this is especially the case in developing countries (e.g., Akin et al, 1985: 8).

Looking at the figures, it is obvious that Kenya's administrative structure is much more complex than Finland's. It is important to bear in mind that both the countries health systems have undergone numerous transformations in the past 40 years as indicated in the introduction above. One of the most notable reforms has been the decentralization of decision-making and responsibilities. As part of government-wide reforms, both countries embarked on long-running 'decentralization', 'de-institutionalization', and 'deregulation' in 1982 (Mutiso, 1986: 213; Hägglund and Modeen, 1988). However, and focusing on the health sector, the achievements are not nearly as comparable. Finland has emerged as one of the most decentralized health care systems in the world with the responsibility for its organization, administration, and decision-making resting with the democratically elected 448 municipalities across the country. In contrast, decentralization in Kenya is only currently in trial in 14 of the country's 71 districts. 20 years after the *District Focus for Rural Development* government reform program embarked in 1983, much of the decision-making has rested with the Ministry of Health (MOH) represented by a cadre of officials at the

¹ Although the administrative organizational structure refers only to the public sector system, the NGO system is represented only for the analysis given later as to the nature of its interactions with the public system. This is done here in order not to duplicate the pictograms. In developing these figures, recent and current health policy/programs and reforms in the countries are taken into account.

provincial level lead by the Provincial Medical Officer and the district level with the District Medical Officer of Health, all of who are appointed from the Ministry. These officials are responsible for decision-making and reporting to the office above them in their area of responsibility supported by management teams and boards.

While the Ministry of Social Affairs and Health (MSAH) in Finland is only responsible for overall policy direction, supervision, legislation and health policy reforms, the MOH in Kenya not only does all of these but also owns the health infrastructure and directly provides the health services in over 2,000 health institutions across the country under the diverse organizational levels shown. In 2001, this system comprised 1,583 dispensaries, 465 health centres, 82 district and sub-district hospitals, 7 provincial general hospitals and the national flagship Kenyatta National Hospital (Republic of Kenya, 2001: 63; Wamai, 2004: 120). In the case of Finland, as noted, the public health system is run by the municipalities under the *Public Health Act* of 1972. Although most municipalities run a health centre of their own, and some may run hospitals independently, most operate the hospitals jointly with other municipalities. Thus the public system comprises 278 health centres and 54 hospitals operated by 20 hospital districts (formed by coalitions of the municipalities) of varying sizes by ownership and population across the country (Wamai, 2004). The major health system data for both countries are presented in tables 1 and 2 below. These data include the NGO and private health sectors for an overall picture and comparable analysis.

Table 1: Distribution of Health Facilities by Type and Provider Sector in Kenya, 1998

Type of Facility	Government		NGOs		Private		Total No.
	No.	%	No.	%	No.	%	
Hospital	109	50	67	30.7	42	19.3	218
Health Centre	460	80	100	17.4	15	2.6	575
Dispensary	1,537	60.9	595	23.6	391	15.5	2,523
Nursing & Maternity Home	0	0	11	5.8	180	94.2	191
Health Clinics/Medical Centres	43	0.1	72	10.2	592	83.7	707
Total	2,149	51	845	20	1,220	29	4,214

Source: Republic of Kenya (1999a: 5)

Table 2. Distribution of Major Health Infrastructures by Delivery Sectors in Finland, 2003*

	Public			Private		NGOs		Total	
	Municipal	University	Total	No.	%	No.	%		
Hospitals	54	5	60	58.8	21	20.6	21	20.6	102
Health centres	278		278	99.6			1	0.4	279
Hospital Beds	17,171		41,081	95.9	1,760**	4.1			42,841
Health centre beds	23,910								
Health personnel			127,632	83.2	17,688	11.5	7,998	5.3	153,318

Source: field data (2003).

Notes: *Hospitals, health centres and beds data, 2003, and personnel data for 31.12.2000; ** includes NGO sector data.

As can be seen in the tables, on the health facilities level, the systems in both countries are quite mixed. In Kenya the government operates 51% of the country's health facilities while NGOs and private businesses operate 20% and 29%, respectively (table 1). Table 2 shows that the picture is not much different in Finland with 58.8%, 20.6% and 20.6% distribution across the public, NGO and private sectors, respectively. However, there are wide variations in sector penetration in the different facility types in both countries. In Kenya the government operates most health centres and dispensaries as well as hospitals with 80%, 60.9% and 50%, respectively seconded by NGOs in these types of facilities with 17.4%, 23.6% and 30.7%, respectively. On the other hand, the private sector has a commanding domination in nursing and maternity homes and health clinics and medical centres with 94.2% and 83.7%, respectively. The one health centre run by an NGO is, a unique case and is discussed in the next chapter. The Finnish data has not been categorized into broader typologies as in the Kenya case.² However the research was able to identify that most of the hospitals operated by the Finnish NGOs are comparable to nursing homes or rehabilitation centres except for a few highly specialized hospitals; this is likely also the case for the private sector hospitals. In general, as pointed earlier, the systems are pyramidal with a heavy bottom and a thin top as shown by 74% concentration in the primary health care facilities (health centres and dispensaries in Kenya) and 73% (health centres) in Finland.

With regard to the distribution of inpatient capacity – taking two sets of indicators (beds and personnel) – the picture becomes more varied and differentiated across the sectors and countries. The available data in the national health management information system (HMIS) in Kenya indicates that in 1999 there were 54,378 beds and cots (Wamai, 2004: 136), out of which an estimated 36% were in the NGO sector (Owino, 1999: 270). In the case of Finland, the bed share of the public system is overwhelmingly large at 95.9% compared to only 4.1% for both the NGO and private sector systems. While data was not separately available for these two sectors, the research identified that many government hospitals have over 500 beds and many NGOs typically less than 100. The Finnish data show a strong welfare state model. In terms of health personnel, the data from Kenya shows there were a total of 53,612 in 1999 for all sectors. Although the majority (69%) of the personnel come from the Ministry of Health training institutions (Wang'ombe et al, 1998: 3), a larger number work in private practice (in NGOs or private sector) as, for example, shown by the fact that of the over the 5,000 doctors, only about 1,000 work in the public sector (Kimani, 2003). In Finland, the government's share of overall personnel is again dominant at 83.2% as compared to 5.3% for NGOs and 11.5% for the private sector. Clearly, the large number of NGO (and private sector) hospital institutions in Finland, while remarkable, is not reflected in the number of hospital beds and health personnel. Still, a large number of physicians operate (also) in the private sector (Lehto, 2002: 252).

² The amount and richness of data for a country's health indicators is a matter for the health management information system (HMIS). None of the two countries' HMIS is comprehensive enough and efforts are being made to expand the amount of data and information reported; in Finland this is being done along a Organization of Economic Commission and Development (OECD) framework (Nenonen and Nylander, 2001).

3. Analysing the NGO Health Care Systems in Health Services, Health Promotion and Policy Making in Kenya and Finland

3.1. A Contextual View

To understand the role, nature and significance of NGOs in any societal sector, one needs to review the context of their operations in the country. Towards this end, the following key observations can be made. As stated earlier, NGOs have played a central role in both Kenya's and Finland's health care systems prior to the development of a state/public health care system. Evidently, the emergence of large public systems is emblematic of the development of the welfare state in both countries, albeit to differing extents – Kenya being embryonic and Finland well-developed; the welfare state development in Kenya is a post-colonial phenomenon whereas it is a post-World War II one in Finland. Post-colonial political developments have impacted in diverse ways on NGOs operational context in Kenya. In the 1980s, President Moi's regime was largely harsh opening up significantly in the 1990s, arguably due to the economic deterioration and near collapse of the public social welfare service system. In Finland, the operational context of NGOs in the social policy fields in the 1980s and 1990s has largely been shaped and influenced by the changing welfare state. The change, experienced largely around the Western developed countries, is easily discerned from the combination of fiscal, demographic and political imperatives (e.g., Clasen, 1999: 3-4; Salamon, 1999: 344).

Although NGO/Mission³ hospitals (in Kenya) and specialized foundational NGO hospitals (in Finland) have continued to exist even during and through the development of the welfare state, the growth and manifestation of NGOs in all spheres of societal life is largely a post-1980s phenomena. The general proliferation of NGOs has expanded civil society so tremendously that they have come into the lime-light catching the attention of policy makers and researchers in the countries and around the world. This has been marked by an increasing role and significance of NGOs especially in the social development and social policy fields in the countries.⁴ In fact, significant social development and social policy programs in these countries have aimed at developing a welfare mix type of service system that is more versatile to needs, situations and localities (e.g., Kinnunen, 2000: 93). In the health care field, system reforms, legislation, support mechanisms and policies have been instituted that emphasize and support the role of NGOs. It is in this light and context that this study focuses on the roles, organization and participation of NGOs in the countries' health services, health promotion and policy making.

3.2. Some Indicators of the NGO Health Service Systems in Kenya and Finland

Two sets of related indicators can be used to assess the NGO health system in the two countries: system size and financing. The key system size data have already been presented above in tables 1 and 2. This section aims at expanding that picture by examining the data with information on financing of the sector as well as discussing some case studies. While the

³ The major health institutions in the NGO sector are run by religious bodies or faith-based organizations. Generally, these are defined as part of NGOs. In this research, only Christian-based missions are studied.

⁴ It should be noted that the terms 'social development' and 'social policy' essentially refer to the same outcomes but disciplinary tendencies place the former in development studies, thus referring to (processes in) developing countries, and the latter in social or public policy studies, thus referring to (processes in) developed countries.

following tables attempt to capture the picture, it should be recognized that since the countries health information management system (HMIS) do not contain comprehensive sectorized data and there is no agency for gathering the sector data, what is shown is not the complete NGO health system.⁵ The data can however be taken to be representative of the largest part of the system. The tables are meant to be self-explanatory and thus will not be discussed in great detail.

Though not the only form of financing,⁶ the National Hospital Insurance Fund (NHIF) – the only statutory health insurance scheme – best captures the NGO health service system in Kenya. The fund was established in 1996, soon after Kenya’s independence in 1963, and operates as a sickness insurance scheme for contributing members covering only in-patient care. In 2003, the scheme covered about 10 million Kenyans (household members of a contributing person are covered). Any duly licensed hospital (government, NGO, private or community-owned) can apply for accreditation to be reimbursed for insured patients to whom care is given. In May 2003, a total of 414 institutions were accredited out of which 63 (15.2%) were NGO/Mission run and have 6,755 (18.5%) beds. The majority (55 or 87.3%) of these institutions are hospitals with a few maternity homes and health clinics and medical centres. Table 3 shows the financial flows from NHIF to the NGO system.

Table 3. Summary of NHIF Claims and Payouts to Mission/NGO Hospitals (1998/99-2002/03 Financial Years) (Ksh)

	No. Of Claims	% Of Total	Amount Reimbursed	% Of Total
1998/99	17,986	34	79,988,379	37
1999/00	28,616	30	127,920,074	33
2000/01	24,742	26	104,606,740	29
2001/02	27,085	25	153,298,752	26
2002/03	24,711	24	171,609,599	26
Total	123,140	27	637,423,544	29

Source: field data (May, 2003).

Although the figures fluctuate in the years, the total reimbursements for all the years countrywide indicate that NGOs have received the highest payments of 29% compared to the other sectors. But, in fact, the role of NGOs in inpatient hospitalization seen from the point of view of the national health insurance scheme in Kenya varies from region to region. One example from Central Province, one of the smallest in the country’s seven provinces, show that four NGO/mission hospitals working in the area (17% of the total) with 32% of all beds

⁵ Since 2000, following a reform of the health system, NGO (and private) health institutions in Kenya are required obtain a license of operation from the Medical and Practitioners and Dentists Board (MPDB), a specialized agency of the MOH. After the reform, those previously operating health institutions were required to obtain a new license. In reality, more NGOs are running health care operations than the number licensed by the board and therefore the agency does not have comprehensive figures. In Finland, NGO (and private) health operators are licensed by the 5 provincial government administrations having 12 regions each of which keeps its own records. The regions are required to supply the data annually to the national information system kept by National Research and Development Centre for Welfare and Health (STAKES) but it has not been complete.

⁶ NGO health financing comes from various sources mainly fees paid either directly by patients or by the health insurance system (notably NHIF), donations (foreign or domestic fundraising) and government grants either direct cash or in-kind (particularly drugs, equipment or secondment of health personnel).

and 22% of all doctors attracted 62% of all NHIF claimant beneficiaries netting a whopping 85% of all reimbursements in year 2002.

Table 4. Characteristic Features of the Two Main NGO Health Systems in Kenya

Type of Facilities	Christian Health Association of Kenya (CHAK)		Kenya Episcopal Conference Catholic Secretariat (KCS)	
	2001	2003	2001	2003*
Hospitals	16	20	39	41
Health centres & cottage hospitals	13	40	93	94
Dispensaries	250	253	272	276
Total Facilities	279	313	404	411
Secretariat employees	-	16	-	-
Districts operated	-	60	-	71

Sources: field data (2002, 2003).

Notes: *KCS data are being updated from 2002; current numbers are expectedly higher; the number of KCS secretariat employees was not established; all country districts are covered. “-” data not available.

Looking closer at the Kenyan data, we note that the NGO health system is largely operated by two different religious organizations: the Kenya Catholic Secretariat (KCS) and the Christian Health Association of Kenya (CHAK), a grouping of 44 Protestant Churches. The Catholic system has been operative since 1957 and was re-organized as KCS by the Kenya Episcopal Conference (KEC) of Bishops in 1960. It’s health system is administered by the Commission for Health and Family Life, one of eight KEC commissions. The CHAK system has existed since the 1930s and was known as the Protestant Churches Medical Association after 1946 till it got its new name in 1982. KCS and CHAK act as secretariats promoting the roles of the units, which are independent in their operations. Table 4 depicts key features of the two systems. As can be seen, both operate all the major types of health institutions. Notably also, the KCS system is significantly larger and operates in all the 71 districts of the country. Together, these two systems operate about 20% of the country’s health institutions.

Assessing the size and scope of the Finnish NGO health service system is not easy due to lack of a national reporting system and umbrella or overall organization, as in the case of Kenya’s KCS and CHAK systems. The only national data available is of expenditures and personnel by type of major services as shown in table 5 below. There is however no information about the source of the financing or the number of NGOs or institutions involved due to lack of complete recording of the information in the HMIS. Evidently however, financing comes predominantly from fees for services (Helander et al, 1999: 74) either paid by municipalities as reimbursements for statutory services (which the municipalities are obliged to provide – these constitute the largest part), by the National Health Insurance (NHI) and out-of-pocket payments. Still, there exists a joint state-NGO venture capital mobilization scheme – the Finnish Slot Machine Association, known popularly by its Finnish acronym as RAY – that disburses all its funds as grants to health and social NGOs on project basis.

Table 5. Size of the NGO Health System by Expenditure and Personnel in Finland, 2000

Type of Service	Expenditure €	Personnel
Health care services*	232,678,413	7,998
Hospital services	181,333,176	5,044
Doctor services	29,463,933	1,147
Other doctor services	29,463,933	-
Dental care	-	24
Other health care services	21,881,303	1,783
Physical therapy	2,166,466	118
Lab and imaging services	5,416,164	854
Hospital transportation	3,249,698	80
Other health services	11,048,975	731
Total	284,023,649	9,781

Source: Kauppinen and Niskanen (2003).

Notes: * These include the hospital services, the doctor services, dental care and other health services. Hence the expenditure and personnel shown are totals of all these; other health services include, for example, visits of private nurses and practical rehabilitation nurses, etc. “-” data not available.

The NHI is the main buyer of rehabilitation services in a competitive contractual arrangement that almost exclusively procures from the NGO/private systems. In 2002 it spent about 225 million Euros in about 80 producers a vast majority of which are NGOs. RAY also exclusively funds (in grant forms, as contrasted to the NHI financing) the NGO system. In 2003, 403 projects in rehabilitation and treatment services amounting to 17.5% of RAY’s overall €302 million were funded.

Another indicator of the scope of the sector in Finland is data of services purchased by municipalities. One research in 211 municipalities indicated that NGOs are quite active especially in fields that are on the health and social borderline, such as elderly housing and elderly institutional care, thus difficult to categorize into either. The range (in 17 types of services) was from zero in environmental health to 44% in elderly housing services (Wamai, 2004: 164). As another research showed, overall, 10% of municipal spending on health and social services is paid to NGOs and private providers (Kauppinen and Niskanen, 2003: 49). In fact, municipal purchases from NGOs is widespread but obviously varies from place to place depending on factors such as the strength and reach of the municipal services vis the NGOs’. For example, case illuminations from the field research revealed that two NGO hospitals – one specialized in rheumatology and the other in orthopaedics – received patients from over 300 municipalities each. In one small municipality of about 9,000 inhabitants one large national NGO (with the Swedish name, *Folkhälsan*, literally, “People’s Health”) established in the 1920s runs the entire primary health care system, and much of the secondary care, for the municipality. A matter largely of competitive contractual agreement with the municipality since 1998, the case is unique in Finland and may very well be a future model for municipalities facing similar problems of unmanageable health care costs and other organizational difficulties (for an analysis, see: Laamanen, Häppölä and Brommels, 1997; and Wamai, 2004: 168-170).

To conclude, evidently the role of NGOs in both countries' health care services developments cannot be underestimated. In the 1980s, NGOs were already providing 35% of the health services in Kenya (Bratton, 1989: 571). In both countries, they also train a sizeable number of health personnel mainly nurses and clinical officers. They play a much larger role in the health promotion fields as will be shown below.

3.3. Some Indicators of the NGO Health Promotion/Preventive Systems in Kenya and Finland

Health promotion (HP) refers to “the process of enabling people to increase control over and improve their health” (Last, 1987: 10). Health promotion includes, among others, environmental health, sanitation, immunizations, nutrition, control of intoxicants, healthy living, screenings, and general protection of society from ill health (ibid.). Although some studies suggest that the private and NGO sectors play a typically marginal role in HP in the developing countries (Harding, 2003: 46-7), because, it is argued, the sector is usually “excluded from public health programs”, this does not seem to be the case per se in Kenya. The *National Health Sector Strategic Plan* (NHSSP) lays special emphasis on health education in several of its components to which NGOs are regarded as key stakeholders responsible in their implementation. Another area of importance is in the sustainability of the Bamako Initiative.⁷

Table 6. Promotive/Preventive Health Financing by Sector in Kenya (1994) (Millions Ksh.)

	Total	%
MOH	441	38.5
Other Ministries	84	7.3
Local Government	101	8.8
Out-of-pocket	172	15
NGOs	348	30.4
Total	1,146	100

Source: ROK (1999b: 14)

The policy programme has two objectives for health education: to “increase public knowledge and understanding on mode of spread and preventive measures of all diseases up to the community level”; and to “enhance the capacity of the division of health education to coordinate planning and implementation of health communication” in the country (ROK, 199b: 35, 37). Generally, however, NGOs work often detached from this policy context mainly because they are not coordinated either among themselves or in the Division of Health Education (DHE) at the Ministry of Health and its regional offices at the provincial and district levels. In light of this, it is not easy to capture the size or scope of the sector. A key measure is derived from the country's constituted *National Health Accounts* (1994).

⁷ The initiative was promulgated by a conference of African health ministers in Bamako, Mali, in 1987 with the support of UNICEF and WHO as a developing-countries' approach towards the WHO health for all by year 2000 initiatives targets and in line with the 1986 Ottawa Charter. The initiative emphasizes the mobilization and commitment of communities' own resources in developing primary health care services through selling drugs in community-owned and managed pharmacies.

Accordingly, promotive/preventive health services account for only 4% of the country's health expenditure of which NGOs expended 30.4% as depicted in table 6 above (ROK, 1999b: 14). It is crucially important, however, to note that Ksh476 million or 99.8% of the NGO expenditures captured for the NHA was donor financing and the rest from government (ibid. 12). This would mean that 73% of the donor-financed NGO expenditure (of US\$6,402,000) went for promotive/preventive health. Other national indicatory data available for NGO health promotion/prevention work, also largely donor financed, come from the national HIV/AIDS programme, *Kenya National HIV/AIDS Strategic Plan (KNASP) 2000-2005* (Office of the President, 2000). In this programme, 58% of the Ksh14,059 million (US\$188,762,000) budgeted, was targeted for 'prevention and advocacy' sub-fields. Of the US\$50 million sourced from the World Bank, 60% is being channelled directly to NGOs by the governmental body established for administering the programme, the National AIDS Control Council (NACC), with the rest going to government and private sectors.

The case of Finland is much clearer with regard to NGO health promotion activities and system. This is because there exist a visible system of public financing, legislation and NGO organization in this field of health work. In Finland, health promotion is an integral part of primary health care as legislated in the Primary Health Care Act of 1972 (Hélen and Jauho, 2002: 8) and in the amended Constitution Act (965) of 1995 (Ministry of Social Affairs and Health (MSAH), 1996: 16). Government financing is made available to NGOs by the MSAH primarily through a tobacco and alcohol and temperance work legislations, which provide for a certain percentage of state tax revenue to be used for health promotion. However, 18 different sources of health promotion financing for NGOs have been identified ranging from governmental sources at the state, regional and local levels, the Slot Machine Association (RAY), private corporations and NGOs. In effect, health promotion is carried out largely as a partnership exercise between mainly the public health system and NGOs.

Since 1997, administration of application procedures, budget planning, and project implementation, monitoring and evaluation for health promotion has been agentized to the umbrella NGO for 121 health NGOs, the Finnish Centre for Health Promotion (FCHP). According to comprehensive data from the MSAH, NGOs are the largest single block of organizations implementing the health promotion appropriations (Wamai, 2004: 176). Each of the agencies noted in table 7 above is responsible for different categories of applicants. As shown in the table, NGOs have implemented 41% of the funds appropriated for all the years shown through the FCHP system. The projects address a range of problems mainly tobacco, alcohol and drugs abuse as well as mental and physical health through educative campaigns in schools, homes, work or other public places. In addition to the MSAH financing, health promotion NGOs also receive exclusive funding for health promotion work from RAY, and from budgets of the municipal health system.

3.4. Some Indicators of the NGO Participation in Health Policy-Making in Kenya and Finland

The adoption and streamlining of NGOs in government policies in both Kenya and Finland is a phenomenon of only the last 20 years. Their participation in health policy-making has no doubt increased notably in the 1990s following their prominence and proliferation all over the world. Today, hardly any social policy of government is lacking in input from, or consideration, of the NGO sector. Their participation includes not only policy advocacy, which attempts to create awareness in order to influence policy process, but also the provision of expert services, advise and decision-making in the policy process (e.g.,

Chatterjee, 1988: 106; Mpamila, 2000: 2). This may be achieved through different mechanisms such as public hearings, through written presentations and representation in relevant governmental committees. In Kenya health policy is more widely framed within the social development frameworks for poverty reduction. Of the long-term, medium-term and short-term frameworks, the notable one is the 2000 short-term interim *Poverty Reduction Strategy Paper (PRSP) 2000-2003*. Here, the health component aims at radically shifting resources from curative to rural preventive/promotive primary health care. This aim was more centrally articulated in the *Kenya Health Policy Framework (KHPF)* and the NHSSP.

In the reforming health policy, various institutional and legal mechanisms opened a wide door for NGO participation in shaping the policies and decision-making in the 1990s. One is the District Health Management Board (DHMB) established through *Legal Notice 162* of the Public Health Act in 1992. Each DHMB has seven to nine members of whom two are from NGOs active in the region. With 71 districts in the country, each with a DHMB, NGOs have 142 representatives in the district health care system. The boards have three committees dealing with finance and general purposes, quality of curative services, and public health care services. Another institutional dynamic in participatory health planning and operation is the District Health Stakeholder Forum (DHSF). Although operational in only a few (pilot) districts, it is expected to be replicated throughout the country. The forum brings together all stakeholders in health care in the district four times in a year to discuss challenges, seek solutions by sharing experiences and inform the district's health development plans. At the national level, a Donor and NGO Coordination Division (DNCD) was established in 1997 to help operationalize the intentions of the government to “engage dialogue with NGO/private health providers” (ROK, 1999a: 63). Although not much progress in the direction of institutionalising it has been made to date, it is a much needed development owing to the significant scale of these agencies in the country's health system.

Overall, participation of NGOs in the broader health reforms and development processes has been quite significant. They were involved in the development of the NHSSP, and in the development of the new organizational structure of the decentralized MOH, which seeks to incorporate them as part of the national health care system (see Appendix 1, figure 2). Most of the MOH's working groups and technical committees charting policies and programs have representatives from the NGO sector providing NGOs an “opportunity to participate and contribute to policy formulation” (CHAK, 2001: 5). For example, there is a representative from CHAK in the governing board of the NHIF. In the HIV/AIDS area, NGOs – under the banner of the Kenya AIDS NGO Consortium (KANCO), now an umbrella for over 750 organizations in the NGO, government and businesses – were the engine for the development of the policy and have continued to play a forefront role in shaping the policy and institutional responses to the scourge.

As in Kenya, NGOs in Finland also contribute to the design, reviews, monitoring and implementation of public health programmes. Their participation is tied to the wider discourse of citizen participation that has characterized the WHO Health for All by Year 2000 policy framework. And as such, though the discourse of citizen participation is not new (Hélen and Jauho, 2002: 2-3), it has received renewed governmental boost more recently in the *Kuule Kansalaista* (“Listen to Citizens”) project realized in 2000 (Ministry of Finance, 2001) under which Ministries are urged to develop a strategy of how to ensure citizens participation in their decision-making processes with NGOs as the channel for participation. At the forefront is the Ministry of Social Affairs and Health. Consequently, within the

Ministry there are about 50 advisory boards and about 90 working groups among which 30% and 40%, respectively, have NGOs representation (MSAH, 2003: 16).

Although some of these boards are older, the *Target Action Plan for Social Welfare and Health Care 2000-2003* (TATO) (MSAH, 1999b) was the first government policy programme to involve NGOs as “full partners”. The government recognizes this participation in designing social policy programmes as a “new type of role played by NGOs” (MSAH, 2001b: 18). Consequently, all the current government programs in health and social care have been developed in consultation with NGOs. Most notable is the *Health 2015 Public Health Programme* launched in 2001. The first, developed by the Advisory Board for Public Health (ABPH), a legislated body launched in 1997 with a responsibility for shaping and implementing the government’s long-term, and inter-sectoral, public health policy, the programme firmly recognizes NGOs as key players in public health interventions. Under its establishment legislation, NGOs are recognized as constituent members. Currently, the NGO community is represented by three NGOs. The board’s three sub-committees for implementing decisions, supporting horizontal implementation across other ministries and for coordinating at the local level with municipalities and STAKES also have NGO representation.

In the medium-term 2002-2007 *National Project on Securing the Future of Health Care* consultative processes, NGOs also played a significant role and are involved in its ongoing implementation and monitoring. The core aim of the project is “to develop health services as cooperation between municipalities and the state so that the activities of NGOs and the private sector are also taken into consideration” (MSAH, 2002: 11). In its design, four pairs of working groups were involved one of which was responsible for developing the “division of labour and cooperation in the public health care, private and third sector” (ibid.) and chaired by two persons one from the NGO sector and the other from the municipal hospital district health service system. The whole consultative process involved about 400 experts from the health care field across all sectors. In its implementation, 40 projects were identified, which are being monitored by a monitoring group comprised of 24 members from all sectors including NGO health providers.

4. Conclusion: Increasing Room for Health NGOs Participation in Transforming Health Care Systems

As is evident from the presentation of data and process of participation of NGOs in health care delivery, education and policy making in Kenya and Finland, it is obvious that their significance cannot be understated. That being a general statement from the evidence, in fact, their role for certain population (client) groups and localities, is central to their health needs. Current health sector reforms in these countries are steered by just this insight on the need to provide services to those who are vulnerable, those needing specialized attention, those who may be falling out of the ‘universal’ health care system for reasons of costs, access/distribution and demographic imperatives. The aim of the far-reaching and long-running reforms in health care has been aimed at creating a more responsive service system. Decentralization, for example, is one of such measures that have been pursued for some time in the countries. The decentralization has involved deconcentration, devolution, delegation and privatization, all of which have had varied implications for health care NGOs.

As example of deconcentration, we note the transferring of decision-making authority to a lower *administrative* level from the Ministry of Health headquarters to the provincial and district levels in Kenya (see Appendix 1, figure 2), a process that has been going on over the last ten years. This process, which many commentators see as too slow, has, among other things established a framework for NGOs to formally participate in the District Health Management Boards. On the other hand, an example of devolution is the transferring decision-making to a lower *political* level in Finland. The Finnish health care system is one of the most decentralized in the world. This means that all decision-making for organizing, administration and development of health care services are made by the politically-elected municipal councils numbering 448. Although municipalities typically organize their own services or jointly with others, recent legislation (1995 Act on Planning and Government Grants for Social Welfare and Health Care and the Finnish Local Government) has authorized them to buy from private and NGO providers. The extent to which the purchasing prerogative is balanced on political issue, service, or financial/market issues is an extremely interesting issue for further research especially as it has certain implications for NGO health providers.

With regard to delegation of *duties* to a lower level, we could see the moving of responsibility for licensing health NGO (and private) operators from the MOH – which merely gazetted successful applicants without issuing any licences – to the Medical Practitioners and Dentists Board (MPDB), a professional body, since 2000 as a form of delegation. The liberalizing measure saw the easing of registration processes as well as an increase of private hospitals, which created increased competition in the health care market. In Finland this could be compared to the agentization of administration of application procedures, budget planning, and project implementation, monitoring and evaluation for health promotion by the Ministry of Social Affairs and Health to the NGO Finnish Centre for Health Promotion in 1997. This is indicative of a heightening of the level of recognition and awareness of NGOs, their firm leadership in this field of health as well as collaborations between NGOs and government.

Privatisation occurs with transfer of *ownership* from government into private hands. Alongside the theme for privatization is marketization of services and corporatization of agencies. The World Bank's *Financing Health Services in Developing Countries: An Agenda for Reform* (1987) set the tone for the privatization/marketization and liberalizing of health care markets in Africa and other developing countries. Such measures included, among other things, the introduction of user fees, the development of an insurance system, and the development of the NGO sector (Koivusalo and Ollila, 1996: 149). The consequent introduction of user fees in 1989, and subsequent re-introduction in 1992 after failure for the scheme to take off due to poor management structures, had an enormous impact on health care and the development of the health care system. In the years that followed, the government system deteriorated due to a whole range of problems related to mismanagement, lack of drugs, worsening health facilities and migration of health professionals. At the same time, the Mission/NGO service system grew significantly as well as faced numerous challenges as the number of people/patients seeking services from them increased. For example, 36% during 1994-1999, the overall NGO and private sector grew by 36% as compared to the government's 12% growth. Although privatization in Finland has not been generally the norm, the introduction of user fees in the primary health care system in 1993 can be seen was a form of marketization. We can also note the case of the NGO Folkhälsan mentioned earlier that manages and provides the primary and secondary health care system for one municipality as a form of privatization. Again, it is also the case that mixed-

ownership hospitals are only a recent phenomenon as, for example, one case of a hospital owned by a municipality, an NGO and businesses in the second largest city (Tampere) show.

The increased participation of NGOs in the health care system is not only a process of decentralization but also of changing society and the needs or types of responses the health care system needs to address. The change of emphasis from curative to preventive health care across the two countries has also meant the increase in the profile and recognition of NGOs that have already been doing a great deal of this work, especially in Finland, which was among the first Organization for Economic Cooperation and Development (OECD) countries to adopt the WHO Health for All by Year 2000 primary and preventive health care framework (Lehto, 2002: 254). With growing demographic demands from the stresses of HIV/AIDS and ageing population, spiralling health care costs and disparities brought by growing influences on pharmaceuticals, the health service system all over the world is under constant pressures for reform. NGOs are learning to respond with the changes and pressures from increased health care demands as well as competition from the market and are poised to play an increasing role not only in Kenya and Finland but in other similar countries as well.

References

- Akin, J. S., Griffin, C. C., Guilkey, D. K. and Popkin, B. M. (1985): *The Demand for Primary Health Services in the Third World*; New Jersey: Rowman and Allanheld.
- Bratton, M. (1989): "The Politics of NGO-Governmental Relations in Africa"; *World Development*, 17 (4), pp. 569-587.
- Chatterjee, M. (1988): *Implementing Health Policy*; New Delhi: Manohar
- Christian Health Association of Kenya (CHAK) (2001c): "Annual Report"; Nairobi: CHAK.
- Clasen, J. (1999): "Introduction", in Clasen, J. (Ed.), *Comparative Social Policy: Concepts, Theories and Methods*; Massachusetts: Blackwell.
- Harding, A. (2003): "Introduction to Private Participation in Health Services", in Harding, A. and Preker, A. S. (Eds.), *Private Participation in Health Services*; Human Development Network Health, Nutrition, and Population Series; Washington, DC: World Bank.
- Harding, A. and Preker, A. S. (Eds.), *Private Participation in Health Services*; Human Development Network Health, Nutrition, and Population Series; Washington, DC: World Bank.
- Harris, P. (2002): "Welfare Rewritten: Change and Interplay in Social and Economic Accounts"; *Journal of Social Policy*, Vol. 31 (3), pp. 377-398.
- Hägglund, H. and Modeen, T. (1988): "Deregulation – A Remedy for Bureaucratization?" – Finnish National Report; Finnish Branch of the International Institute of Administrative Sciences, Round Table, Budapest (30 August - 2 September).
- Helander, V., Laaksonen, H., Sundback, S., Anheier, H. K. and Salamon, L. M. (1999): "Finland", in Salamon, L. M. et al (Eds.), *Global Civil Society: Dimensions of the Non-profit Sector*; Baltimore, MD. USA: The Johns Hopkins Comparative Non-profit Sector Project; The Johns Hopkins Centre for Civil Society Studies.

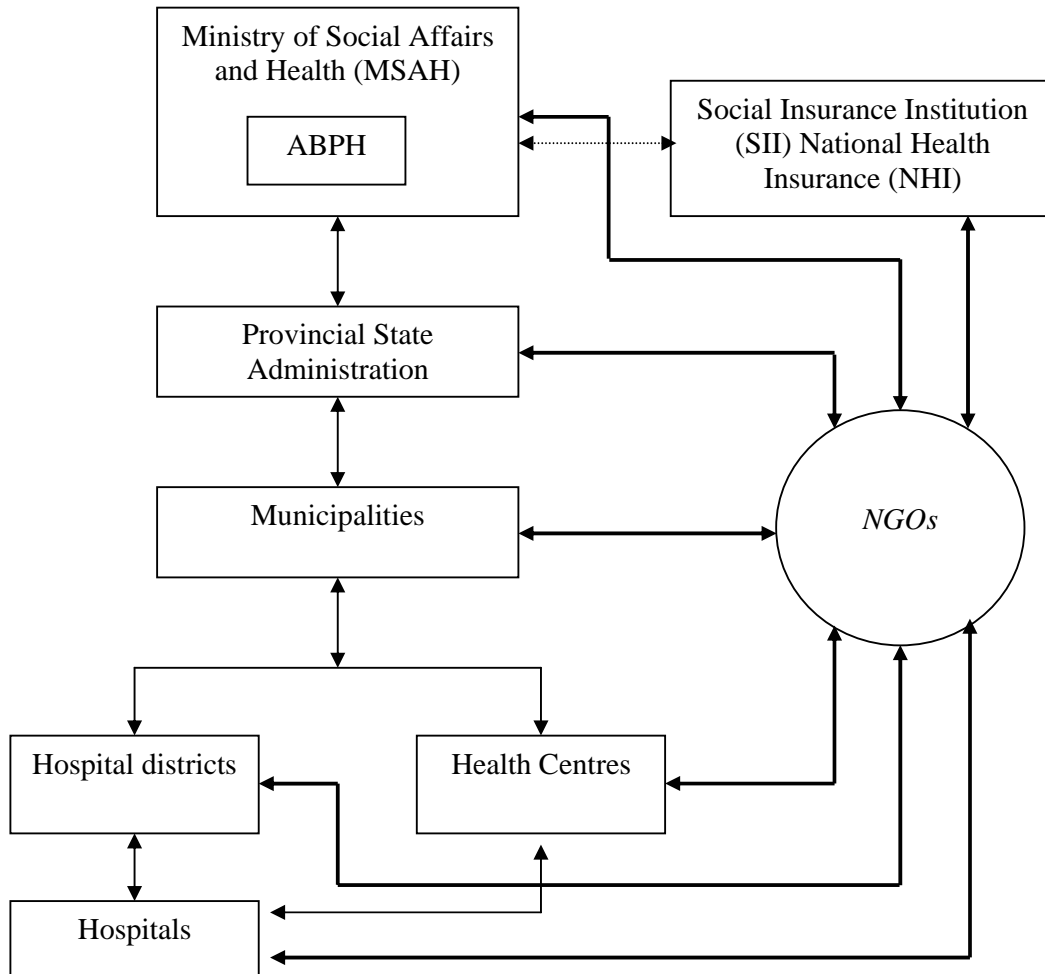
- Helén, I. and Jauho, M. (2002): "Governing Public Health in Finland 1879-1972; Working paper presented at the conference on European Health and Social Welfare Policies; Evora University, Evora, Portugal (19-21 September).
- International Society for Third Sector Research (ISTR) (2002): "Inside ISTR", Vol. 10 (3, July-September); Baltimore, MD. USA: ISTR.
- Kauppinen, S. and Niskanen, T. (2003): *Yksityinen Palvelutuotanto Sosiaali ja Terveysthuollossa* ("Private Production in Social and Health Care Services"); (Reports 274) Helsinki: STAKES.
- Kautto, M., Heikkilä, M., Hvinden, B., Marklund, S. and Plough, N. (1999): "Introduction: The Nordic Welfare States in the 1990s", in Kautto, M., Heikkilä, M., Hvinden, B., Marklund, S. and Plough, N. (Eds.), *Nordic Social Policy: Changing Welfare States*; London, Routledge.
- Kinnunen, P. (2000): "The Social Welfare Support of Citizens and the Third Sector", in Siisiäinen, M., Kinnunen, P. and Hietanen, E. (Eds.), *The Third Sector in Finland: Review to the Research of the Finnish Third Sector*; Helsinki: The Finnish Federation for the Social Welfare and Health, and Rovaniemi: University of Lapland.
- Kimani, D. (2003): "What Ails the Medical Profession?" *Daily Nation* (November 2); Nairobi: Nation Newspapers Ltd.
- Koivusalo, M. and Ollila, E. (1996): *International Organizations and Health Policies*; Helsinki: STAKES.
- Laamanen, R. Häppölä, A. and Brommels, M. (1997): "Näytelmä Ilman Käsikirjoitusta: Tapaustutkimus Meltolan Erikoissairaanhoidon Lakkauttamisesta Uudenmaan Sairaanhoidopiirissä (*The Scriptless Play: A Case Study of the Meltola Hospital Closure*); Helsinki: Association of Finnish Local and Regional Authorities.
- Last, J. M. (1987): *Public Health and Human Ecology*; East Norwalk, Connecticut: Appleton and Lange.
- Le Grand, J. (2003): "Foreword", in Harding, A. and Preker, A. S. (Eds.), *Private Participation in Health Services*; Human Development Network Health, Nutrition, and Population Series; Washington, DC: World Bank.
- Lehto, J. (2002): "Finland: Is it Globalization that Changes our Health Care?" *Global Social Policy*, Vol. 2 (3), pp. 252-255.
- Mabbett, D. and Bolderson, H. (1999): "Theories and Methods in Comparative Social Policy", in Clasen, J. (Ed.), *Comparative Social Policy: Concepts, Theories and Methods*; Massachusetts: Blackwell.
- Ministry of Finance (2001): *Kuule Kansalaista–Hankkeen Loppuraportti, Työryhmämuistioita* ("Listen to Citizens – End of Project Report"); Helsinki: Ministry of Finance, Hallinnon kehittämisosasto (May 5).
- Ministry of Social Affairs and Health (MSAH) (2003a): *NGOs as Actors in Social Welfare and Health Policy: Strategy for NGO Activities*; Helsinki: MSAH (4).
- _____ (2002): *Decision in Principle by the Council of State on Securing The Future of Health Care*; Helsinki: MSAH (6).
- _____ (2001a): *Government Resolution on The Health 2015 Public Health Programme*; Helsinki: MSAH (6).
- _____ (2001b): *National Action Plan Against Poverty and Social Exclusion*; Helsinki: MSAH (12).
- _____ (1996): *Health Promotion in the Municipality: The Health for All by Year 2000 Municipal Programme*; Helsinki: MSAH (18).
- Mohan, G., Brown, E., Milward, B. and Zack-Williams, A. B. (2000): *Structural Adjustment: Theory, Practice and Impacts*; New York: Routledge.

- Mpamila, M. M. (2000): "The Relationship Between Non-Governmental Organizations and Local Government Authorities in Tanzania: A Case Study of Morogoro and Babati District Councils"; Kristianstand, Norway: Agder University College, and Mzumbe, Tanzania: Institute of Development Management, *Research Report No. 26*.
- Mullard, M. and Spicker, P. (1998): *Social Policy in a Changing Society*; London: Routledge.
- Munishi, G. K. (2002): "Decentralized Management of Social Services Delivered by NGOs and the Government in Tanzania", in *The Role of Non-Governmental Organizations (NGOs) in Fostering Good Governance and Development at the Local Level in Africa*; UNCRD Research Report Series No. 41. United Nations Centre for Regional Development (UNCRD), Africa Office Nairobi, Kenya; pp. 75-92.
- Mutiso, R. M. (1986): "Kenya and the Future of the Welfare State", in Oyen, E. (Ed.), *Comparing Welfare States and Their Futures*; Aldershot, UK: Gower.
- Mwabu, G. (1998): "Health Development in Africa"; *Economic Research Papers Series* (38), The African Development Bank Group: Abidjan, Cote d'Ivoire.
- Mwabu, G., Ugaz, C. and White, G. (2001): *Social Provision in Low-Income Countries: New Patterns and Emerging Trends* (Eds.); Oxford: Oxford University Press.
- Nenonen, M. and Nylander, O. (2001): "A Theoretical Framework for Health Information Systems"; *Themes from Finland* (3); Helsinki: STAKES.
- Newton, K. (2000): "Trust, Social Capital, Civil Society, and Democracy"; *International Political Science Review*, Vol. 22 (2), pp. 201-214.
- Nissinen, A., Berrios, X., Puska, P. (2001): "Community-Based Noncommunicable Disease Interventions: Lessons from Developed Countries to Developing Ones"; *Bulletin of the World Health Organization*, Vol. 79 (10), p. 963-970.
- Office of the President (2000): *The Kenya National HIV/AIDS Strategic Plan 2000-2005, Popular Version*; Nairobi: National AIDS Control Council (October).
- Owino, W. (1999): "Revamping Kenya's Health Care Financing and Delivery for the 21st Century", in Kimuyu, P., Wagacha, M., Abagi, O. (Eds.), *Kenya's Strategic Policies for the 21st Century: Macroeconomic and Sectoral Choices*; Nairobi: Institute of Policy Analysis and Research (IPAR).
- Øvretveit, J. (1998). *Comparative and Cross-Cultural Health Research: A Practical Guide*; Abingdon, Oxon: Radcliffe Medical Press.
- Republic of Kenya (2001): *Health Management Information Systems Report for the 1996-1999 Period*; Nairobi: Health Management Information Systems, MOH.
- _____ (1999a): *National Health Sector Strategic Plan: 1999-2004* (NHSSP); Nairobi: Ministry of Health, Health Sector Reform Secretariat.
- _____ (1999b): *Kenya National Health Accounts 1994*; Nairobi: Partnership for Health Reform, Department of Planning, MOH (Draft Report, May).
- _____ (1994): *Kenya Health Policy Framework Paper*; Nairobi: Government Printer.
- Room, G. and 6, P. (1994): "Welfare States in Europe and the Third Sector", in 6, P. and Vidal, I. (Eds), *Delivering Welfare – Repositioning Non-profit and Co-operative Action in Western European Welfare States*; Barcelona: CIES.
- Salamon, L. M. (1999): "Government-Nonprofit Relations in International Perspective", in Elizabeth T. Bolris and C. Eugene Steuerle (Eds.), *Nonprofits and Government: Collaboration and Conflict*; Washington, D. C.: The Urban Institute Press.
- _____ (1995): *Partners in Public Service: Government-Nonprofit Relations in the Modern Welfare State*; The Johns Hopkins University Press: Baltimore.
- Salamon, L. M. et al (1999): "Civil Society in Comparative Perspective", in Salamon, L. M. et al (Eds.), *Global Civil Society: Dimensions of the Non-profit Sector*; Baltimore, MD. USA: The Johns Hopkins Comparative Non-profit Sector Project; The Johns Hopkins Centre for Civil Society Studies.

- Singh, P. K. (2002): “Effective Health Care: The Role of Government, Market and Civil Society”; *Regional Health Forum*, Vol. 6 (1), pp. 7-21.
- United Nations Development Programme (UNDP)–Kenya (2002): *Kenya Human Development Report 2001: Addressing Social and Economic Disparities*; Nairobi: UNDP.
- United Nations Development Programme (UNDP) (2001): *Human Development Report 2001: Making New Technologies Work for Human Development*; Oxford: Oxford University Press.
- Vogel, R. J. and Stephens, B. (1989): “Availability of Pharmaceuticals in Sub-Saharan Africa: Roles of the Public, Private and Church Mission Sectors”; *Social Science and Medicine*, Vol. 29 (4), pp. 479-486.
- Wamai, R. G. (2004): *Recent International Trends in NGO Health System Development, Organization and Collaborations with Government in Transforming Health Care Systems: The Case of Finland and Kenya*; Department of Social Policy/Institute of Development Studies, University of Helsinki, Finland (Unpublished PhD Dissertation).
- Wang’ombe, J. K. et al (1998): *Capacity of Non-Governmental Providers in Delivery of Healthcare in Kenya*; Nairobi: DANIDA.
- World Bank (2001): *World Development Indicators*; Washington DC: World Bank.
- World Health Organization (2000): *The World Health Report 2000: Health Systems: Improving Performance*; Geneva: WHO.

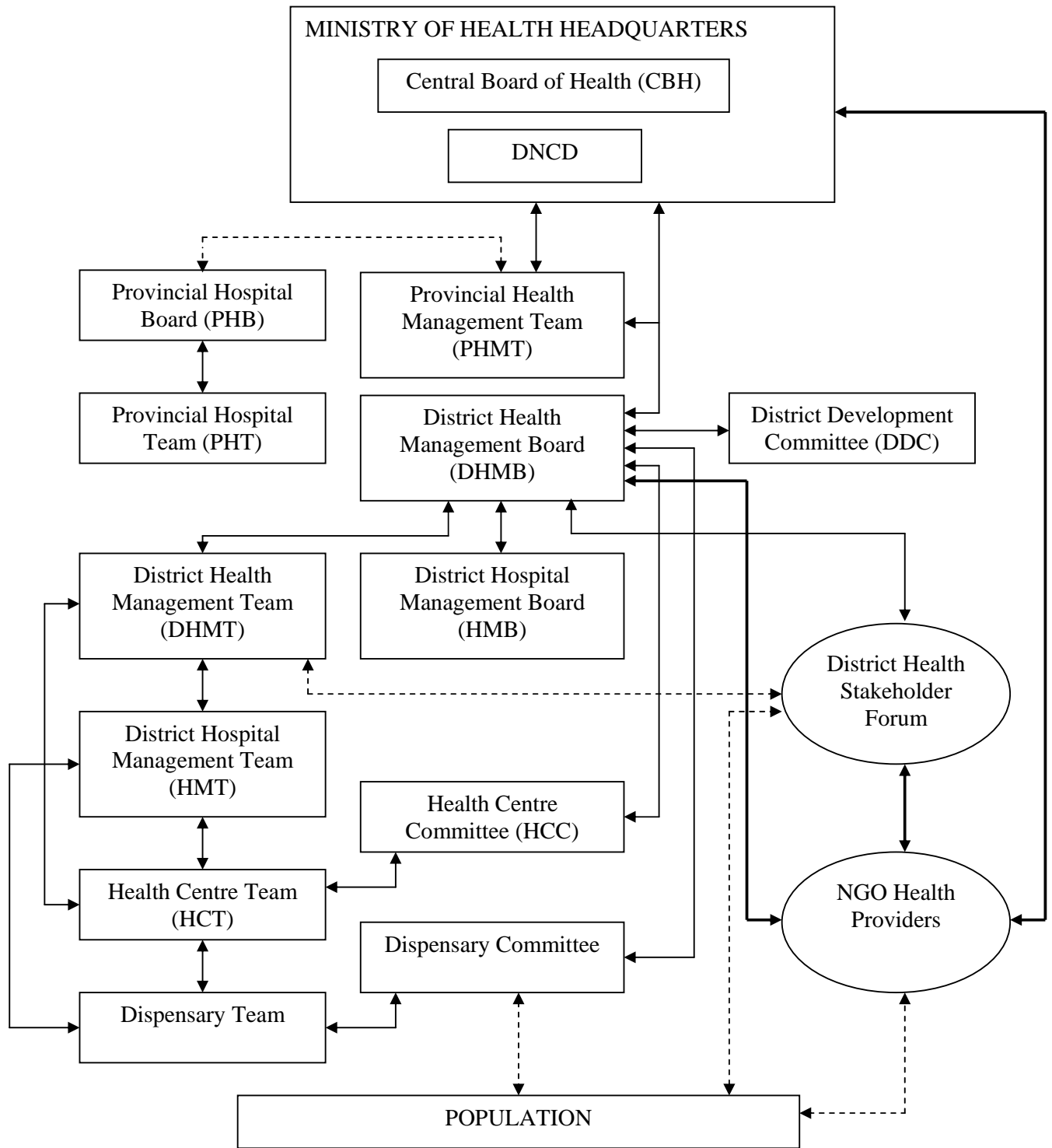
Appendix: Organizational of the Kenyan and Finnish Health Care Systems

Figure 1. Complex Organogram for the Inter-organizational Finnish Health Care System



Source: Adapted from Järvelin (2002: 18).

Figure 2. Complex Organogram for the Interactive Decentralized Health Service System in Kenya



Source: adapted from MOH Decentralization Workshop Report (March 13-16, 2000).