THE ROLE OF THE CHURCH IN DELIVERY OF SUSTAINABLE HEALTH CARE: REFLECTION ON BASIC THEOLOGY AND ETHICAL PRINCIPLES

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Health care has long been associated with the mission of the church to evangelise, to bring the Good News to all nations. In Mark's account of the missioning of the first disciples after the Resurrection, Jesus promises that believers would "place their hands on sick people, who will get well." (Mark 16:18) This ministry of healing is a continuation of Jesus' healing activity. Throughout the Gospels, we have examples of the cure of the sick as a integral part of the preaching of the coming of the Kingdom of God (e.g., Luke 10:9). In its missionary activity worldwide, the church has always had a role in the delivery of health care.

Will that delivery of health care be sustainable? This question that we struggle with during this workshop takes on a particularly urgent character when we reflect on the reality confronting the countries that serve as the focus of our attention, the "countries with limited resources." (Is this today's *politically-correct* language for the "poor countries"?)

My own reflections come from the stance neither of a theologian nor a health-care professional. My training is in the political economy of development and my immediate experience is in a very poor African country. Therefore in preparing the topic assigned to me, I was particularly touched by the message of the World Health Organisation's publication earlier this year, *The World Health Report 1995: Bridging the Gaps.* I am sure you many of you also have read this and have equally been touched by the power of its opening paragraphs:

> The world's most ruthless killer and the greatest cause of suffering on earth is ... extreme poverty.
>
> Poverty is the main reason why babies are not vaccinated, clean water and sanitation not provided, and curative drugs and other treatments are unavailable and why mothers die in childbirth. Poverty is the main cause of reduced life expectancy, of handicap and disability, and of starvation. Poverty is a major contributor to mental illness, stress, suicide, family disintegration and substance abuse.
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> Poverty wields its destructive influence at every stage of human life from the moment of conception to the grave. It conspires with the most deadly and painful diseases to bring a wretched existence to all who suffer from it. During the second half of the 1980s, the number of people in the world living in extreme poverty increased, and was estimated at over 1.1 billion in 1990 -- more than one-fifth of humanity.[1]

Our discussions here go on in the face of this recognition that poverty is the number one health problem in today's world. What we say about the church's role in the delivery of sustainable health care must of course address that sad fact. My contribution in this presentation is to provide some contextual theology and macro-ethical principles for us to reflect on as we look at this topic.

A CHANGING CONTEXT

Today the delivery of health care by church-related institutions and organisations continues to go on around the world as it has for many centuries. But within many of the countries with limited resources, there is a new context for the church's role. This new context is marked by two signficant movements, two important transitions. These are the movements toward (1) *political democratisation* and (2) *economic liberalisation.*[2] The first provides a new context for church-state relations, and the second a new context for meeting the economics of

health care. Because this topic is so broad, let me narrow it to the continent of my own experience, Africa, and be very specific with examples from the country of my own mission, Zambia.

Political democratisation is the transition from authoritarian regimes to forms of government that allow greater popular participation under a constitutional rule of law that respects basic human rights. The 1960's in Africa was the period of "First Independence," when freedom from colonial rule was achieved and national identity secured. Hopes were high, as majority rule governments took control and parliaments with multi-party organisation were put in place. But the experience of full freedom and dignity was short-lived in many if not most of the new African states. For a variety of reasons, internal and external, the hopes of the First Independence gave way to the rise of one-person and one-party totalitarian rule, and, in many instances, the oppression of military dictatorship. By the end of the 1980's, out of the 44 sub-Saharan African states, some 38 were governed by authoritarian regimes.

Then a new experience of "Second Independence" began in the 1990's throughout Africa. Again for a variety of internal and external reasons, there has occurred a move toward political democracy, the rise of or return to a system of multi-party competition, the respect for a free press, and the hope of protection and promotion of basic human rights. In Zambia, for example, we ended a period of 27 years of one-person, one-party rule with a peaceful transition in 1991 to multi-party democracy. Other African countries have experienced similar transitions. South Africa, of course, is the most dramatic instance of transition to democratic majority rule and offers the greatest hope even amidst extremely difficult circumstances.

But the political democractisation movement is still too young to make evaluations of its success or predictions of its sustainability. In many parts of Africa there have been setbacks -- most notably in Nigeria with the retention in power of a cruel military dictatorship. But what is important for our disussions here is that the movement for political democratisation provides a new context for the church's mission of health care. Another paper of this Worshop will specifically address church and state relations. Here it is sufficient to point to two questions that arise: (1) is a democratic context more conducive or less conducive to the orientation of health care under church sponsorship? and (2) does sustainable health care itself require today a more democratic style?

Economic liberalisation is the transition from a centrally-planned, state-controlled economy (socialism) to a free-market, privatised economy (capitalism). For a variety of reasons, internal and external, African economies declined in the period after Independence. Deteriorating terms of trade, increasing debt burdens, mistakes and misplaced priorities meant a fall in production and a decline in standards of living. Basic services and infrastuctures deteriorated. Social indicators of health and education that had risen after Independence took a turn downward. By the end of the 1980's, of the poorest forty nations in the world, 27 were in sub-Saharan Africa.

In an effort to turn around the economic decline of Africa and address the serious problems of widespread poverty, the international donors began pressuring governments to change significantly the direction of their economies. The model of change adopted was that formulated by Northern economists associated with the International Monetary Fund and the World Bank. The "Structural Adjustment Programme" (SAP) is an effort to bring short-term *stabilisation* (e.g., through devaluation, budget constraints, credit restrictions, etc.) and long-term *restructuring* (e.g., through removal of price controls, privatisation, trade liberalisation,

etc.). Faithful adherence to this economic liberalisation is now a condition for any further aid and assistance.[3]

The experience of a country like Zambia is illustrative of the problems created by SAP. First, there is widespread suffering of the people. The elements of SAP such as the withdrawal of subsidies, imposition of fees in health and education, and retrenchment of workers impose especially hash burdens on those who are already suffering. This is a point strongly made by the Zambian Bishops in their 1993 Pastoral Letter, *Hear the Cry of the Poor.* Second, there is serious questioning of the long-term development consequences of SAP, since it does not address key questions such as employment generation, agricultural production to feed the nation, the informal sector, regional coopration, and the environment.

This is not the place to go into detailed analysis of the economic liberalisation movement. Other workshop papers will take up questions of resources, financial aspects, etc., as these affect sustainable health care. But it is possible to point to two questions arising in this new context for the church's health care mission: (1) What is the impact of increased poverty and suffering of the people on demands made on the church's health mission? and (2) Will governments make increased efforts to put health care back into private hands of groups like the church?

The context for the church's health care mission is of course affected by other important events on the continent of Africa, all deserving much more analysis than is possible here. These events include:

- The rise in internal conflicts such as that experienced in Somalia, Liberia, Rwanda and Burundi, and the danger of regionalisation of these conflicts

- Increased numbers of refugees and internally displaced people, caused by these conflicts and also by natural disasters such as droughts and pestilence

- The HIV/ADIS pandemic with consequences not only for health care but for economic development and political stability

THEOLOGICAL REFLECTION

Theological reflection is necessarily *contextual.* For this reason, this paper has begun with an analysis of the changing context. To discuss the role of the church in the delivery of sustainable health care it can help to provide now a theological model that addresses the challenge posed by these two movements of political democratisation and economic liberalisation. Such a model will by no means provide specific answers for the difficult practical questions of day-to-day health care but can provide a framework for evaluation of what is currently going on and for stimulation for our thinking and planning about new directions for the future.

I want to suggest as a theological model the three-fold action of the *Good Samaritan* that we find in the well-known Lucan parable (Luke 10:30-37). The Samaritan's response to the health care needs of the person beaten by robbers and left for dead along the Jerusalem-Jericho road included these elements:

- *compassionate awareness*: not ignoring the needs despite pressures to do so

- *effective immediate response*: providing personal care even at great expense
- *long-term structural response*: providing institutionalised care in cooperation with others

To begin with, the church's sustainable health care must be *compassionate*. One writer describes compassion as "that divine quality which, when present in human beings, enables them to share deeply in the sufferings and needs of others and enables them to move from one world to the other; from the world of helper to the one needing help; from the world of the innocent to that of sinner."[4] Jesus in his ministry is certainly the model of compassion, as again and again we are told in the Gospels that he is moved with compassion to take some healing, comforting, uplifting action (e.g., raising the widow's son, Luke 7:13; feeding the 5000, Mark 8:2; teaching the crowds, Mark 6:34) ; healing the sick, Matthew 14:14).

Coming along the road to Jericho after the priest and Levite, the Samaritan sees what they also had seen: a man lying badly injured in the road. But the Samaritan sees with the eyes of compassion and enters into the suffering man's world. His awareness is not blocked by the pressures of going off for other important business, of fearing what involvement might bring, of revulsion toward such pain and anguish. He does not ignore the needs of the man precisely because he has been moved by compassion; his is a compassionate awareness, much deeper and much more compelling than the superficial and selfish awareness of priest and Levite.

But let us be honest. In today's context of *economic reductionism*, there is little place in government and business policy circles for compassion. The neo-liberal economics that guides structural adjustment programmes creates pressures to ignore and marginalise the poor and the suffering. Compassionate awareness is blocked by systemic emphases on budgetary constrains, competition, efficiences, bottom-line exigencies, etc. Furthermore, the sheer magnitude of human suffering in much of the world has given rise to the frightening phenomenon described as "compassion fatigue": people are simply exhausted, worn-out and wearied by stories of and contact with those who are suffering. "Don't tell us any more! We've done our part!" (Who knows, possibly the priest and the Levite had just come from tending to the needs of many others who had been beaten up on the road to Jericho?!)

This theological model tells us first, therefore, that sustainable health care in today's context must be motivated by a compassionate awareness that may be pressured and may be wearied but is never blinded.

The second thing to note in the Good Samaritan model is the *immediate personal response.* The Samaritan takes time to become personally involved, providing what help he can at the moment: "he poured oil and wine on his wounds and bandaged them; then he put the man on his own animal and took him to an inn, where he took care of him." (Luke 10:34) Throughout the Gospels, we have stories of how Jesus reached out and touched someone in need, a sign of his personal involvement (e.g., curing a leper, Luke 5:13; straightening a crippled women, Luke 12:13; healing a deaf-mute, Mark 7:33; comforting Peter's mother-in-law, Matthew 8:15; feeding his own disciples, John 21:13). His was not a distant, aloof, detached ministry. He became personally involved and shared whatever he could, most especially his loving presence and personal touch.

What does this personal involvement shown in the Good Samaritan model say to our efforts for sustainable health care in today's context? As I will explain in greater detail later in

this paper, there is a serious tension in health care in the industrialised world between two competing models of health care: health care *ministry* and health care *industry*. In the former model, there is more personal, hands-on emphasis; in the latter, a technical, specialised approach means greater de-personalisation. But as you know so very well, personal involvement, the personal touch, is a medicine -- preventive and curative -- that no amount of technological sophistication can replace. And this is especailly true in "countries with limited resources."

And so, secondly, our theological model points to the fact that sustainable health care must emphasise personal involvement of health-care givers.

Finally, we need to take note of the *long-term structural response* present in the Good Samaritan model. Not only was the Samaritan compassionately aware and immediately involved; he was also committed to further assistance through arrangements that involved planning, financing, and cooperative efforts. "The next day he took out two silver coins and gave them to the innkeeper. 'Take care of him,' he told the innkeeper, 'and when I come back this way, I will pay you whatever else you spend on him.'" (Luke 10:35) The Samaritan took steps to institutionalise the care given so that it would be effective. As important as his own immediate and personal care was for the injured person, it was not enough.

This "institutionalisation" of loving care has been a mark of church-related health care over the years, in the best sense of the word. Hospitals, clinics, hospices, homes, etc., are all ways of assuring that the loving care can go on. Indeed, the establishment of these institutions by the church was a signficant step toward "sustainability" of health care before that phrase ever became popular. In the tight economic situations of today in countries with limited resources, commitments to institutions may be more difficult but also more necessary. The control over these institutions -- not simply in financial terms but also, and more importantly, in terms of values -- is also a serious challenge in the new political environment.

Thus, sustainable health care in today's context must, according to our theological model of the Good Samaritan, find ways of effective institutionalisation of the compassionate and personal response of the church.

ETHICAL PRINCIPLES

In looking at ethical principles that would guide the church in the delivery of sustainable health care, I want to make an initial distinction between the *macro*-ethical and the *micro*-ethical.

- *Macro-ethical* principles guide societal and institutional response and refer to topics in social policy areas such as access of the poor to facilities, priorities for the future, etc.

- *Micro-ethical* principles guide individual response and refer to topics in personal choice areas such as contraception, maintenance of life-support systems, etc.

Because my own training and experience is in the field of the political economy of development, my focus here will necessarily be on the macro-ethical principles. Someone with more specialised medical ethics background would have to address the micro-ethical principles. But I will say this. From my involvement in consultancy with church-related health care systems in the United States in the 1980's, my impression is that considerably more

attention has been spent on the micro-ethical issues that on the macro-ethical issues. That has meant in practice that some very significant points regarding ecclesial policies, organisational priorities, and institutional practices have not been subjected to as critical an ethical evaluation process as have been individual practices of medical personnel and personal choices of people, especially in narrow areas of sexualtiy.

An obvious point, for example, is that the ethical demand of concern for the poor -- the implementation of the church's mandatory "option of the poor" -- has signficant consequences that should affect institutional decisions and policies.[5] These consequences relate essentailly to the religious and evangelical character of our health care ministry.

To provoke our discussion here this morning, to stimulate questions in our discussion groups today, and to focus our potential resolutions in the days ahead, let me suggest a set of *four macro-ethical principles* that should guide the role of the church in the delivery of sustainable health care. These principles are related and all can be rooted in the theological model of the Good Samaritan that I have presented. As you hear the principles, I ask you to apply them to your own specific experiences and test their validity and relevancy.

Sustainable health care in today's context should be primarily:

1. Ministerial (not industrial)

"Sustainable health care should follow a ministerial model and not an industrial model."

This first and indeed foundational principle states very simply that providing health care is a form of service in and for the community before it is a form of economic activity, a commodity exchanged for profit. Care is to be provided for whoever needs it. Who pays for that care is an important consideration, but it definitely is a secondary consideration. This at least has been the traditional ethic guiding health care over the years.

Now this principle may be simple to state, but it is increasingly difficult to implement. Of late, particularly in the rich countries, health care has followed more of an *industrial* model than a *ministerial* model.[6] This is understandable, given the pressures arising when health care assumes the economic proportion it does. For example, in the Untied States of America health care currently accounts for more than 14% of the annual GNP. The fastest-growing sector of health care activity is the for-profit sector.

The *ministerial* model of health care emphasises:

- the service of persons with respect for equal dignity of all
- a holistic approach relating to the whole person in the whole community
- a focus on the spiritual dimension of the person
- a preference for the poor, the so-called "option for the poor"

The *industrial* model of health care emphasises:

- the pursuit of profit for a return on investment
- specialisation for efficiency with attention to individual parts
- technological effectiveness
- competition in order to survive economically

Although these models can be complementary -- one must survive in order to serve! -- they also can be conflicting in the values, directions, standards and ethos of an institution. For example, the option for the poor may be pressured to give way in the face of stiff competition and budgetary constraints. Sustainable health care in a church-related institution in today's political and economic context must be guided by this macro-ethical principle of ministerial service if it is to maintain the religious character, the link to Jesus' ministry of evangelisation, that was the mark of its founding.

2. Holistic (not isolationist)

"Sustainable health care treats the whole person in the whole community, not isolating personal parts from the rest of the body or individuals from the rest of the community."

This ethical principle recognises that a human person is not a unique organism with isolated problems, but a whole. Not just a whole individual person either, but a part of that whole that is the web of relationships to the wider community, to the person's family, to their work, to their social situation.

Sustainable health care is guided by this principle when it avoids a hyper-specialised approach to taking care of a sick person or to preventing illness. I am more than my inflamed appendix, more than my malaria-caused fever. Moreover, there is a spiritual dimension to my existence, in the sense of my beliefs, my hopes, my loves. This dimension too must be taken into account when I am seeking health care. For example, other professionals in society must be recognised besides simply the physician or the nurse. Religious personnel are not simply for offering "spiritual consolation" but have a role in the preventive and curative processes.

Furthermore, I am not alone, a *lone* individual. There is a societal dimension to my existence, a dimension that cannot be ignored in diagnosising needs and in prescribing remedies. Families, support groups, work places, all come into consideration in an holistic approach. And the cultural aspects of my existence are likewise seen as important. This is especially true where explicit cultural emphases are significant factors in holding a society together and in giving it its identity.

One consequence for sustainable health care guided by this principle: the role of the traditional healer and of traditional medicine asssumes a much more important role. This is certainly true in Africa. Recently I was in a conversation with some West African friends about the significance of advice from traditional healers and of the use of herbs, special diets, etc., that followed traditional patterns. They were not speaking of consulting the *ng'anga* (witch doctor) for medicines to seek revenge or enhance domination. Rather, they sought to be in touch with the wisdom of a community that knew health remedies before the chemistry, technology and "scientific rationalism" of Western medicine came to control so much of health care activities. There is greater interest today in this traditional wisdom. It is certainly in line with the holistic ethical principle we have been speaking of here.

3. Structural (not symptomatic)

"Sustainable health care should take account of the structural causes of sicknesses and not treat only the symptoms."

It is certainly clear from our earlier discussion of the changing political and economic context that sustainable health care is profoundly affected by what is occurring today in countries with limited resources, such as African countries. The structures of political participation and of economic distribution touch the life and the livelihood of every individual. Institutions and services of health care are themselves involved in the transitions taking place around them.

It is for this reason that church-related sustainable health care must be guided by an ethical principle that recognises the deeper causes of sickness in society, especially sicknesses that affect the poor. Dr. Paul Farmer, a physician and anthropologist at Harvard Medical School who has worked in rural Haiti, has argued that health care is ineffective in poor societies unless it addresses the deeper, poverty-related forces that are the root causes of many of the serious diseases on the increase, such as tuberculosis.[7] If TB, for example, is viewed as an exclusively biological phenomenon, then available resources will be devoted to pharmaceutical and immunological research. If the problem is viewed primarily one of patient compliance (e.g., whether or not medicine is taken, diet is followed, etc.), then plans will be made to change the patient's behaviour. But if a more serious structural analyis is done, and the poverty-related forces are identified (e.g., overcrowding, hunger, lack of education, inability to pay for drugs, etc.) , then effective sustainable health care must also necessarily address these forces.

What strikes me about Dr. Farmer's analysis is that it is remarkably substantiated by the World Health Report 1995 that I referred to at the opening of my remarks. According to WHO, "The world's biggest killer and the greatest cause of ill-health and suffering across the globe is ... extreme poverty." Let me give an example that I know of from personal experience in Zambia. The UNICEF efforts to promote universal immunisation have been very successful -- a rate of 88% for tuburculosis, for instance. But this rate has been falling in the past year or two, as very poor parents have stayed away from clinics that now are charging user fees. Although the immunisations are free, they are associated in people's minds with clinics that charge fees for other services -- and are avoided!

Health care cannot, of course, solve problems of poverty. Nor should it be expected to! The point I am making is that sustainable health care must be guided by a macro-ethical principle that recognises that sicknesses and ill health are in many instances caused by the deeper societal structures of poverty, inequity and injustice. It does not help to address only the symptoms; the structures must also be addressed. This is where we can see the importance of the emphasis in the church's social teaching of the need to move beyond *charity* to *justice*.

4. Liberative (not dependency-building)

"Sustainable health care should be liberating to all those involved, health-care givers as well as receivers, and not build dependencies."

In countries with limited resources, one of the most serious challenges in the development process today is to avoid building bonds of dependency. A major critique offered in recent decades of "developmentalism" -- the political-economic ideology espoused by many Northern countries and donor institutions -- has been that it ignored the structural dependency existing in North-South relationships. Structures of trade, aid, investments, and monetary arrangements have all maintained the dominant influence of the rich countries.

These dependency relationships can, of course, also go on within and between organisations and between individuals. It is thus a challenge to design and implement relationships that are liberative and not dependency-building. This is true in the efforts of sustainable health care. On the level of individual interactions, it is important that the style of exchange between the health-care giver and receiver be such that people are empowered to build on their own ideas, to make new discoveries for themselves. The people must become actively responsible for their own and the community's health. To use the expression of Paulo Freire, people become *subjects* of their own development, not *objects* of someone else's efforts to develop them.

In Zambia, we make use of a popular development education approach called "Training for Transformation" that is based on Freierean methodology.[8] (It is also used in several other countries in eastern, southern and western Africa.) I myself have participated in programmes with health care workers in which the emphasis has been in the liberative direction. Local communities build their own clinics; local health workers involve people in education, nutrition, sanitation, and environmental programmes. The well-known handbook for village health care, *Where There Is No Doctor,* is another excellent example of promotion of a liberative health care approach.[9]

There is also the sensitive issue of the dependency on outside funding of church-related health care efforts in countries of limited resources. This is surely an issue of importance for the members of this audience and for the CIDSE/Caritas Internationalis sponsors. The dilemma is that without some outside assistance, much health care would be curtailed and would not be sustainable. Yet the question arises: does outside assistance build dependencies and also absolve local governments, groups and individuals from their personal responsibilities? (This is not an academic question for me in Zambia, since I personally arrange for donations of much-needed medicines to be shipped from the United States to our mission hospitals that experience the constraints of severe national poverty.)

The African Synod message of last year addressed the point of dependency in general terms in a paragraph significantly entitled, "Examination of Conscience of the Churches in Africa," when it stated: "Our dignity demands that we do everything to bring about our financial self-reliance." That call to "do everything" is surely a challenge for all of us![10]

CONCLUSION

What "sustainable health care" demands in the situation of countries with limited resources will become more clear over the remaining days of this workshop. What I have attempted to do in this presentation is to provide an analysis of the context of political and economic transition; to offer a model of contextual theology based upon the compassion, personal involvement and institutional commitment shown by the Good Samaritan; and to suggest a set of macro-ethical guiding principles that emphasise a ministerial, holistic, structural and liberative approach.

I close where I opened, by repeating the message of the World Health Organisation: "The world's most ruthless killer and the greatest cause of suffering on earth is ... extreme poverty." Can we of the church find a role in the delivery of sustainable health care in such a world? Faithful to following the way of Jesus who said, "I have come that you may have life and have that life more abundantly" (John 10:10), we must seek our role humbly, wisely, courageously.

ENDNOTES

[1]World Health Organisation, *The World Health Report 1995: Bridging the Gaps (Geneva: World Health Organisation, 1995), p. 1.*

[2]For a more complete treatment of these topics, see Peter J. Henriot, S.J., "The Social Context of the AMECEA Countries on the Eve of the African Synod," *AFER (African Ecclesial Review)*, Vol 34, No. 6, December 1992, pp. 340-363.

[3]For further explanation of SAP, see Peter J. Henriot, S.J., "Effect of Structural Adjustment Programmes on African Familes, in *African Christian Studies* (Journal of the Catholic University of Eastern Africa), forthcoming 1995.

[4]From a privately circulated paper by Howard Gray, S.J., "Moving Ahead."

[5]See Peter J. Henriot, S.J., "Service of the Poor: The Foundation of Judeo-Christian Response," in James E. Hug, S.J., ed., *Dimensions of the Healing Ministry* (St. Louis: Catholic Health Association, 1989), Pp. 66-85.

[6]See Peter J. Henriot, S.J., "Catholic Healthcare: Competing and Complementary Models," in Hug, *op. cit.*, pp. 19-19-35.

[7]Paul Farmer, "Medicine and Social Justice," *America*, July 15 1995 pp. 13-17.

[8]Anne Hope and Sally Timmel, *Training for Transformation: A Handbook for Community Workers*, 3 vols. (Harare, Zimbabwe: Mambo Press, 1984).

[9]David Werner, *Where There Is No Doctor: A Village Health Care Handbook for Africa* (London: Macmillan Publishers, 1987).

[10]"Message of the Synod," #44, in *The African Synod* (Nairobi: Paulines Publications Africa, 1994), p. 26.

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September 1995 Case Study: The Role of the Church in Delivery of Sustainable Health Care: Reflection on Basic Theology and Ethical Principles

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