



A HEALTHY MARKET?

Healthcare Hereafter: The Third Sector

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Having proven its utility in the United Kingdom, the third sector is spreading around Europe; taking examples of success and failures this paper provides an analysis of the Third Sector and demonstrates how it can help public services in their quest for universal health-care.

In recent years, post-war democracies have experienced dramatic changes when it comes to state power and political decision-making. The era of 'big government' of the first half of the 20th century has largely faded as a range of institutions in civil society have become resurgent. Today, in a globalised and more competitive world, the state increasingly finds itself facing institutional movements that are beyond its control. It is in this context that institutions in civil society – the so-called Third Sector - create a buffer between the private world of profit and the centralising force of government.

In May 2006, the British government formally acknowledged the rising significance of institutions in civil society by creating within the Cabinet Office a department for the Third Sector. Recognising the capacity of institutions in civil society to supplant the state across a wide range of services – not least to empower citizens in innovative ways – this development signals the birth of a new era.

While the Third Sector has a proven and growing track record in the tertiary – or service – sector, it is recognised by most commentators that institutions in the voluntary, charitable and not-for-profit sector are making huge contributions in such areas as health and social care. Moreover, these institutions are making an ever greater contribution to the elaboration of public policy and in the provision of a range of services that once came under the purview of the state.

If the end of the Second World War ushered in a substantial welfare state which initially promised to end poverty and give universal access to care, today we see this system has been significantly challenged by a number of social and economic factors including the rise of a psychology of consumerism across society. People have a more active attitude towards public services and higher expectations of them; therefore greater tax finance is required to satisfy the demand. A vicious circle is created whereby tax-payers are unsatisfied twice: by shoddy services and by cumbersome taxation. It has become a political, social and economic problem that needs to be solved.

If we take the example of the National Health Service (NHS)¹ in the United Kingdom we can see not only how a complex and often unwieldy state bureaucracy has lurched from one crisis to another – from endless waiting lists to bed shortages, all the while struggling to cope with overwhelming demand. But, more importantly, we can note how ordinary people have become ever more reliant on a range of institutions in civil society which are now providing key elements of healthcare provision rather than the NHS.

Today, the modern democratic state has realised that it does not have the capacity to fund unlimited and universal healthcare. While the word 'private' may, on first hearing, sound somewhat harsh in the context of such quintessentially human affairs, the not-for-profit element of the sector does nevertheless offer an attractive alternative to the State or for-profit provision. From a practical perspective, the Third Sector offers an ideal channel through which a government can outsource key elements of healthcare provision in order to respond more effectively to an overwhelming demand.

Historical Overview

Away from the rubrics of statism and market profit, what may be termed 'molecular associations' are actually nothing new in Europe. For many centuries, churches and religious entities have pioneered a range of charitable works in local communities. Over centuries, when medical knowledge and care was scarce, priests and friars were usually the most educated and trusted to provide healing cures and spiritually relieve the poor and the indigent.

¹ The NHS provides the majority of healthcare in England; it was founded in 1948 and has become an integral part of English society, culture and everyday life.

In England in 1601 Queen Elizabeth I passed an Act on Charitable Uses² which established the first legislative framework and offered a formal definition for charitable organisations and their work in the relief of poverty, the advancement of education, and a host of other purposes deemed beneficial to the community.

Later, in the 18th century, groups of intellectuals questioned the role and power of monarchs in Europe. Particularly relevant to groups such as the Freemasons and other private networks, it was the French Revolution which opened the door to the multiplication of such groups. However, while in France during the 19th century the state did everything in its power to prevent such associations, in July 1901 the “Loi sur les Associations” (Association Act) was passed. It “substitute[d] individual selfishness to the fecund law of fraternity” (Pierre Waldeck-Rousseau)³, and in many ways became the base for the French democratic system, which in turn led the way to other founding liberties - such as the Bill on the separation of Church and state in 1905.

Philanthropy, in particular, played a great role in Victorian Britain.

To prove their moral worth, well-off Victorians felt compelled to 'do good'. Examples of such philanthropy include the efforts of Lord Shaftesbury to alleviate harsh economic conditions by campaigning to limit by law the number of hours that women and children had to work. Other philanthropists became reformers who tackled public sanitation or the problems of the poor. On a more local level, individual gentlemen and concerned ladies distributed relief to the poor, set up hospitals and schools, and endowed colleges, museums or libraries. Outstanding Victorian philanthropists included Octavia Hill, A B Walker, William Booth, Thomas Barnardo and Charles Booth.⁴

While the Third Sector boomed in Britain during the nineteenth century it was disorganised and certainly did not have the capacity to respond to the needs of all of the needy all of the time. That led to the implementation of the 1911 National Insurance Act⁵ which overshadowed for a while the development of the Third Sector until the vibrant rebirth of non-for-profit dynamism in healthcare at the end of 20th century.

In many ways the politics of the general election of 1997 and the New Labour promotion of ‘Third Way’ politics offered new and hugely symbolic opportunities for the Third Sector, harking back to earlier concepts of ‘self-help’ and mutual provision which had been popular among some leftwing thinkers in the past. Prime Minister Tony Blair not only spoke of recreating a ‘stakeholder society’ in which citizens could become more responsible and active against social exclusion but they could also become autonomous agents, free from state handouts.

Although such language might seem rather tarnished now, charities and non-government organisations have nevertheless benefited from the government’s legislative framework. That said, the government has not sought to promote privatisation for its own sake but instead to hone and use it in new forms to improve state efficiency. As a result, the dichotomy between the state and the for-profit sector has become seemingly less important. A flexible space has emerged in which universal provision can be replaced by a variable provision according to the judgment of individual citizens and the contributions they make for themselves, in association with a range of self-help institutions in civil society.

In the UK in 1998 the annual income of registered charities was roughly £20 million; in 2004 it rose to almost £35 million.⁶

² “Whereas Lands, Tenements, Rents, Annuities, Profits, Hereditaments, Goods, Chattels, Money and Stocks of Money, have been heretofore given, limited, appointed and assigned, as well by the Queen’s most excellent Majesty, and her most noble Progenitors, as by sundry other well disposed Persons; some for Relief of aged, impotent and poor people, some for Maintenance of sick and maimed Soldiers and Mariners, Schools of learning, Free Schools, and scholars in universities, some for Repair of Bridges, Ports, Havens, Causeways, Churches, Sea-banks and Highways, some for education and Preferment of Orphans, some for or towards Relief, Stock or Maintenance for Houses of Correction, some for Marriages of poor Maids, some for Supportation, Aid and Help of young Tradesmen, Handicraftsmen and persons decayed, and others for Relief or redemption of prisoners or Captives, and for Aid or ease of any poor Inhabitants concerning payments of Fifteens, setting out of Soldiers and other taxes; which Lands, Tenements, Rents, Annuities, profits, Hereditaments, Goods, Chattels, Money and Stocks of Money, nevertheless have not been employed according to the charitable Intent of the givers and Founders thereof, by reason of Frauds, Breaches of Trust, and Negligence in those that should pay, deliver and employ the same: For Redress and Remedy whereof, Be it enacted”

³ French politician of the 3rd Republic

⁴ <http://www.channel4.com/history/microsites/H/history/guide19/part03.html#philanthropy>

⁵ The Act provided for a National Insurance scheme with provision for time-limited unemployment and medical benefits

⁶ Data from the Charity Commission, www.charity-commission.go.uk

Concept and Definition

Along with the burgeoning growth of the Third Sector, a new lexicon was born. We can distinguish between a whole selection of expressions such as social economy, social enterprise, charity, non-governmental organisation, associations and so forth.

According to the Cabinet Office, a social enterprise is:

“A business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners.”⁷

This definition is distinct from the concept of charity, which connotes religious benevolence and is also demarcated from business concepts.

An NGO (non-governmental organisation) in most cases implies an international association e.g. Médecins Sans Frontières.⁸

The notion of an association tends to have an even broader purpose but is usually differentiated from the idea of exclusively helping the needy for the general benefit e.g. Association Française du Poisson Rouge (French Associations for the promotion of the goldfish!)

Today, all these organisations are actors in the Third Sector and are therefore part of the ‘social economy’.

The social economy spans a wide range of economic activity in the community which includes developing employment opportunities, financial transactions, property management, pensions, and trading. Successful organisations in the social economy play an important role in helping deliver many key government objectives. These include:

- helping to drive up productivity and competitiveness
- contributing to socially inclusive wealth creation
- enabling individuals and communities to work towards regenerating their local neighbourhoods
- showing new ways to deliver public services
- helping to develop an inclusive society and an active citizenship.

What do charitable organisations do in the health sector?

Disenchantment with the welfare state has opened up opportunities for the charitable sector to fill. However, this phenomenon is not only increasing within nation states, but at the international level too. Witnessing a rise in global solidarity awareness, intergovernmental organisations (IOs) are increasingly challenged by non-governmental organisations – particularly in the areas of health and social care.

Even when it comes to areas such international health aid, IOs are increasingly being dethroned by NGOs such Médecins sans Frontières (www.msf.org) and Action Aid International (www.actionaid.org).⁹

In addition to their more traditional charitable work in the field, these organisations have become active in political areas such as monitoring the impact of global agreements on public health, and fuelling demand for more effective public health safeguards. They have participated in global policy areas such as trade agreements and health, prices of and access to drugs, international conventions and treaties on health related subjects such as landmines, environment, breast milk substitutes and tobacco - and in debates around policies and public health standards.

Many international NGOs seek to capitalise on the increasing profile given to human rights issues. They monitor health and human rights issues such as women's and children's health rights, reproductive health rights (www.IPPF.org)¹⁰ and occupational health risks. Their activity promotes discontent over inequalities in access to health care and on such issues as failing provision.

⁷ http://www.cabinetoffice.gov.uk/third_sector

⁸ MSF was founded in 1971 and its aim is to provide medical care in regions that suffer from wars and natural disasters.

⁹ Formed in 1972, ActionAid is an international agency whose aim is to fight poverty worldwide

IPPF has been providing sexual and reproductive health services since 1952.

¹⁰ Formed in 1952, IPPF (International Planned Parenthood Federation) provides sexual and reproductive health services.

Together, these developments at a local, national and global level mean that charities are an increasingly important channel for involvement in healthcare systems. They bring human resources, technical expertise and new knowledge - and they provide a powerful additional pressure for the recognition of public interests within the health sector.

Today, charities often:

- manage nursing homes;
- provide domiciliary care for the elderly and infirm;
- provide health and care services for people with a range of progressive conditions such as multiple sclerosis, cancer, Parkinson's disease and epilepsy;
- provide a wide range of health and care services for the disabled
- provide medical and psychological support to patients and their families;
- provide information and prevention, organs donors and so forth.
- E.g.: The Anthony Nolan Trust (UK) is a charity which finds donors of bone marrow or peripheral stem cells for people suffering from leukaemia. Finding a compatible donor is a cumbersome task and one that the state alone cannot undertake by itself. www.anthonynolan.org.uk.
- They can be not-for-profit insurers:
- E.g. BUPA is non-profit healthcare organisation - www.bupa.com – it is a mutual offering a wide range of private medical insurance and health cash benefits. It has a national network of more than 35 hospitals and 200 care homes. Established in 1947, the British United Provident Association is the amalgamation of seventeen historic provident associations and today covers more than 3 million people - many of whom are trade union members.
- They fund medical research (e.g.: Cancer Research UK is the UK's biggest charity), often filling gaps in the funding of research by the public sector and the pharmaceutical companies.
- They represent patients and service users through lobbying activities to influence policy makers

Significantly, Third Sector health organisations provide a range of general services that facilitate valuable community interactions. They are to be found at local, national and sometimes international level and for many in marginalised populations become the sole interface for providing care. For example:

- They distribute health resources such as condoms, or cement for toilets (cf. the RNID/RNIB Community Equipment); and for building up health worker moral and support.
- They promote health and information exchange, obtaining and disseminating health information; building informed public choice on health; implementing and using health research; helping to shift social attitudes; mobilising and organising for health. This is particularly true for specific disease organisations such as AIDS charities e.g. AIDES (www.aides.org).¹¹
- They lobby and shape policy by representing public and society interests in policy and negotiating public health standards by building policy consensus, disseminating policy positions; and enhancing public support for policies.
- They mobilise resource and allocate finance; raise community preferences in resource allocation; mobilise and organise community co-financing of services; promoting pro-poor and equity concerns in resource allocation; and build public accountability and transparency in raising, allocating and managing resources.
- They monitor quality of care and of health services; give voice to marginalised groups, representing patient rights in quality of care issues; and channel and negotiate patient complaints and claims.

In addition to service provision, health charities make important inputs to health such as transforming public understanding and attitudes about health. They promote health choices and enhance civil society control over and commitment to health interventions. Not-for-profit health associations often offer new perspectives, technical expertise, and informed leadership on health. They also increase service provision and implementation of public programmes, particularly among marginal communities and in remote areas, and increase financial contributions to health programmes.

Charitable associations have the ability to reach out to many groups and individuals that government cannot reach. They also have the ability to establish levels of trust that government has difficulty reaching.

They have the ability to give voice to disempowered citizens and to put pressure on a sometimes seemingly distant government. Thanks to their closeness to users, their ability to connect and their flexibility and responsiveness as organisations, they have led the way in innovating in public services and beyond.

¹¹ Created in 1984, Aides is the predominant French organization to combat Aids.

Last but not least, Third Sector associations have the advantage of being driven by passion and are completely committed to a cause; whilst Government's universalism is sometimes hampered by electoral priorities. This passion is an outstanding asset as it provides motivation, the main quality driving forward best practice.

A European Trend

The quest for better public services has become a core issue in most modern democracies. Even key elements of the European left no longer view the state as a utopian provider of social and public services. Realising that a tax-funded monopoly often fails to deliver choice and responsiveness, reform is regularly aimed at delivering newly configured services provided by the Third Sector. In the UK, the Strategy Unit of the Cabinet Office noted in 2006 that: "Higher socio-economic groups are 40 per cent more likely to get a heart bypass than those from lower socio-economic groups, despite a much higher mortality rate from heart disease among the latter."¹²

This is antithetical to the primary goal of the welfare state and its founding egalitarian philosophy. If the end goal for public service is to provide equality in life and basic security, the means would be – not only for healthcare purposes, but also in terms of service in general – to outsource to the Third Sector in order to reach the population at the most local level.

To consider the Third Sector as being an efficient end is not only a solution for parties of the left (e.g. Labour's creation of the Office of the Third Sector in the Cabinet Office) but to every entity involved in the public services.

Outside the UK, change is already underway. While Sweden has introduced extensive reforms in healthcare to make services more flexible and responsive, The Netherlands has introduced a comprehensive package of health reforms to improve services and contain costs. This involves giving people an open choice of health insurer and introducing a major extension of competition between hospitals and other providers.

Looking in more detail at the French health system, although it has a strong attachment to state interventionism, it is a system that combines a range of public-private partnerships and is therefore more flexible than a fully nationalised system - such as the NHS.

Similarly, French 'social security' is characterised by egalitarian objectives. However, the poorest are exempt from contributions and receive the same service whilst the rest of the population pays in proportion to its income - up to 20% - counting both employers' and employees' contributions. Moreover, most employees pay an additional percentage to a private insurer – that can be either for profit or not-for-profit.

Therefore, the French system contains public and private elements which combine to achieve a better service. In spite of the theoretical egalitarianism of the system, French healthcare is, in practice, deeply rooted in the principles of competitiveness and freedom of choice. Not surprisingly, the system has been described by the World Health Organisation as being one of the best in the world. "The World Health Organization has carried out the first ever analysis of the world's health systems. Using five performance indicators to measure health systems in 191 member states, it finds that France provides the best overall health care followed among major countries by Italy, Spain, Oman, Austria and Japan".¹³

While doctors' fees are subject to state control and patients are reimbursed according to a flat rate, most specialists ask for a higher fee. In the latter situation, patients are not reimbursed for the monies that exceed the state-agreed rate. As one might expect in any functioning market, France is a country where the most competent doctors are available to the bulk of the population.

Again, patients are allowed to choose whichever practitioner they want. And as one might again expect, patients demand a real service from consultants. Crucially, patients can compare, choose and decide what is best for them.

In France, hospitals are divided into three categories: private for profit, private not-for-profit and public. More than a third of the beds are privately owned or managed and public hospitals have managerial autonomy. Whereas private not-for-profit hospitals are usually in charge of long-term care, private for-profit hospitals, which represent 20% of hospital capacity – usually oversee specialist care - i.e. surgery.

¹² http://www.cabinetoffice.gov.uk/third_sector

¹³ <http://www.who.int/inf-pr-2000/en/pr2000-44.html>

This example of the French health service shows the advantage of mixing the sectors together. It seems constructive to develop a partnership between the private and public sector whereby governments could outsource the tasks that charities are inclined to do better and use taxpayers' money to fund these organisations. The amount of money spent would ultimately be lower than in a monopolised public service and the outcome would be much more efficient and responsive to patient demand.

It also shows that deferring public prerogatives to the private sector does not necessarily involve the end of an equitable service for the general good, nor does it involve a loss of efficiency. On the contrary it is very likely that each actor in the process, patients, public and private sector would benefit from a more flexible service.

Case Studies

The Royal National Institute for Deaf and Hard of Hearing People (RNID) is the largest British charity working for deaf people. In the past couple of years, it has launched a campaign called 'Impact' (a group promoting more transparency in the charity sector) and to a large extent it has replaced the role of the NHS in the support and representation of deaf people:

“RNID has been instrumental in promoting the potential of the voluntary sector. Our groundbreaking work in modernising NHS audiology services continues to revolutionise the lives of people with hearing loss. Digital hearing aids are now fitted as standard across the NHS with more than a million people having already benefited. That's over half of all people currently using a hearing aid.”¹⁴

With pressure from the RNID, the NHS and the Department of Health have reformed the provision of equipment for deaf and hard of hearing people. In 2005, a consortium formed by RNID, the Royal National Institute for the Blind (RNIB), and the British Red Cross worked together to provide a new type of on-line community – Community Equipment.com - a classified advertisement website for special needs equipment. It allows NHS store managers across the U.K. to advertise items of equipment to other store managers and occupational therapists. This exchange of equipment ensures a more efficient provision of special needs equipment where it is needed and avoids the unnecessary purchase of new and expensive equipment.

RNID also worked in partnership with the Department of Health to roll out a programme of modernisation of audiology service: the charity was responsible for training audiologists in NHS trusts to adopt digital hearing aid technology.

Ed Miliband, British Minister for the Third Sector, in a speech for Unison¹⁵ and Compass¹⁶ in January 2006 said: “As we seek to redesign our services, we have to use all the means at our disposal. Sometimes this will involve the Third Sector, because of their closeness to users, in helping in that task. An example of this is the way that digital hearing aids were revolutionised by the RNID's advice because of their closeness to the user.”

What we can learn from the RNID is that it has developed best practice concerning audiology issues, thanks to its proximity to deaf people and deafness; they can provide support, sign language courses and an array of things that would need to be run by different government agencies.

What are the risks?

The nature of welfare restructuring in Europe at the beginning of the 21st century means that a space is opening up for a new and explicit awareness of the limitations of politics and democracy in delivering public services, as well as a generally recognised re-emergence of voluntary arrangements in civil society.

While some might complain that both the state and commercial interests might want to exploit the Third Sector – for example, charities could conceal corporate or political interests – it is certainly clear that dependence on the state for access or resources would compromise the autonomy, accountability or self-determination of charities and make them reluctant to criticise political masters.

Similarly, it is important that, while the Third Sector retains its diversity, it does not become so complex that it endlessly and inefficiently produces an unnecessary array of duplicates. In a real social economy the market would be

¹⁴ www.rnid.org.uk

¹⁵ Unison is the biggest trade union in Britain, representing people who work in public services, the voluntary and private sectors.

¹⁶ Compass is a left-wing pressure group.

allowed to optimise the institutional arrangements without artificial incentives coming from government funding. To this end, social enterprises need to be managed like private enterprises and with the same seriousness and effectiveness.

A failure? The question of the French non-profit organisation AFM

In 1987 in France the first TV fundraising show, the Telethon, was broadcast in order to raise money to tackle research on muscular diseases and in particular myopathy; a genetic disease that causes a dystrophy of the muscular tissue leading to premature death but which also confines the patient to a wheel-chair, incapacitated by the weakness of his muscles. Due to the early death induced by the disease, only children and adolescents are affected, which makes it an especially emotive disease to fight against.

The Telethon is a TV marathon lasting 30 hours which raises almost 100 million euros a year. No other cause in France is capable of raising that amount of money - apart from one-off campaigns particularly charged with pathos, such as the South East Asia Tsunami appeal.

The Telethon and the all the money raised through it is managed by one not-for-profit organisation, the AFM (French Association for the fight against myopathies). Showing young and incapacitated children in the claws of the disease makes the Telethon highly emotionally-charged and guarantees not only a considerable fundraising capacity but also a shield against any kind of criticism, as they guarantee a possible future without genetic disease.

The problem is that AFM has monopolised the field of research – whilst the funds are supposed to go into genetic diseases research – it actually concentrates mostly on muscular degenerations while other types of genetic research are left aside or behind.

According to Jacques Testart¹⁷, a biologist who received physical threats for having criticised the Telethon, after almost twenty years of Telethon there has not been much progress. With that amount of money other types of care could arguably have been developed.

There is also another unhealthy phenomenon that occurs in French laboratories: in order to receive more funds they align with the Telethon's policies and do not protest against iniquitous funds redistribution. Therefore, a vicious circle operates, preventing other types of research from developing. Ultimately, patients are misled and misrepresentation becomes a by-product of charitable work. One of the main reasons for this distortion is that AFM is lobbied by parents of myopathic children and donors demanding results that are not realistic. In fact, the yearly Telethon needs to show the audience some therapeutic improvements and unfortunately they are not in tune with the timing of realistic research that takes years, if not decades, to reach some embryonic result. Instead of putting money towards other possible therapies that could be developed for other diseases, dubious results and placebos are shown to the lobbyists in order to placate their requirements.

Towards a Solution

If the Third Sector can offer a great deal in term of efficiency and knowledge – it is, however, the role of the legislator to implement a conducive framework that would allow a fair competition between charities; otherwise it will inevitably lead once again to the sclerotic situation that was sought to be avoided in the first place. This would have to be done through tax benefits for charities and even greater tax breaks for charitable donors.

Furthermore, the example of RNID shows how specialised associations can do better than the clay-footed colossus that is the state. And in order to encourage the spread of competent charities more power should be devolved to local authorities so that they could support people in engaging more within their communities and through this create an even greater network of benevolence at the fringe of public service. The government should also promote voluntarism at school as part of programmes like work experience or internship. That would have a multi-level beneficial outcome: it would give work experience to young people, it would develop awareness of the Third Sector within the population, and it would develop an awareness of social solidarity and voluntarism amongst people and potentially reduce reliance on a paternalistic provider such as the state.

The government should also implement legislation that would make these associations accountable for what they do. If they are indeed developing best-practice, they should become responsible for what they do and therefore liable. It is essential that a watchdog system is implemented in order to avoid abuses, such as corruption. In 1993 a report was released on the Arc (French cancer research associations), which discovered that only 25% of the donors' funds were allocated to research and that the most of the rest of the money was taken away by the senior staff of the

¹⁷ Interview of Jacques Testart in Technikart numéro 88 Dec 04 –Janvier 2005

organisation. Charities should therefore respond to a wide range of criteria that would certify their competence. Monthly and yearly checks and audits would operate to verify the results and the efficiency of the charity.

The example of Telethon illustrates that some diseases are nobler than others and that they are represented by a more powerful lobbying machine. This means that certain fringes of the population as well as certain types of medical conditions are not taken care of. The government should therefore regulate and control in order to ensure that there is a competent association that responds to every citizen's demand and that there are no unnecessary redundancies

Conclusion

While it is true that human generosity is not a new phenomenon, the Third Sector has nevertheless earned a powerful and legitimate place in a world still dominated on the one hand by the profit motive of commerce and on the other by the electoral motives of politicians.

Today, one of the main assets of Third Sector is that in blurring the lines of the public-private divide, both sides have in fact been given a huge stimulus for change and innovation. Spontaneous associations have become an extra democratic and liberal guarantee: a balance that harks back to the 18th Century Enlightenment and puts the primacy of the individual before politics and business.

As such, the social economy has a distinct and valuable role to play in creating a prosperous, sustainable and inclusive society.

When the state is overwhelmed by a failure to deliver its own past promises, organisations in civil society are well placed to replace it in key areas of activity. However, in doing so it is imperative that an appropriate legal framework is allowed to operate which avoids the adverse concentration of power and influence in the market.

With healthcare there is much at stake. In today's Europe, the involvement of the Third Sector can only be welcomed and praised. Eventually one can only hope that Third Sector will phase out a rusty public service and that the Government will move towards having a regulatory role rather than a hands-on role when it comes to the provision of health care.

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