Church of Ireland Journal of the General Synod 2004, 279-288

CHURCH of IRELAND GENERAL SYNOD
CHURCH in SOCIETY COMMITTEE
Medical Ethics, Science and Technology Sub-Committee

The introduction of a nationalised health service was promoted with the strong conviction that improved health would lead to reduced spending by the State. This, as is well known, has failed to be the result. By way of background this paper will discuss the issues of:-

1. Resources available in a health care system
2. The use of those resources
3. The scarcity of resources – The why
   The how to use
   The where to distribute

The paper will then discuss the implications of rationing both for individual Christians and for the Church.

The Resources

These can be divided into two parts the tangible and the intangible.

The tangible includes, firstly, the people involved - those who promote health, prevent disease and provide care; the buildings where these take place from simple clinics to the modern highly sophisticated hospitals; and the equipment that is found in them, which may vary from a few pounds/euros to several millions. All of these need money for salaries or purchase.

As there is a need for the tangible so there is a need for the intangible of the people involved. There is the attitude and skills, the energy and enthusiasm of those who work in the system, associated with a concern and care for those they are looking after, and augmented with a desire for training and constant learning and improving. This should be supported by a population educated in healthy living.

One of the most important resources of a health care system is a population that is motivated to care for individuals, concerned for the public good and provides examples of healthy living.

The Use of Resources

a. To promote health
b. To prevent disease
c. To provide care

a. To promote health

Health is a gift to each of us, and each person has a responsibility to care for it to their best ability. Until recently it was very limited what could be done to improve health, as it was given, but modern surgery and recent drug and genetic developments have the ability to improve somewhat, though significant improvement is still some way off. Therefore the maintenance of health is vital and this will depend on the environment in which we live and on education. In any community the state of the environment is vital and includes the provision of clean air, fresh and wholesome food, pure water, adequate shelter, proper sanitation and disposal, safe agricultural practices and working environment.

b. To prevent disease

As with promotion, an appropriate environment will help prevent disease, as is well recognised when there is a breakdown in any of the major utilities of water or sanitation, as occurs after a significant earthquake or a major refugee exodus into camps. In most First World countries, where much of the environmental contribution is safe, the biggest factor in prevention of disease is through changes in personal behaviour, especially smoking, alcohol consumption, and increasingly recognised problems of obesity, as well as a sedentary life, of all age groups.

These changes of themselves do not require spending of any monies but there is a direct need for money such as for immunisation programmes, disease eradication and proper sewage disposal. There is an entirely legitimate use of resources, if only at a humanitarian level, to lessen suffering and to enable people to live healthy and happy lives. This will have a positive spin-off as people can work and provide for themselves and allow the local and national economies to grow and improve. This may appear to apply only to Third World countries but there are areas in our own communities where this can apply.

c. To provide care

Care becomes necessary when health breaks down, and the care sequence will include diagnosis, treatment, aftercare and rehabilitation to allow for a return to the best condition possible. This care programme may need multiple resources, which in turn should be appropriately allocated and distributed and responsibly used.

The promotion, maintenance and restoration of good health are the core of a health service. It is not a commercial concern but is a humanitarian activity

expressing man's care for fellow beings, an obligation to help. It cannot be defined in commercial terms but has to be in the terms of the special status and dignity of man.

Scarcity of Resources

In looking at resources in any health system there is a major paradox in that rather than there being a decrease, it is a fact that the more that is provided the more that is needed. This fact has bedeviled health care throughout the world.

Why are resources scarce? For most systems it has been the case that resources were inadequate from their start and have never caught up. This has been compounded by the following:-

1. There has been an increased need as a result of advances in civilized living, which have proved to be a mixed blessing of both advance and regression. With increased mastery of the environment there has been increased pollution. With increased affluence there is excessive consumption of food, of alcohol, of tobacco and of drugs and on the other side of the scales a lack of exercise, physical, mental and spiritual; and with increased mobility there is an increase in injury and mortality.

   There has also been a change in the nature of need. Not only has there been the direct cost of increased medical knowledge and skills, but this has led to survival of those with handicaps and decreased death from infection, all leading to an ageing population with different diseases of degeneration and malignancy, and therefore increased need. The swing is from acute disease to chronic, and this is shown in increased costs with the average medical needs of a 70 year old twice that of a 50 year old.

2. There have been increased demands, which largely reflect needs as covered in (1) above. In addition there is an increased expectation in both the individual and in society of results that are always perfect and without risk and of medical intervention at a much earlier stage than before, some of which may not improve the situation and some of which may appear to be cosmetic. A lot of these demands may actually be desires not needs, but active pressure groups can influence politicians and therefore political decisions.

3. There have been increased costs, which have appeared on occasion to be exponential In the United Kingdom the costs of the National Health Service rose four fold in the first 40 years, way out-stripping inflation.

   The reasons lie in the increased needs and demands, the increased sophistication and advanced technologies. The new tests and investigations, regularly rolled out, do not lead to decreased cost, and there have been massive increases in the costs of getting new drugs onto the market.

4. There is an issue of wastage affecting all groups involved in health care both on the provider side and on the user side.

a. Patients with unnecessary attendances, inappropriate demands and a failure to take or use prescribed drugs and medicines.

b. Health care workers who make inappropriate referrals, tests and investigations, whether as a result of demand or as a part of defensive medicine, or too frequent or too long follow-up periods. There is a failure to follow the best evidence base and therefore inappropriate prescriptions may be written or new expensive drugs used instead.

c. Changes in administrative structures have increased considerably the numbers of support staff at all levels and this has inevitably increased paper work and time spent by many in the system on administrative matters rather than on direct care. There are also the normal issues of extravagance in the wastages of heating and equipment, and regrettably theft.

   We should remember that we are an affluent country and it is in affluent countries that the wastage is greatest.

5. There have been unfulfilled expectations. In the early years of state systems, already in existence in the 1950s and 1960s, it was generally found that the increasing costs were being met by increasing prosperity but in the 1970s through to the present day the rise in prosperity has been more limited but costs have been rising ever faster.

   Systems of free prescriptions and supply led to an expectation that every aspirin and every dressing should be free. And as mentioned earlier there has been a reduced tolerance of what is regarded as "disease" and what constitutes "disease". This is seen particularly in the field of cosmesis.

   Finally some expectations of reduced costs were met, such as the treatment and reduced incidence of tuberculosis. However this disease has now returned with a significant drug resistance pattern, thereby increasing costs both in drugs and other aspects of management.

   The paradoxes therefore are that advances and improvements lead to increased costs; human behaviour, where the more one has the more one wants and that knowledge does not, in general, affect that behaviour; and in the pursuit of health, the more one worries the more likely it is to lead to ill health

What are the Options if Resources are Scarce?

1. The first option is to do nothing. This may be justified in the short term so that all parties affected can see the results and therefore are encouraged to participate to achieve an agreed and fair solution. However it is not a long-

term solution as it leads to demoralisation of people, and even less is it acceptable, if it threatens the health or life of those in need.

2. There can be an aim for increased efficiency. This can be at the personal level of all working in the system and how they work. It can be technical by only using tests and equipment that are necessary. It is easy to compare what is achieved in the Third World, with minimum levels of equipment, though this should not be a totally valid argument, as the wish should be that they be much better supplied with material needs and equipment. Thirdly it can be allocative where resources are used most beneficially for the community served with a clear recognition that not everything can be done.

3. There can be an attempt to reduce demand.

a. Those working in the system play a large part in controlling supply and demand. Demand for money can be reduced by using generic drugs; by rationalising services and where they are provided e.g. by doing more minor surgery in Health Centres or in local hospitals, rather that in the major central units, and by more day procedures and day care rather than as inpatients.

b. It can be helped by disease prevention. This is the responsibility of both the state and of each individual, and neither can pass it to the other. Both have a part in maintaining the environment, and both in influencing personal behaviour. Doll, 1983, stated that "The avoidance of smoking would alone reduce the mortality from all cancers by about a third.....It would almost eliminate chronic obstructive lung disease". This is a good example of both the state and the individual being responsible for controlling or even eliminating a major health hazard.

c. The introduction of charges does help reduce demand on central resourcing. This has happened with the introduction of prescription and dental charges, but it must not be at the expense of those who cannot afford necessary drugs and other items. No one in genuine need should be refused health care for lack of the ability to pay.

4. The obvious solution is to increase expenditure, but this does not encourage efficiency. If it is done then the new monies are rapidly absorbed and the demands are rekindled.

5. The introduction of rationing becomes inevitable where demand, usually nearly infinite, is balanced by limited resources. Rationing already exists in the form of limited time available for appointments by health care professionals for individual patients, by the presence of waiting lists for hospital appointments and for investigation and treatment. This does not even consider aspects of having restricted lists of conditions that will be treated within the state system, as has already been tried in Oregon State in the USA,

and in a small way in the United Kingdom, but caused a major public outcry.

What are the Principles That Should Underpin Decisions on Rationing?

These seem to be the four of beneficence, magnanimity, fairness and stewardship.

Beneficence - the doing of good to all - though it may have to be qualified. If resources are limited then it cannot be universal, and if it is limited it may not be accepted by those to whom it is offered, who may want something else. It may be that those wants are reasonable and affordable, and therefore it is important to talk to the user groups. However an attempt must be made to balance demands and needs. It cannot be at an unreasonable cost either in what is demanded nor its effect on reducing resources for others in need.

Magnanimity - being generous to all people even to the point of sacrifice. This is open to abuse and therefore must be qualified, when resources are short, though not in a partisan way. People will either have to go short or go without, and they need to be involved in discussions. It is easy to be magnanimous if those making the decisions are not affected by them either financially or in kind.

Fairness is usually regarded as meaning equality - treating all as equals. But Aristotle observed: "injustice consists as much in treating unequals equally, as treating equals unequally". Therefore fairness has to be on the basis of equity, meaning fair shares for all, reflecting needs. Fairness in this context is being limited to personal medical needs.

Stewardship is the charge made on all of us to make the best use of the resources available to us, as they are limited. In the last analysis none of them are our own to use as we choose.

The allocation of resources needs to be looked at all levels from the individual to the international via the local and national. For most looking at this issue it is at the personal and the local levels that decisions impinge on us, and opinions are formed. Objectivity and statistics are much more difficult with an individual patient in front, or for someone involved in a pressure group to look at the wider picture. How do we choose to allocate resources? Is it to the patient in greatest distress? Do we choose those whose demands are less costly financially and therefore more can be treated from the same limited pot? Do we treat those with the greatest potential to return to "useful lives"? What is the implication of this for the elderly or those who are disabled? Do we choose randomly those to be treated? This latter may be the least offensive, but the problem is not knowing how many patients, with a particular condition, there will be to treat in a year, so that they can be randomly allocated. This will be seen by many as an “opt out” and not reflecting the status of man as made in the image of God, but just as a number. At the local level there are major problems with pressure groups and

local politics, and this can affect decisions that should be comprehensive and objective. Though proposed formulae for fair allocation are produced they rarely seem to satisfy everyone.

At the national level the case is even more complex. Governments, as the producers of the funding can produce programmes of care, can produce aims and targets and throughputs that may have had no input from those who are affected, either to carry out those programmes or the recipients. Decisions can rapidly become political and even discriminatory. Minorities may either be ignored because they do not "fit" or alternatively through pressure groups, they have too much influence. These considerations also apply at the international level, but from where will pressure come to influence and prevent the worst excesses of these decisions?

Who Should Make the Decisions Regarding Allocation and Rationing?

There are three parties involved in this, the government, healthcare professionals and the public as users, but where should the emphasis be. For a long time it has tended to be centralised with government, who hold the purse strings and where the expectation is that decisions are less likely to be influenced by narrow parochial influences, and that there would be a programme of priorities. It has also been at the level of the professionals who "knew best" how and where to use the resources, but were just as likely as other groups to be influenced by pressure groups and fashion. However in the past few years it has become common for governments to highlight the importance of public involvement in decision making and in Northern Ireland the Review of Public Administration highlights "the need to give a greater coordinating, scrutinising and influencing role to local voices" and "the need for arrangements which will encourage the community especially women, the elderly and young people to participate in local issues". How best is the public to use that role, and will it carry any influence in the final decision?

What is the Role for the Church?

The first thing is to remember the historical role of the church in health care. The part played by various religious orders over many centuries, and long before there was any suggestion of a state system, in caring for those ill and destitute was a prime example of Christian charity for one’s fellow being. There is still a vital role for the church to continue that role, even if resources were adequate, but even more when they are not, to maintain the voluntary ethos. The example of care is to demonstrate and remind people of their unique humanity and divine connections. It is a reminder in the midst of all the technological advances, that there is a human being with a soul who is often frightened and confused, crying out for that humanity and care that should come from all involved in health care acting as our Lord would have done and would wish to see done in His name.

There appear to be two major roles for the Church in this debate. The first is its influence on individual participation to encourage the members of the Church to get involved, to attend public meetings of health boards, hospital trusts and to show a presence. The other is the role of the Church itself as an institution and as a lobbyist. This lobbying should be to represent the equity factor and should therefore be active. This should be particularly to help those groups who are naturally disadvantaged through lack of confidence to represent themselves have a lack of information or education, or are physically or mentally unable to make their case. The Church at the level of the Representative Body can be a powerful advocate at government levels and with the respective Departments of Health to make sure that the disadvantaged are not left out of any planning process. It should all the time make sure that it is equity that is the basis of decisions and not equality, even if there is an apparent element of positive discrimination. There should be a role to balance those who are articulate, wealthy and in positions to influence, by representing those without these advantages. The history of disability movements for example shows how much it is needed to give user organizations the resources to push through change and even to represent themselves to government and to politicians. The Church is also in a position to respond to major published policy proposals from government, area health authorities and even at more local levels.

The Church can also get involved through its various groups such as the Mothers Union and men's groups to discuss items that develop either locally or regionally that they feel are not being addressed appropriately or to raise issues that are being ignored. These groups also have a major potential as a route for education in health matters, especially in Prevention of disease, by discussing smoking, drinking, excess eating and other deficits in everyday lifestyles that compromise health and therefore the personal relationship with God. This particularly applies to the youth groups, though great sensitivity will need to be shown in this direction, if it is to be perceived as relevant and not just a message from elderly killjoys.

For the **individual member** of the Church of Ireland there are major contributions to be made both as advocates and as standard setters. Each one is made in the image of God, each one is special, and each has a status and each is given their health, at whatever level that is and it is the duty for each person to look after the health of their own bodies as a response of gratitude to our Maker, and so to reduce the demands that may be made on the limited resources that are available. The action of a Christian is not to live so as to make unnecessary calls on the service. This is particularly relevant when considering rationing, if those diseases that are perceived as being self-induced, are put down at the bottom of any priority list. At the same time this is a major issue that all members of the Church should be considering, if and when it becomes a political item. It is already being discussed when funding issues are being discussed.

It is also incumbent on each member, that when they need to call on the resources of health care, that they should only use what they need and should be neither extravagant nor wasteful. Of recent times the word "responsibility" is entering the political vocabulary. If central government is going to provide funds for any particular need, or particular choice, then it is going to expect something back in return, and that may well be in compliance in use of drugs, or in changes in lifestyle after a medical intervention.

Future Trends

What are the trends that society will have to face as it considers where funding is going to go and who may or may not receive all or any that is made available?

1. Prevention. This is probably the way to get the best return for investment, but can funds be diverted from care of the unwell, or can we afford not to?

2. Increase in chronic disease and longevity of the population. This is throwing major demands on all aspects of health care resources, especially personnel. Around half the use of hospital beds is by the elderly, this is going to get greater, and therefore alternative systems must be found apart from high tech hospital beds.

3. Better drugs. These will be better targeted to disease and perhaps even individualised, but at a price. Again where will this money be taken from?

4. Patient choice. Where is the service going to be provided? What has to be carried out in the major centres and what can be safely delivered close to home, economically and effectively? Patients will have to ask is intervention appropriate or necessary. This may be the need to see a doctor, to get a prescription, to be referred to hospital or to have the latest expensive test.

5. Rise of primary care. Modern technology is allowing for the laboratory to be moved ever closer to the patient in their own home or at the doctor's surgery. This will reduce demand more centrally, and reduce time spent travelling and waiting. It will however require decisions regarding the allocation of resources between primary and secondary care.

6. Sexually transmitted disease and substance abuse. The rise in these is putting further pressures on the purse, and puts the focus firmly on prevention and the need to influence human behaviour. The situation that prevails in so many countries in Africa could have the same impact on resources and on priorities in any of the First World countries.

7. Rationing is always going to be necessary and the rising costs are forcing a rigorous review of all spending and there has been a rise in effectiveness studies. Do treatments work? Are there cheaper alternatives? How far do

interventions improve health? These are considerations both for society and for the individual.

Conclusion

Modern health delivery is frustrating for the Christian. When finance precedes provision or when rationing prevents accessibility, this runs counter to Christian ethics such as serving God, self-sacrifice and love of the other. Faith is challenged, as are personal relationships with God and other Christians. The miracle of the feeding of the multitude is the example to consider. The disciples were preoccupied with performance, yet Jesus took them aside, away from the people to rest. When it came to feeding the multitude, there were very limited resources apparently available, but what was the source of power, "who" was in control of their lives, and we know the result.

It is important to recognise that God is omnipotent and to ask through prayer for guidance in making these fundamental decisions. Christians set priorities on the basis of love and compassion, with an overarching concept of sacrifice because of Jesus. The huge inter-related problems of limited resource, inequality and rationing cannot be resolved by regulation, but by deep-rooted principles of Christian love, and prioritising need in an egalitarian system.

The list of priorities and the mechanisms to ration care mean that the way in which services are financed, rationed and delivered depend on organisational and institutional characteristics, which may allow the individual to hide behind a bureaucratic system. Organisations tend to favour a consensus, which gives equal weighting to "good" and "bad" rather than agreeing ethical systems of behaviour.

There is no right to life, health or resources. Christian teaching is that all has been created and given by God; therefore it is a matter of responsibility, duty and stewardship. Indeed seeking another value system could be seen as seeking another god. We should not compromise our beliefs and the teaching of Jesus. Through this we can keep our core values and principles and apply them in context when faced with a decision of "rationing in health care".

"It is the Lord who gives wisdom; from him come knowledge and understanding. If you listen to me, you will know what is right, just and fair. You will know what you should do." (Proverbs 2.6 and 9 GNB)