POSITION PAPER ON HEALTH CARE AND JUSTICE

In order to present a synthesis of the main concerns expressed at its July 1973 annual meeting, members of the Christian Medical Commission, during the meeting, drafted, reviewed and accepted in its final form the paper which follows. The paper appeared in the report of the meeting and was also published as CONTACT 16, August 1973.

When the Christian Medical Commission was formed in 1968, its first major activity was to evaluate the existing patterns of relationship between church medical institutions and the people they served. We are deeply conscious of the tremendous dedication and selfless service that have made church-related hospitals unique symbols of the proclamation of Christian love in action. Continuing contributions have been made in changing whole systems of service, providing pioneering approaches to new geographical areas, opening new educational perspectives, and in all of this in demonstrating a high quality of concern. Problems have now arisen which require new adjustments to changing conditions, without derogating in any way the contributions of the past.

1. A SYSTEM WHICH IS INEFFECTIVE, INEFFICIENT AND UNJUST

One sign of trouble has been our inability to keep up with the progressive effort to match in the overseas setting the qualitative improvements in hospital care which have characterized the scientific surge in world medicine. This has required a rapidly escalating investment in both facilities and personnel that increasingly specialized physicians can work with more elaborate and expensive equipment. Hospitals are doing more and more for the same limited number of patients.

The comments which follow are directed to those in all parts of the world who share our concern. The Commission’s studies of the past five years have shown that the traditional hospital-based approaches have been ineffective and inefficient.

Our approach has been ineffective in meeting the total needs of populations for both physical and spiritual healing. Community surveys show that we reach only a fraction of the people in a hospital’s orbit. It is no longer enough to say that our responsibility is only to provide a facility and then it is up to the people to come. Rather, the service personnel must take more initiative. The fact that the most intolerable health conditions are perpetuated immediately around hospitals is scarcely a Christian witness. Deplorable health conditions cannot be casually blamed on prevailing social and political conditions. When we did not have effectual measures for health improvement, it may have been justifiable only to practise curative medicine. Now that we have increasingly potent tools for both curative and preventive services, we must apply a whole new standard of priorities, based on careful analysis of those approaches which are most effective in improving health. Almost all hospitals are doing something about prevention, but no effort has
been made to use a cost/effectiveness approach in getting a more appropriate balance between curative and preventive activities. A common response is that we will get around to prevention after we have taken care of immediate medical needs and emergencies. The seen sick patient before us has an emotional imperative that draws us away from such activities as caring for the unseen thousands of children around us who need better nutrition. But a concern for effectiveness will require a better balance of preventive activities.

The hospital-focused health care system is also inefficient. A clinical condition that requires massive investments – especially in the most precious commodity of personnel time – could often have been prevented at a fraction of the cost. This is especially true of the health problems that crowd the wards in poor communities. Our inefficiency is also evident in the way we use time within the hospital. Because of archaic medical prejudices about clinical care being the doctor’s preserve, we do not turn routine treatment over to auxiliary personnel, although it has been abundantly demonstrated that they can care for 90 per cent of illnesses as effectively as physicians. Patients must invest inordinate amounts of wasted time in waiting while nothing is done – both as inpatients and outpatients – while the harassed doctor is trying to get through a phenomenal daily burden, most of which could be handled just as well by others. The fact is that elaborate hospital facilities are designed more to serve the professional convenience of overly busy physicians than the well-being of patients. Most seriously, the people are not given the education that would permit them to take care of their own health problems. They are also not given the compassionate listening time needed to unburden their psychological problems and fears.

The Christian Medical Commission has shared with others increasing attempts to publicize these areas of concern. The generally favourable response has been most encouraging. Our further deliberations have now brought us to an additional insight, which we are planning to explore in more depth. We communicate our thinking at this time with the hope that we will get the widest possible participation in our exploration.

For Christians the most serious indictment of a primarily hospital-oriented health care system is that it is not only ineffective and inefficient but that it is also unjust. In fact, it is unjust partly because it is ineffective and inefficient. The technical inefficiency and ineffectiveness we must be sensitive to professionally, but those with Christian concern must be especially sensitive to the injustices of the health system.

2. **EQUITABLE DISTRIBUTION OF HEALTH CARE**

The definition of injustice here starts with the conviction that basic morality requires equitable distribution. The greatest moral dilemma of medical care is to find the least unjust way to allocate scarce resources. We cannot just open facilities and wait for the centripetal and spontaneous inflow of patients. Our concern must be centrifugal in reaching out to all those in need. Accessibility has three sorts of constraints:
• geographical
  – this means that we must decentralize services;

• sociocultural
  – this requires the removal of real or imagined barriers, especially those that are culturally misinterpreted because the impersonal environment of the hospital tends to frighten the ordinary patient; we must also be prepared to help patients understand the root causes of their disease so as to promote prevention; and to help them adjust to questions such as, “Why did this disease happen to me?”;

• economic
  – here we need innovative ways of avoiding the dehumanizing aspects both of expensive private care and of free treatment through providing a mix of financial arrangements for care that is inexpensive while still being good.

The primary requirement then is that there be no discrimination in the way we assume responsibility for total populations around our institutions. This does not imply forcing services on anyone but rather seeing that their needs are recognized and taken into account, and then reaching out to make services available to everyone in the area. Two steps are involved. First, instead of spending all our precious resources on those who come spontaneously, we must work out new ways of defining and providing a basic minimum of services for all. The definition of this basic minimum must be locally derived and strictly limited to ensure coverage. The second part of providing equitable distribution is to set and follow priorities in care. The purpose is to focus on the measures that will do the most for particularly vulnerable groups. This exercise must combine technical understanding with community participation in planning. A major result is that people are helped to solve their own problems.

3. HEALTH CARE RELATED TO THE TOTAL DEVELOPMENT OF THE PERSON

Another pattern of differential deprivation of care is built into the institutional structure of the large modern hospital. Traditional village communities provided multiple mechanisms for social and psychological support for the sick and their families. Modern institutional organization becomes depersonalized, partly because size demands routines and these tend to be dehumanizing. As Christians we can try to compensate by being loving. However, the institutional environment itself often discriminates against the families most in need of support. The provision of health care, particularly in a prestigious hospital, may combine technical excellence with procedures which are destructive of family and social relationships. Ill health in itself places great strains on personal relationships, and the way that problems are handled can be
healing in strengthening bonds of caring, or grossly disruptive in callous unconcern for subtle relationships which form the fabric of life.

An important element in the effort to reduce injustice through better health care is to relate health deliberately to the total development of the whole person. Attention must be given to the needs of individuals, families and communities. This requires real collaboration of health workers with those working in the economic and political sectors of community life. It involves especially an awareness and willingness to do something about such problems as environment, malnutrition and the balance between population growth and development. An exciting possibility is to learn whether a simple, auxiliary-based programme of integrated health and family planning can be an entering wedge in the process of development, both through changing personal attitudes and expectations about the future and also by providing a community-based channel through which felt needs can be expressed.

We speak here mainly of discrimination in the distribution of services available to the communities surrounding hospitals. The same principles apply with even greater force in the planning of regional and national health services.

A truly community-based approach in health care offers a whole new range of involvement and potential renewal for the church. Showing love in action through healing can be a cooperative service activity of Christians. With professional guidance, many community activities can be best done by simply trained auxiliaries and volunteers. But church involvement must not be exclusive, it must be inclusive of all who want to serve.

In summary, injustices arise because of:

1. Inequitable distribution of scarce resources. This requires a basic minimum of services for all and priority arrangements to provide special services for vulnerable groups.
2. Communities and individuals do not have opportunities to participate in health care decisions, especially as they relate to total development.
3. The health care system does not promote the wholeness of individual, family and community life through its tendency to depersonalize individual care and disrupt interpersonal relationships, with those who suffer most often being those most in need.

4. **CHALLENGES**

This leads us to present three challenges to policy makers and funding agencies, to health workers and educators, and to all who share our concern. We reiterate that these challenges represent a new recognition that we hope to explore with many. The Commission commits itself to respond to these challenges and to the further insights that will come out of continuing efforts to improve our understanding and perception.
1. We share in a call to openness, to new vision and insight and a daring readiness to explore complex relationships at the interface between science and human values.

2. The challenge to individuals is that in our daily working setting and relationships we must make our part of the action more just in allocating more equitably those resources we control. But we have to start where we are and use what we have as we move incrementally to innovation.

3. The corporate challenge is that we review critically the justness of the health system as a whole. This does not mean condemning or discarding the means and understanding that have contributed so much in the past. We can now build on the past with our new insights, just as those in the future will build more just systems as today’s justice becomes tomorrow’s injustice. We justify this call in the belief that there is no force so aggressive yet so healing as love.