SOCIOPOLITICAL IMPERATIVES IN THE HISTORY OF HEALTH DEVELOPMENT IN KENYA

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ABSTRACT

European Colonial Powers have shaped the philosophies and the social structures in their former colonies. Institutions currently dominating lives in the African states are a reflection of colonial domination. The thrust of colonial activity was to mold political systems, socioeconomic activities and cultural patterns which were largely consistent with the prevailing or desired European molds. The greatest hindrances to change in the health and other systems in Africa today lie in what was inherited, however inappropriate. A historical analysis of the Kenyan health care system shows that inheritance from Britain has not been lost, it is being strengthened. The prevailing health system is tailored to suit the growing and inevitable socio-economic classes.

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INTRODUCTION

The recent history of Africa has been largely influenced by European colonial powers; colonial history has affected the social-economic institutions, structures, social philosophies and the perceptions of African societies both from within and without. Kenya, like other former colonies, has not been immune from diverse forms of domination through conquest. And her institutions have been shaped accordingly, sometimes by way of protest and sometimes by way of positive response to colonial penetration. The thrust of colonial domination was to mold systems in the colonies which were appropriate to the socioeconomic patterns arising out of the development situation in which the colonising countries were. Indeed socioeconomic analysis of both colony and metropolis shows a developmental pattern underlying race rationships or political structure in the colonies. This paper focusses on one of the major institutions - health - and shows the determinants of history on the health systems we have today.

Broadly, the development of human societies is affected by four closely intertwined areas of human activity: the political; the socioeconomic; the cultural and the medical. In this paper I have taken medical to refer to the ideaology governing the concepts of health and disease.

From these four factors, the strongest and most far reaching is the political. Political activity determines the magnitude, and the direction of the rest. Sociopolitical history demonstrates that the principal determinants of the welfare of the population in Kenya during colonial rule were the very thrust of colonial conquest. The paper further shows the influence of political economy on the health system in Kenya.

Areas of Colonial Conquest

In Kenya, colonization started about the end of the 19th Century and quickly covered the four broadly related areas mentioned above. The first of these areas, and as noted the most fundamental, was the political sector. Indigenous ethnic groups and their systems of goverment were subjugated under a new, imposed system. Instead of paramount chiefs and elders of the clans, complicated net-work of "rulers", starting with an imposed chief and culminating in District and Provincial Commissioners, and a governor at the apex, was instituted. The tribal council had to give way to a council of ministers, and later to a parliamentary system, from which the indigenous peoples were excluded. In this way there was total exclusion of the African from the arena of self determination. Decisions were made by others on behalf of Africans. The denail of political rights to the African was the basis for other areas of expropriation, for

without political power there was nothing the indigenous populations could do.

Similar kinds of sociopolitical system were to be found in most former European colonies like Mozambigue and Angola, in Zaire, and in other former British colonies like Zambia and Zimbabwe. Colonial domination are invariably similar.

The second area of conquest was economic. This conguest changed the existing modes of production and distribution of benefits, and reversed the rationale for economic activity. Ordinarily, people spend themselves for their own welfare. Under colonial rule, however, the rationale of production, and the associated aconamic activities and result were for the benefit of the citizens of the United Kingdom. Without exception, this rule applied in all colonized societies. The African populations were used (and are still used, notably in South Africa) as a cheap means of profit-making for European & North American enterpreneurs. The labourers were not citizens, comparable to the European immigrants. On the contrary, they were relegated to the lowest rank in a two or three-tier sociopolitical system. In Kenya, for instance at the top of the structure was the European race, below which was the Asiatic race, and even further down the African. As would be expected, the pyramidal structure had a wide base to support but a sharp apex of European colonial officials, farmers, businessmen and a corps of professionals. Under colonial rule the means of production and the result thereof were for the benefits of the citizens of the United Kingdom. The colonized people were not citizens, inspite of all the African peoples who died during the world wars, laying down their lives for their metropolitan masters.

The third type of conquest was the cultural. Cultural conquest destroyed or attempted to destroy the African ways of living and belief systems, religious, ious, social assimilation patterns and customs. For example the pulpit was used not always to spread words of Christian love and justice, but often, rather to condemn some sacred and intergral African customs. Notable among these areas of antagonism was the Agikuyu femal circumcision and related ceremonial activities. Kenyatta's famous defence of female circumcission in the early 1920s became a rallying point in the struggle for independence. In Uganda, for instance, the Baganda expected a well-brought up future bride to have manipulated and enlongated Labia minora for the purpose of strengthening future marital sexual bonds. The custom was not spared condemnation by European religious leaders. It was argued that the custom was (or is) primitive and immoral. Quite obviously, the understanding of the custom by the Europeans was rare, if at all, perhaps there was no attempt on the part of Europeans to understand such customs. Infact other customs and beliefs were not immune from attacks. African forms of prayer are even today, often regarded as the glorified work of evil spirits at best, or of satan, at worst.

The fourth area of colonial domination followed the patter-established by the other three, indeed they had prepared the grounds, as it were, in which this last would flourish. The above three set the tone for the existing health care system for medical conquest.

No society has existed without a relatively effective health care system that can cope with social, psychological, economic and physical ills or areas of disharmony. The traditional African health system is perhaps best known for the maintenance of some established balance between the individual or the community, on the one hand, and the environment surrounding people, on the other. In this equation is included the spiritual aspects. The practice of this traditional health system is unique in many respects, especially in the interactions between the patient and the doctor and the patient and the family. While the doctor may be a recognized specialist, the "feelinglessness" and detachment characteristic of a modern health care system does not exist. In most cases, the doctor is known by either the patient or the members of his clan. Of necessity, with a few exceptions, the traditional doctor shares the belief system of the patient. Indeed, the doctor and the patient belong to the same integrated sociocultural group supported by an established framework of social norms. This last aspect probably explains the high prescription compliance rate in traditional health systems.

The medical care system existing today was entrenched in Africa partly as a direct attempt to suppress traditional African systems (including health) and partly, and more importantly as a necessary condition for colonial "stewardship of dependent peoples". Even today, modern medicine, in conjuction with other modern institutions, attempts to show that most aspects of traditional medicine are detrimental. When modern medical system was established it was believed that a minimum standard of health of the "natives" was a necessary condition for the African to be able to provide minimum work performance in whatever assignments were given him. Furthermore, the health of the European settlers was indeed partly dependent on the health status of the natives. The danger from communicable disease to which the European had built no immunity, was always present. The use of malaria, cholera and blackwater fever as a common "dens ex-machina" in nineteenth and early twentieth century fiction, reflected a very real concern and acceptance in colonial culture. Effective control of such disease would be limited unless the native carriers were themselves free of such maladies. The European employers were therefore, advised by the health department to invest in the health of their native labourers, for in them lay the very survival and success of the employer. In 1927, for example, the Director of Medical and Sanitary Services Dr. John Gilks (1) wrote in his annual report:-

"Employers of labour and township or municipality authorities must realize that the native living under insanitary conditions is a danger to the public health of the farm or township and that proper provision must be made for his accommodation under sanitary conditions if the health of the other communities is to remain satisfactory and economic progress is not to be retarded".

Gilks recommendation ran counter to the very principle of colonization: exploitation of both the colonized and their environment (2). The colonial office in London and its local administrative wing had so far found it hard to modify this principle. It was perhaps for this reason that Gilks issued a cauticus recommendation regarding the health status of the African labourere, many of whom had died in the First World war on the side of the allies. Insinuating that shortsightedness was endemic among government officialsand local entreprenours regarding an effective and efficient labour force, Gilks (1) wrote:-

> There is now, among many of the more far-seeing employers, a feeling that time is ripe for more definite requirements on the part of Govern ment as to the conditions under which labourers should live and be employed, and almost enough material has been collected to enable such requirements to be formulated. This, of course will have to be done with caution! ! (emphasis added).

Accordingly the then health officials could not even recommend training of Africans. The time was not ripe (3).

Even progressive medical experts were not out to upset the colonial apple cart! In short, the medical system, vigorously instituated, was designed to benefit the European immigrants. The Africans were just a necessary problem of that maintenance process. Total neglect of the natives was deemed impossible in view of the importance of native labour and

in view of high prevalence of infectous diseases. Medical experts therefore recommended health promotion for populations in both native reserve and settled areas. "No section can be neglected either in settled area or in native reserve without some other section being prejudicially affected."

Understanding of the areas of colonialism outlined above and their effect on the current social system is not only desirable but necessary. Medicine, socioeconomic values, political norms and indeed the whole society are closely intertwined.

As Stainbrook (4) once wrote:-

"The understanding of the structures, functions, and values of social organisations is not optional or elective for medicine and public health, but imperative. The sciences of social man and of individual behaviour are an intergal part of basic medical science." The maintenance of any particular system requires partly an articulated regulatiory system, partly an established normative system and partly institutions staffed by individuals devoted toothe survival of the system. It would have been completely out of character to have a colonial system run by people who did not believe in the system.

Indeed, in Kenya and other African countries, we see a similar pattern of system maintenance emerging, perhaps more forcefully. With a few exceptions, staffing of many public institutions is often based on loyalty to the system rather than ability to run the system. The health field is not exception. The growth of hospitals is thus a logical development and will probably continue until health system goals are changed and staffed with personnel who believe in the change.

Sociohistorical Development and Medical Care

Missionary groups established a foothold in Kenya about 1890. They were preceded by the Imperial British East African Company (I.B.E.A.) in 1888. In 1895 colonial domination over Kenya was formerly effected. In 1920, Kenya became a British Colony and Protectorate. This status lasted until 1963 when Kenya attained independence and the following years she became a republic within the Commonwealth. Since the establishment of formal colonial administration the three establishments - I.B.E.A.M Missionaries and the colonial government closely performed their repective roles more or less harmoniously, though not as comfortably as would have been expected.

1. I.B.E.A.: THE ECONOMIC FACTOR

The principal role of IBEA was one of economic activity. This activity required a population with some standard of health. Where necessary, however, the minimum standard was set aside, presummably to increase the profit margin and also because health was not thought to have a direct contribution to profit - making. The Medical services of the I.B.E.A. Company were therefore limited to the employees of the Company but not their relatives. Quantity and the quality of the services offered progressively declined from the Europeans through the Asian to the Africans. Little attempt was made to reach the rural settlements where the African labour actually originated. This became evident during the first world war. When Africans were subjected to medical examination to find out whether they were eligible to join the military activities, 34% of recruits

from central Kenya were found to be unfit to be porters. Another 33% were found to be unfit even as labourers! (5). For the general population the prevailing low socioeconomic conditions, including housing, sanitation and other environmental deficiences in a wider environment of malaria, plague trypanosomaiasis, to name but a few, contributed to the unexpectedly high morbidity and mortality patterns.

Even though the soldiers, the porters and the labourers in the army were the select healthy minority , they lived under harshly sub human conditions from where they inherited other diseases, like syphilis, and concomitant weaknesses. This was evident during the war. It is said that of the 4,300 Kenyans killed in the military 70% succumbed to disease. Even the carriers who were supposed to be of a health standard were not immune to disease. The newly acquired disease were then taken back to the native reserves where they easily spread. Perhaps owing partly to the poor understanding of epidemiology at that time and partly to resource constraints, colonial authorities saw no need to take any precaution to protect the natives from disease to which they had no immunity. On the whole, then what is generally called "peaceful permeation of western civilization", was clearly a forceful and brutal,-though not necessarily deliberate,-penetration of Western socioeconomic pursuits into African. The benefits from western civilization and economic benefits were not as easily permeating into the Natives as the forces of domination.

A modern system that proximates the IBEA health service systems is the occupational health services systen, that is often beyond the reach of those outside the particular occupation or economic concern. Some organizations like the armed forces, large plantations and most of the industrial concerns provide curative services for their workers and their families . As the manufacturing organizations are generally based in urban centres, the occupation health system, together with other systems, enhances the urbanization of health care, Inadvertently, the gap between the quantity and quality of urban care and rural care continues to increase with economic development.

2. THE MISSIONARY FACTOR

The Missionary factor in the development of health services in Kenya has never been doubted. But the relationship between the religious groups and the colonial government is still a contraversial issue. It is necessary, however, to look into the contributions of the religious groups and the rationale behind their work in order to understand the current situation (6,7).

The relationship between missionaries to Africa and European expansionism has been less one of competition and more of complementality. Perhaps the

belief common among African intellectuals that the Bible was the standard for the gun is not completely unfounded.

The missionary workers are known to have played their cards well to again recognition and favour among the African rulers. Medical knowledge and the art of reading and writing were among those cards. In the Buganda for instance Speke is said to have impressed and befriended the Kabaka (King) in 1860 only when he made use of his rudimentary medical knowledge (7). In 1878, the first medical missionary was asked to provide medical advice to the Kabaka's palace. By way of reciprocity the Kabaka bestowed his own blessing on the missionary and christian work. By and large such blessing lasted until the Kabaka's memory was adulterated by a new curiosity about other missionaries. Father Lourdel, the first Catholic missionary to Buganda successfully treated the Kabaka for dysentry largely to attract the King's attention and the privileges accruing from the King's satisfaction. As a consequence of medical miracles, the missionaries were permitted to preach and christianize in the Kingdom.

In Kenya too, healing went hand in hand with proselytization. Perhaps promises of spiritual rewards in the next life required precursors in the form of earthly rewards like health. Both the Catholic and the Protestants recognised health work as a potentially converting element. The missionaries were quick to realize that the praise of the new God and the attempt to banish the old were not sufficient to convince the Natives after all.

Although missionaries opened up outposts in remote areas and larger 'health centres' in their more important areas, their impact in the reserves remained low in a few places and nil in most communities. This fact came to light during the First World War as noted earlier when the health of most of the would-be military conscripts was found to be less than that which the colonial government expected after nearly two decades of administrative activities.

The second half of 1920s saw the expansion of both administrative and missionary medical work in reponse to the earlier disappointment. By and large, however, the religious medical services went exclusively to the African and Asian communities. In spite of dubious motives initially, missionary medical activities were the single most important attempt to affect Africans, in their own environment, outside the prevailing colonial structure. The missionaries may not have provided quality care, but certainly provided a significant portion of the services though not adequate in quantity and extent of coverage.

2.1. THE MISSIONARY HEALTH SERVICES

Today as in the past the missionary health care system has followed

the denominational pattern of acceptance and establishment. For instance, neither the Catholics nor the Protestants church groups have set up a health facility where they do not have a strong following. The health care facility is more often than not a reward to the community for accepting the church and an incentive for the doubtful to commit themselves. Though theoretically a religious community need not express itself through the physical building of a church, in practice the church building becomes an important and often necessary symbol and base. Throughout the missionary presence in Africa the same pattern has dominated health and education activities. Hospitals and schools are seen as the ultimate realisation of health care and education.

The missionary health care system has thus been largely a static-facility-based in rural areas. These facilities are better equiped and staffed than comparable government service points. The focus of the system has been the provision of basic curative services required in the rural and often inaccessible areas (4). In such areas only expatriate nurses are available to provide care. The cultural and training backgrounds are not inconsequent to the type of services they emphasize. But the trend is currently changing in favour of community-based care. The resources the missionaries have, however, are often far too inadequate for rapid expansion of their activities where they are most needed.

3. THE GOVERNMENT/PUBLIC FACTOR

Within a few years of colonial establishment, Kenya, and the neighbouring countries, had three distinct racial groupings, the European, the Asian and the African. The three groups were the basis for the three medical systems (5). As stated earlier the European group assumed the directorship of political power. The Asian group distantly followed and even more distantly, the African "tribes" or natives, a term used pejoratively. The European, the Asian and the Native hospital were not established by accident, they were designed to emphasize the fundamental chasms dividing the three racial groups, and perhaps the colonial administrators became no less a charlatan in political manipulation than in the use of health development. As a rule it was decided that the health system provided to the Natives was to be for the purpose of keeping them usable-that is, exploitable - by the European intrapreneurs and civil servants. Not suprisingly, colonial administrative and economic development, religious expansion and health care growth followed similar paths. Indeed they were inseparable.

Just as there was a three-tiered system of health care, each level ...

serving its particular group. There were European hospitals, African hospitals and "Asiatic Wards". Later the Asian Communities were able to establish their own Asian Hospitals notable the Aga Khan in Nairobi and the Pandya Clinic in Mombasa. There used to be European doctors, Asian doctors but no African doctors. The colonial government position was that the African lacked a well developed brain to learn any advanced work and, in any case, he could not perform tasks independently.

The training of African medical orderlies to staff dispensaries began in 1920 but training of doctors for high, more complex tasks did not start until about 1935. Even then, facilities were limited to a few. The medical graduates from Makerere, a constituent college of the University of London, were very slow in coming. For instance up to 1949, only 15 graduates had been produced for a period of 14 years. Even after training, the African medical graduates had to serve under European and Asian doctors. A European graduate was a "Medical Officer"-an Asian graduate was an "Asian Medical Officer" and the Natives were "Assistant Medical Officers". Reports from the latter indicate that the African doctors received discouraging encounters from other medical colleagues, even in the wards. The ward sisters, invariable Europeans, could sometimes insult the African doctors with impunity. Prescriptions ordered by African doctors were subject to changes by the sisters. In addition, the so-called Assistant Medical Officers were discouraged from further training in specialist areas. This largely explains why the current top medical specialists in Kenya had to leave government service in order to specialize.

Public medical services were limited to the urban centres and to those areas considered to have adequately accepted colonial rule. The relationship between the provision of medical services and the administration is not quite incidental. In most cases medical services were the rewards for subservience. In this regard the administration differed markedly from the missionary: the latter using medical services to gain access to the native souls. For the government, however, medicine and politics were seen as the legendary carrot and stick. A pioneering colonial doctor-, for example-, once said that it was necessary to give "the Native tangible evidence that government is something more than a mere tax collection" (8) in justifying his recommendations for increased budget for the health department. Even after the African had died fighting for the colonial crown, the major causes of death, plague, malaria, sleeping sickness, influenza and environmental sanitation hazards remained largely untouched. The humanitarian aspect of medicine had yet to reach the african reserves. In addition the introduction of the new medical technology was not accompanied by concomitant changes in the living styles. Consequently, the new technology was used to treat illness as presented, without any significant attempt to get the causes of the illness. No medical system can be successful if it works in that kind of a vacuum where the

society, which gives rise to the health problems intended to be controlled, is ignored.

It should be noted, however, that the medical department was not free in its own administration. The colonial office departments and at times laid down regulations in respect to the strategies for achieving the objectives. Budgetary inputs were imposed by the colonial office: the department could not alter the budget presented. This was strong leverage on the part of the colonial office.

Racial differentiation was a necessary condition for colonial rule. As far back as 1903, the colonial office specified the objectives of the medical department as, firstly, to preserve the health of the European community, especially the government officials: secondly, to ensure that the native and Asian labour force was in good working condition: and thirdly, to prevent the spread of infectious disease common in the region. Accordingly, there was greater financial outlay for the Europeans and Asians than for the African groups.

For instance at the mental hospital, the ratio of African to European/Asian cost per patient bed-day was about 1:5 in 1945 and 1946, and about 1:3 from 1947 to 1949 (3). At this hospital, the African patients were kept "in the totally unsuitable prison environment" awaiting vacancies to be found, (emphasis added) for the other races, such conditions were never allowed. An instance of the state of the European patient appears in the 1949 Annual Report where it is said:-

> "Comfortable and homely furnishings were provided on a scale for more generous than ever before" (p.34)

3.1 PUBLIC HEALTH CARE SYSTEM TODAY

There exist four main contenders for determining health goals: the individual, the professional provider of care, the government or policy maker, and the community. For each of these health goals are often expressed as demands for action to cure a prevailing or perceived health problem. Health goals may be identical for a number of groups, yet the strategies to achieve the goals are often dissimilar and sometimes contradictory. At the very elementary level, the chosen strategies will be circumscribed by the previling sociopolitical system, technology, socioeconomic and cultural values and attitudes towards both the assumed problems and the assumed benefits.

How do you convince an individual patient "treat thyself" when the problem is seemingly self-inflicted? How can the individual medical professional be convinced that "prevention is better than cure" when he earns his livelihood by treating the sick? Business ethics has it that no business person should try to

run himself out of business. Similarly a community may demand visible elements of health care, - a hospital - even though that may not be what is needed.

The same problem affects policy makers: that is the dilemma between providing and supporting the glamorous institutions on the one hand, and the less politically visible although more practical institutions, on the other.

In Kenya and other African countries there are always the demands from the majority for more and better health services. Such health services are not necessarily the most technologically sophisticated. A small minority clamours for sophisticated care. Unfortunately, the minority do not share in either the problems or the perceptions of the majority, most of whom may be poor, illiterate and politically isolated (9).

For policy-making purpose the latter segment of the Kenyan society, comprising over 70% of the population, is, in reality, a numerical majority. History has shown that this majority's choices may be limited by the choices of the minority, smaller in numerical terms, but greater in political power. What the majority may want is subject to approval by the elite. What the latter want is what they will fight for and is what may be instituted. If the numerical majority, in this case the rural masses, do not want large hospital, they will have it anyway. That is the current situation in Kenya. In spite of extremely grandiose rural health development rhetoric, hospital development and maintenance absorbs the lion's share of the health budget. In staff development post-graduate training (specialisation) is becoming the norm in a country where the population-doctor ratio is over 50,000:1; Paradoxically the major health problems and causes of death are largely due to environmental health and socioeconomic deficiencies. However, medical education, largely clinical and institution-based, is tailored along the standards imported from Britain, even though Kenya and Britain have little in common in terms of health problems. The goal in the medical profession is to produce medical doctors with an international flavour complete with colleges of Physicians, surgeons etc. (and Community-based or primary health care has no place.)

Characteristically, the management of the needs and worries of the many are controlled by the minority of intellectuals, professionals, business leaders and, not least, policy makers. In this, Kenya is not peculiar. As we have seen there are sociopolitical precedents.

Were the national resources utilized more rationally, the currently available knowledge would reduce whooping cough, TB, STD, URTI GE and others by

100%. Nutrition disorders could be reduced by 70-80% within five years.

The major reason for current health development trends is a paradox so gross as to be pathological among health professionals, health managerial ranks and other elites. (10-12) On the one hand, is the increasing demand by the elite for the establishment of what is assumed to be the "best" care available. On the other hand, is the neglected realisation of the increasing need for basic health care services in rural areas where at present the least quality care exists in most parts of the country. The demands have been especially achieved in urban areas and for the better paid ranks. But for the majority neither the quality nor the quantity is of adequate level. There is a conspicuous lack of balance in the health plans and programming. Reluctant attempts on the part of the elite to reconcile these two demands has led to the existence of a managerial malady which has paralysed effective health planning and service delivery.

As in the past, and presumably due to it, the Kenya health care structure has a distinct character that portrays both the individualistic ideology established during colonial times and a lack of perspective of both priorities and viable direction. Indeed various health components tend to go their own way. e.g?

Although the public health system should provide health care to all equitably, the philosophical goals specified by the government health plans and international agencies have yet to be attained. The largest and best equipped hospitals are actually "Islands of Excellence" in urban areas. The current system has grown along the trend established by the colonial system.

Political activities are games played according to curious rules for the main actors vis-a-vis their followers. Social groups are mobilised around some articulated objectives. Once alliances have been successfully established, however, the rationable for political organization often changes; there is no guarantee that the original objectives will be pursued*? In some cases, even when pursued new rules may have to be formulated. At independence the political Party, Kenya African National Union (KANU) was a strong Nationalistic party. It collapsed to near-extinction within a few years. Politico-Administrative power was transferred from the party and the parliament to the Provincial and District Commissioners, exactly, as it was during the colonial period!

African leaders have demonstrated a few failures, among which are their inability or unwillingness to make structural changes in their independent republics. With a few exceptions notably Tanzania, Mozambique and Guinea - the development philosophies in these republics are largely borrowed from former colonising countries. Examples are numerous. In 1963, Kenya became independent

of the British colonial rule. One of the major areas of contentions between the Europeans, on the one hand, and the Africans, on the other included inequitable distribution of resources and public benefits. As we have seen, Europeans controlled political debate, power, instruments of political processes and, indeed, the results. Large tracts of the best land were reserved for white farmers. Most favourable urban residential areas, schools and other amenities were set aside for whites. Debate and armed clashes (Mau Mau War) were waged to wrestle those privileges from Europeans and Asians or at least share them equalitably with Africans.

But into the shoes of the white man readly stepped in the Black Kenyans endowed with education, leadership ability and even wealth. Most of these had been the vanguard of the struggle for Uhuru (Independence). Since uhuru, Kenya has been roughly dichotomised into a few who inherited 'Mzungu's' (white man's) privileges and consumption habits and those who are still outside the former privileges of the white man -- the masses. For the few, conspicuous consumption habits, exclusive residental areas, schools and hospitals abound largely at the disposal of a near-exclusive class composed of expatriates, Asians and a corps of African elite, what Frantz Fanon calls "Black Skins, White masks". The new society has distinct class character perhaps replacing the pre-uhuru racial criterion for access into privileges. It is not strange then that the colonial institutional structures exist, almost intact. And the health system is one such subsystem.

Indeed there are structural problems-economic and ideaological - entrenching the system. With the unending expansion of hospitals, the more needy rural populations progressively becomes disfranchised vis-a-vis urban populations in terms of the relative significance of rural health expenditures (13-15).

4. THE PRIVATE SECTOR SERVICES

The development outlined above has indeed carried even equally into the private sector. This sector consists of two levels.

a) Large scale and complex metropolitan hospital services operated on rules of the market place. The genesis of these hospitals is related to the historical racial segregation system propagated by the colonial government. Accordingly the hopitals had been set up to serve the European, the Asian or other communities (17). The system flourished after independence because there was a market among the African elite. These hospitals were, and still are, to be found in the major cities.

b) The second level consists of a host of private clinics of varying sizes and capability, usually held by one or more doctors, most of whom are general practitioners. The thrust of the practice is curative medicine, mostly in urban settings where the market is large. Indeed relatively few people can afford the services of private doctors, especially the specialized cadre.

As under the economic and socio-political structure of colonial times the private sector tends to operate on a business pattern. Characteristically specialization is a growing tendency, and is considered to be a necessary achievement in some hospitals. The doctors' specialization requires specialized diagnostic and curative equipment. Consequently the molding of exceptional centres of excellence is already a reality and the norm. Surprisingly, the government health man-power development system, in which specialists are produced at the expense of the public, inadvertently serves the goals of the private sector. The quest for equitable distribution of the quantity and quality of care cannot be met in this manner.

5. CONCLUSIONS

The historical development of Kenya, and Africa in general, has largely determined the existing health system. Attempts have been made to provide health care to the people, who still have remained largely in the periphery of health care prioritization. However, no drastic policy measures have been taken toward structural change of the health care system. Understandably structural changes in large organizations and bureaucracies are difficult and rare. In addition, structural changes are economically expensive. More often than not bureaucracies do their best to avoid having to make structural changes. But in a poor developing country, such changes are necessary if social justice is to be equitably distributed.

The major hindrances to the formulation of more effective health systems would appear to be the value systems of the elite groups and agencies, and the structures these produce. Attempts to solve priority problems among the largest proportion of the population leave much to be desired. Existing health structures and strategies fly in the face of available evidence on effective systems and stategies. In the conflict between political necessity and economic reality many problems have been avoided rather than solved. These problems do not disappear, they grow and magnify. It is the problems we have ignored, rather than

those we have failed to conquer, that are constant difficulties. The challenge in modern health care practice is to design systems that are not only fair and just to all but effecient and effective. It is not a small challenge.

If Kenyans of African extraction found the colonial health system unjust, they must also strive to create a system that is not disproportionately favourable to a few, as is the case in urban Kenya and especially among the "professionals". The African Black elites, formerly "native elites" have inherited the formerly exclusive European and "Asiatic" tastes, hospitals and private clinics and, inevitably, class distinctions. The professionalization currently pursued may not be in the best interest of the majority for every few will ever afford the high "professional fees". As George Bernard Shaw once said:- "Every profession is a conspiracy against the public". Modifying that statement somewhat, Rene Dubos (18), said that individualized health care, common among specialists, entrenches the status quo, which means that the control of those conditions which lead to individual community-wide problems is progressively less important except in rhetoric. Political action is necessary to make relevant and viable socioeconomic change. Kenya's socioeconomic system follows the so-called free-enterprise philosophy long established during the colonial days but now advanced to a very high degree. Within this development ideology democracy and social justice are expected to thrive. One common index of these goals should be the distributionof social services among the Kenyan's. The performance of Kenya's politico-administrative institutions should thus be assessed in that context.

Expansion of the health services, if effective in providing preventive and basic curative care, will be a contribution toward socioeconomic democratization. In a fundamental manner democracy must also include equitable accessibility to basic needs of life, and health is one of them. The question in this paper is directed towards how far the existing system and its institutions can produce the expansion of health services necessary to bring health to the whole population.