FIVE CHALLENGES TO THE CHURCHES IN HEALTH WORK

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INTRODUCTION

There have been major changes in recent years in how health is understood and provided for in developing countries. The churches have led the way in some of these changes and have been seriously behind in others. The churches often seem unaware of both the major problems that need to be addressed and the relevance and strength of their own resources for doing so.

The purpose of this presentation is to identify a series of health-related challenges that have special meaning for the churches in terms of both their historic commitments to serve the poor and the special resources of the churches.

The Context: Disease, Poverty and Patterns of Health Services

The major diseases that afflict the people of developing countries are familiar. Gastroenteritis and pneumonia, together with malnutrition and neonatal tetanus, are the leading causes of death in children. Parasitic infestations are widespread, and one of these, malaria, continues to take a heavy toll among children. High rates of population growth have a deleterious impact on both national socioeconomic growth and families, contributing to crowding, scarcity of food and limited maternal attention. A sad summary of the burden of disease in the poor countries is that 1/4 to 1/2 of children do not survive beyond age 5, and many who survive those early years are disabled.

Poverty is pervasive in developing countries, contributing to and resulting from ill health. There are 750 million people in poverty: 85 per cent in absolute poverty (annual income of less than US$50); the remainder in relative poverty (more than $50 but less than 1/3 of the national per capita income). Asia carries the greatest burden, containing 3/4 of those in absolute poverty, the majority of whom are in India, Pakistan, Bangladesh and Indonesia. Worldwide, 80 per cent of poverty is rural.¹ The problems of urban poverty should not be overlooked, however, particularly with the massive rural-to-urban migrations that are under way.

As part of widespread poverty, resources for health services are strikingly limited. Governmental budgets allow less than $1 per person per year for health services in much of Asia; in Africa the figure is generally $1 to $4; and in Latin America $10 to $30. For contrast, overall expenditures for health care in the USA are about $600 per capita.²

A most sobering statistic is that spending for health services by developing countries has been decreasing at an annual rate of about 2 per cent per year over the past 15 years.³
Limitations of resources – manpower, facilities, supplies – are intensified by their maldistribution, particularly their concentration in large urban areas. Whereas national ratios of physicians to population are in the range of 1:3,000 to 1:25,000, the figures for rural areas – where 70 to 95 per cent of the populations live – reveal the true nature of the problem: ratios of 1:50,000 are commonplace and 1:500,000 is not unusual. Numbers and distribution of fully qualified nurses generally follow that of physicians. Much of the planning and organization of health services is misdirected through wishful hoping that more physicians and nurses will decide to serve in these areas.

Health services in developing countries are largely provided by government. In Africa and Asia the private sector is small except for church-related programmes which provide from a few per cent to nearly 50 per cent of beds and services. Private practice is predominantly in the large urban centres. In Latin America and parts of the Middle East paragovernmental organizations, such as the social security systems and foundations, provide care for employed populations.

The design and function of health services follow patterns that are similar from continent to continent. Health care activities usually take place in three types of settings. Hospital services usually include major national and regional hospitals with specialty and technical capability for handling complex cases, and smaller district hospitals staffed by one or more physicians. In these smaller institutions, many activities are carried out by nurses and auxiliary personnel. A second setting for care is the network of health centres and health posts or dispensaries, with or without a few beds. These are staffed mainly by nursing, midwifery and auxiliary personnel, which provide care for ambulatory patients and serve as a base for activities in the surrounding communities. The third setting is in the community itself. There has been increasing attention to developing community-based programmes under the direction of resident community health workers who can relate to local people in promoting their interest, understanding and participation, including the use of local resources, in health programmes. The reality of developing countries is that most health care must be provided by paramedical, auxiliary and community health workers supported by professional supervision on a visiting basis.

Certain changes in emphasis have taken place as well, particularly in maternal and child care. There has been increased attention to the prevention and care of malnutrition in small children, family planning and control of infectious diseases. Immunization programmes have been expanding, the highly successful smallpox programme being a leading example. Health planning methods and national capabilities for planning have improved substantially.

These are only a few indications of widespread efforts to improve the quality and extent of health services in the face of the extreme resource constraints. It needs to be understood, however, that such changes have been implemented only to a limited extent. In large parts of the developing world the majority of the people do not have reasonable access to health care. Throughout Asia and Africa only 10–30 per cent of the population are reached by health services. It is unusual for the proportion to reach 40 per cent. In Ethiopia the figure is probably less than 5 per cent. In Thailand the proportion reached is currently about 30 per cent. In Latin America, only 30 per cent of rural populations have access to modern health services. And, of course, local availability of the services does not mean benefit from services.
The dilemma is that vast numbers of people do not benefit from modern knowledge and technology relating to health. Resources are limited, to be sure, but much more is possible with those resources than is being accomplished. Many other resources, particularly those of communities, are not being called upon. There is a richness of ideas and potential for extending effective services to more people that is not being utilized.

What, then, are the areas in which the churches can contribute? What resources of the churches are particularly suited to grappling with health problems and with the obstacles that stand in the way of improving health services for the underserved people of the developing world? I identify five areas that call for special concern and action by the churches, and I offer them as challenges.

**Challenges to the Churches**

1. **SERVE THE POOR**

   Economic definitions fall short of describing the full meaning of poverty. Per capita income information can hide the reality that even among the poor, some are poorer than others and have greater needs for health care than others.

   The poorest are often excluded by social, political and religious values and structures from whatever benefits and opportunities are available even to poor communities. They are lost from sight; difficult to find. A word for the poor in the Indonesian language means “they who are not”, the linguistic expression of their exclusion. Those who enter communities to serve the poor generally assume that they need to work through community leaders, but those leaders may be sources of exclusion and exploitation. Assisting the poor out of poverty is more than an economic problem.

   Certain distinctions need to be made with respect to the poor and their needs for health care. Many are already sick with a variety of diseases. Some may not yet be ill but are at high risk to become ill (a child born too soon after a preceding sibling is at risk to become malnourished; a mother in her sixth pregnancy is at risk to have complications). Further, those who need care may not seek it because they don’t know of their need or because care is too difficult to reach.

   These problems afflict the poor, particularly the very poor, more than the well-to-do, but existing arrangements for health care are not structured to lessen the problems. Resources are concentrated in urban hospitals that emphasize specialty and technology-intensive services and caring for those who have access to them; these clearly favour those who are not poor.

   The churches have an historic commitment to the poor, but they have also been part of the problem, contributing to the imbalances toward technology-intensive, specialty-oriented, curative services, often adding a fee-for-service component because of their own financial needs. These aspects of the churches’ involvement in health care are not surface associations but have deep roots in the professionalization of church-related health systems.

   The challenge to the churches is carried in the Biblical meaning of serving the poor: those who are not cared for and to whose care no prestige is attached. The dilemma for the churches is that serving the poor will require not only working for change in the secular systems of governments.
and private sectors, but also overriding long-standing orientations of the churches themselves and their health professionals.

2. **REDEFINE DEVELOPMENT**

Definitions of development in the recent past have centred largely on economic criteria such as per capita gross national product, and development assistance programmes have often been directed toward increasing that measure of development. An underlying assumption has been that benefits of economic development would eventually also benefit the poor. This concept has been shown to be inadequate; the benefits that are experienced by the poor are actually small, or none at all. The benefits remain largely with the most productive sectors where they were invested. Further, there has been widespread resistance to defining human development in terms that are predominantly economic.

Other measures have been used to characterize development, for example, the percentage of school-age children in school, and nutritional measures that take into account both quality and quantity of food. Such figures are helpful in measuring specific aspects of development, but they miss essential qualities that are important to individual community life.

Alternative definitions of development are needed to reflect the dynamics of community life and social growth. Additionally, communities should be viewed in terms of their local uniqueness and not only as part of some national average. In order for the rural majority to grow in self-reliance, dignity and full participation in its own affairs, human and social development should proceed more rapidly than economic development.

One approach has been to think of development in terms of meeting basic human needs. I follow that approach here by identifying certain minimal services, resources and opportunities that should be available to persons and their communities if basic human needs are to be met:

1. To be protected against preventable diseases (through immunizations, control of vectors, access to appropriate nutrients and to safe water, family planning, health education, etc.); to have access to primary health care and, through that, to more specialized forms of care when they are needed.
2. To have access to at least primary education, and more advanced education according to individual ability if resources are available.
3. To have adequate and safe shelter.
4. To have an income necessary to support a family.
5. To live in a safe environment that retains some of its natural beauty.
6. To have political and religious freedom.
7. To participate in decision making that determines one’s future.

Quantitative measures of some of these minima could be included, such as selected mortality and morbidity rates, indicators of access to health services, rates of literacy and access to education, employment and income indicators, and so forth, applicable at local as well as national levels.

Using these minima as indicators of development, it is clear that economically more developed countries and communities are not necessarily more advanced. Loss of environmental beauty and
religious and political freedom are examples of deteriorations that can occur as nations develop in economic terms. But these indicators still fall short of fully expressing the nature of human development. They fail to capture the richness of human life in individual, social and spiritual terms. What insights can the church offer about the dynamics and quality of development, human rights and values, the role of health in national and community development, and the possibility that those who are economically poor can be rich in other aspects of development?

3. PROMOTE SOCIAL JUSTICE

Taking social justice to mean the fair and equitable distribution of services and resources, major injustices in the health sector are widespread nationally and internationally, partly as a consequence of limited resources, but largely due to social, political and professional actions that deprive the poor. At times these actions are taken without any deliberate effort to steer resources away from the poor. A ministry of health, for example, decides to enlarge an urban hospital in order to provide referral services for a regional or national population, but the result is further diversion of resources from the rural population. A church executive does not understand the technical possibilities of reaching the poor and fails to make decisions that will direct resources towards them. A medical school has admission policies that perpetuate the cycle of well-educated parents who provide quality education for their children that gives them competitive advantage in gaining entry into medical school.

Much of the time, of course, there is nothing inadvertent about decisions that lead to injustice; they are made with the clear intent to maintain an existing imbalance between the urban and rural, the rich and the poor, the powerful and the powerless.

The underlying causes of these injustices are deeply imbedded in the social, economic and political structures of society, and attempts to root them out often involve direct confrontation with the power centres of society. One approach to the problem, admittedly a somewhat theoretical one, is to define principles of justice for health care than can be used as guidelines for getting at injustices.

The general principle is:

*Health services should be available to all; any imbalance in distribution should be to the advantage of the least well off.*

Secondary principles follow:

*A minimum of health services should be available for all.* What is included here will depend on resources: a network of primary health services including preventive, treatment and environmental programmes would be desirable; where there are more limitations of resources, perhaps only immunizations, health education and protection against selected widespread diseases such as malaria would be possible.

*Resources which can provide more than this minimum should be directed toward those most in need* (not necessarily those who seek care). Means should be developed for reaching out,
searching through populations for those most in need and whose conditions can be helped through health services.

*Potential recipients of services should participate in decisions on how health-related resources should be used.*

The churches have committed themselves to combat social injustice. They have also contributed to injustice, unknowingly for the most part, through their medical mission and medical education programmes. Can the churches redirect their own programmes so as to promote greater justice? Can the churches be advocates for social justice in governments and other organizations when taking such positions will run up against established orders, both within the churches and in the larger society?

4. **DISTRIBUTE HEALTH SERVICES EQUITABLY**

Answering this challenge requires the practical implementation of the commitment to social justice. It involves facing the dual problems of limited resources and reaching those most in need of health care. A balanced system is required that includes different levels of health services – hospitals, health centres and community-based programmes – that are fitted to the health problems, environmental conditions and sociocultural aspects of community life.

Building community-based health services can be the most difficult because it requires sharing knowledge, resources and decisions with community people rather than proceeding unilaterally in the name of the health care system. While the resources of the formal part of the health care system – professionals with their expertise, well-trained auxiliaries, material resources, etc. – are necessary, they are of little avail unless joined by community resources – the ideas, commitment of land, crops, money and social organization of local people.

The church is eminently suited to function at this level and has a heritage of serving people as they are and where they are. The question is: can the church balance its involvement with medical schools and hospitals (often with specialty and technological emphasis), to develop community health programmes and to become closely enough involved with communities in order to realize the greater strength that comes from sharing, rather than simply providing, resources?

5. **DEVELOP EDUCATIONAL PROGRAMMES FOR HEALTH PERSONNEL THAT LEAD TO COMPETENCE AND COMMITMENT TO SERVE THE POOR**

Here is a technical/ethical dilemma that I will address mainly as it applies to medical education. Medical education and health service programmes are needed that encompass technological excellence, including specialty clinical capacity, but the process of establishing such technological excellence has resulted in serious imbalances. There has been overemphasis on specialty training and associated services, and medical students have tended to make career choices that carry them in the same direction, drawn often by the prestige and financial reward which they see coming to their professors and physicians practising in urban settings. One obvious result is that relatively few medical students choose career positions that serve the rural majority of the people and the poor. In this respect, medical education is often socially
dysfunctional and misses the mark for the society in its widest sense: vast investments of public funds intended to meet public needs come to naught.

The problem is familiar, and many remedies have been sought. Unfortunately, the usual solutions have had only marginal effects. The development of community outreach programmes by medical schools, the addition of departments of preventive and social medicine, etc., are intended to shape the competencies and interests of students toward working with populations with great needs.

However, the values and attractions of technology-intensive, specialty-oriented hospitals are strong and often make such socially oriented educational methods ineffective.

The important point is that the usual solutions to gaps in socially-oriented values of students follow the same pattern as most “solutions” to curriculum defects, namely to change the content by adding a new course or department. While changing curriculum content might be expected to add to students’ knowledge and skills, only a limited effect on their values, attitudes and commitments can be expected. To affect those attitudes calls for entirely different strategies, probably including radical change of the entire educational milieu.12

It is very difficult to know how to structure an educational programme that will result in students and graduates being competently trained and committed to serve the poor. Extensive changes in traditional approaches to medical education are required. New educational policies and styles need to be developed. The criteria by which candidates for medical training are selected need to be changed to include an assessment of motivation, expectations and human values. The question is: do the churches have the commitment, understanding and internal strength to work their way through this set of questions?

CONCLUSION

These challenges to the churches – to serve the poor, redefine development to include social as well as economic growth, promote social justice, distribute health services equitably, and develop educational programmes for health personnel that will lead to competence and commitment to serve the poor – carry a certain irony. Each challenge is already part of the historic purpose of the churches, and the churches have already pioneered in these areas. But works that were pioneering in the past are now criticized at times as being self-serving, redundant and even contributory to social injustice. Such criticisms are puzzling and frustrating to those who have followed in the historic path of Christian commitment to serve those in need.

Meeting these challenges under contemporary conditions requires the churches to go on to new ground where there are often new ground rules. Actually, there are already many examples of the churches responding creatively and constructively to these challenges – the Drs Arole in Jamkhed, India; Dr Sibley and his colleagues on Kojedo, Korea; Drs Hendrata and Wardoyo in Central Java; the Medical Mission Sisters in Africa, Asia and now in Tennessee and North Carolina – to name but a few of those who are internationally recognized for their leadership on these modern frontiers. Many other programmes not so well-known as these, are also proving worthy to the challenge in creative, locally relevant and quiet ways.
They are the forerunners in addressing these issues; the challenge to the churches is to support them and those who will join them in their creative explorations while bringing the churches into closer alignment with these advances in serving people in need around the world.

BIBLIOGRAPHY

2 Ibid.