# Healthcare Mission Forum

Seminar on Christian Hospitals
Presented by Ann Fursdon at Global Connections Healthcare Mission Forum
26/11/03

To be considered:

- Why start Christian hospitals?
- What is effective hospital ministry? In terms of:
  - What we do
  - Who we help
  - Sustainability of Christian hospitals
- Challenges facing Christian hospitals
- Who should govern Christian hospitals?

Presentations include results of study at A.I.C. Kapsowar and A.I.C. Litein Hospitals for MA dissertation: - "Challenges facing Christian hospitals in Kenya:
Different perceptions of role and purpose in the light of contemporary developments"

**Should we start new hospitals?**

1. How will we Assess need?
   - Spiritual – Do we look at the level of local church e.g. how strong it is and what proportion of local people are Christians?
   - Medical – e.g. what other facilities are there locally, what quality medicine do they provide and how accessible are they?
   - In practice in my research it seemed that people didn't consider state of other hospitals locally as of such importance in deciding whether to start a hospital. Nor did they consider that the growth and strengthening of the church locally made any difference to the need for having a hospital. "There are still opportunities to witness in a hospital to people who would not otherwise hear the gospel."
2. What can such hospitals achieve?

The question remains, "How would we decide in new field whether to start a hospital?"

**Effective Hospital Ministry**

In considering what constitutes effective hospital ministry :

1. Who are we aiming to help?

2. What effect do we want?

**Who do we hope to treat?** Are we aiming at particular groups and if so how will we target them?

In my research, respondents were asked which (if any) groups they considered Christian hospitals should particularly reach out to. The following lists show which groups they mentioned and what percentage mentioned them. Respondents could name more than one group.

1. Poor (44.3%)
2. HIV patients (34.4%),
3. Orphans and widows (13.1%) (Usually mentioned by people who also mentioned the poor)
4. Terminally ill patients (11.5%),
5. Patients with chronic diseases (11.5%)

6. Outcasts (6.5%)
7. No particular group (26.2%)

Helping poor has frequently been the aim of Christian hospitals from their inception and AIC Health Ministries mentions it as part of their policies and yet amongst respondents associated with the two AIC hospitals their was a wide range amongst the groups interviewed as to what proportion thought the poor should be targeted thus:

Attitudes to the poor amongst different groups of respondents

| | Those believing that Christians should have an especial concern for the poor | Those expressing a desire to help patients who cannot pay * |
|---|---|---|
| Operating board members | 38.89% | 50.00% |
| staff | 48.39% | 71.00% |
| Pastors** | 22.20% | 50.00% |
| missionary | 50.00% | 75.00% |
| all | 44.26% | 62.30% |

* People were asked how patients should be treated who said they could not pay. This column gives those who said they wanted to help them. Others mentioned the need to avoid helping those who are cheats and the difficulties of sustaining the hospital if fees are not paid.

** Pastors excludes those who were members of the board or who were chaplains

Questions which remain are

1. How will we target such groups
2. How will we finance treating them and with what income?
   When respondents were asked about helping those who cannot pay, 70% recognised that this would cause financial difficulty The need for outside funding was mentioned with 21.3% suggesting church should help, 21.3% suggesting looking for donors, and 11. 5 % suggesting government should help
3. Do we reach them? E.g. at Oicha hospital with a large number of internally displaced people nearby, these “IDP” cannot come to the hospital because they cannot afford to do so.
4. Do we target some of these groups to create a niche because our numbers are going down? Is this appropriate or should we go to where the needs are more obvious. At Kapsowar the hospital resorted to advertising itself and its services. Is this appropriate?
5. Is sustainability “an ideological tool to withdraw funding?

**Sustainability**

Sustainability is increasingly an issue in various areas: -

1. Financial

Options are:

(a) Self supported

- Fees i.e. rich subsidise the poor or poor are excluded

- Income generating activities – variable reports of success from "don't try it" to "very successful"

(b) Funds from within the country e.g. churches – some pastors recognise that this should occur but then also recognise that churches often don't support their own workers adequately

(c) Funds from international community?

2. Sustainable in staff

Is this possible without support of global church?

Challenges to sustainability

- HIV/AIDS and other chronic diseases
- Misperceptions of sources of income
- Reducing income
  - Reducing patient numbers
  - Poor economies in Africa
  - Can we have hospitals which are sustainable and help the poor?
- Increasing Costs
  - Nationalisation
  - Drugs/equipment
  - Facilities for patients

**What effect do we want?**

1. Reaching unreached
2. Caring for suffering (including offering hope + encouragement)
3. Improving health of community
4. Witness of church's concern for people (support church's mission)
5. Holistic care demonstrating God's love
6. Training Leaders

If we take reaching the unreached as our aim,

- We must consider that for many the "unreached" (depending on definition) are far away
- We must decide if preaching the gospel takes precedence over medical care or is equal?
- How can this be preserved as priority?
  - AIM Questionnaire suggested that there is a danger that seeking for quality of care can become more important than preaching the gospel
  - In the Kenya study respondents were asked "Why start a hospital?" Results from study follow: -

| Reason mentioned for starting a hospital | Number (%) mentioning |
|---|---|
| Spreading the gospel | 33 (54.1%) |
| Need for medical care | 29 (47.5%) |
| In order to bring care near | 12 (19.6%) |
| In order to provide holistic care | 12 (19.6%) |

Only 22% put both spiritual and medical

The need to offer spiritual encouragement to sick and grieving people was considered a good reason to demonstrate need for a hospital

When asked what they would like to see in their hospitals in five years time, almost 70% wanted to see an improvement in the spiritual impact of the hospitals.

**Level of care issues - Helping the suffering or promoting health?**

If we are searching to provide effective care we must consider what is effective – Helping the suffering or promoting health? We must also recognise pressures to "improve" care

What Level of Care should we provide?

- Community Health
  - Awareness – In the Kenyan study, 35% were not aware that this effects health more than curative care

Essential Health services Treating major needs, using essential drugs list from W.H.O.

Is it true that "Care that is culturally appropriate and good value for money is a better standard than 'excellent'" Does quality necessitate increasing complexity?

- Tiered health care in Country – often not there in African systems particularly with rising numbers of private health institutions
  - Where on the pyramid are we and where should we be?

Most AIM missionaries agreed when asked that "AIM will wherever possible work with partner churches to strengthen national health care systems at all levels where AIM health personnel can make a unique and identified contribution." If this is so, should we aim to be at a particular level of care regardless of other pressures?

**Level of Care – Pressures**

1. Opportunities/Challenges
   - Unprecedented increase in potential for care but in the Kenyan study, 38% were apparently unaware of improvements in available drugs and equipment but the following table shows how many wanted improvements in patient care when asked about how they would like the hospital to be in five years time.

| | More specialised care | Improving quality of health care | Improving staff quality | Improving infra-structure |
|---|---|---|---|---|
| % of Kenyans | 37.7 | 37.7 | 16.9 | 32 |
| % Mission | 12.5 | 12.5 | 0 | 37.5 |

Only 31% of respondents recognised the cost implications of improving care but these are significant.

2. Competition

Patients have increasing choice as to where they go for care because of increased numbers of facilities and increased mobility. A study by the Church Health Association of Kenya in 2000 showed a reduction in bed occupancy 18% in Christian hospitals cf. Govt. up 6%

Respondents in the Kenyan study mentioned the following effects, which this has on Christian hospitals:

| Effect of increasing choice | Number mentioning (% of total) |
|---|---|
| Increased Competition | 18 (29.5%) |
| Reducing patient numbers | 18 (29.5%) |
| No effect noted | 10 (16.4%) |
| Poor finance in hospital | 8 (13.1%) |
| Medical care is nearer the patient | 5 (8.2%) |

3. Expectations

Expectations are increasing amongst the following groups:

- Public - particularly the paying public (this was mentioned by a number in the Kenyan study along with the idea that referral of patients for any reason undermines any confidence in a hospital
- Medical staff – particularly expatriate?
- Government – in order to train must have sufficient level.
- Board – not always realistic in expectations particularly with non medical members

**Level of care – Staffing issues**

1. getting sufficiently qualified staff

Demanded by Government (although they don't follow rules)
getting sufficiently qualified staff

2. Christian commitment – perceived as less because of pressure for qualifications by 24.5% in Kenyan study so poor testimony of hospital as effect by 19.7%

A comment in the AIM medical review questionnaire was "Excellent health care should not come at the expense of Christian witness"

3. Retaining qualified staff – they want more money and better benefits. The need to start discipling at an early stage, e.g. in Medical schools has been mentioned[1]

4. Missionaries or nationals?

Suitable missionaries, particularly long term are often not available but cost of nationals is a problem (See later)

5. Sustainability

In the Kenya study, the desire/need for more qualified staff was recognised to have negative financial implications by only 31.1% almost none said about consequent affordability issues.

**Issues of Governance**

1. Who do people think own/govern Christian hospitals and who do they think *should* own/govern them?
    - Church
    - BOG
    - Management
    - Missionaries
    - Professionals

What do people think? In response to the AIM questionnaire one missionary said, "The church should not own the health care programme" presumably as a consequence of concerns about training or ability or …?

[1] Philip, V. (Ed.) (2003) A distant thunder and a different drum beat- challenge of medical missions in India (India: Evangelical Medical Fellowship of India)

In the Kenya study, respondents were asked who ran their hospital and who owned the hospital. Results are as follows:

| | Who runs the hospitals | Who owns the hospitals |
|---|---|---|
| Church | 17 (32.1%)<br>(5 Litein) | 40 (75.5%) |
| Board | 13 (24.5%) | 1 (1.6%) |
| Management | 14 (26.4%) | 1 (1.6%) |
| Missionaries | 21 (39.6%)<br>16 Kapsowar | 12 (22.6%)<br>(All Kapsowar) |

NB Kapsowar hospital at the time of the study had 5 missionaries while Litein hospital had only 1.
Thus it is seen that confusion reigns as to who runs the hospitals.

2. How ought ownership to be manifest?

What do we expect of those who are supposed to own hospitals in which we work?
Perhaps:-

- Leadership
- Finance
- Involvement
- Understanding of health care as part of Christian mission
- Vision

One might think that where churches own hospitals this is not clear.

Results of study at Kapsowar/Litein showed that people often did not see the churches were involved in the above activities.

| Why call them “church” hospitals? | | Total number mentioning |
|---|---|---|
| Reasons implying only is a Christian hospital | Staff are Christians | 22 (36.1%) |
| | Preaching or other activities occur within it | 16 (26.2%) |
| | Manner of service is distinctive | 15 (24.6%) |
| | Chaplain present | 7 (11.5%) |
| The church runs the hospital (including through Board) | | 17 (27.9%) |
| The manner of its founding | | 15 (24.6%) |
| The church should finance | | 4 (5.4%) |

3. What is seen of church ownership?

**a) Leadership** in Boards – or

●Involved or interference?

●Training Are they capable?

Some comments:

"It is important that a good proportion of the representatives of the church on the hospital board do have some experience of what it means to run a hospital or health facility".

Possible? Some are looking for this in their boards e.g. Litein and Kapsowar.

Should pastors be excluded?

Need training of board members – done by CHAK previously. The Kenyan study showed pastors less likely to understand issues challenging Christian hospitals today

"The church sees the church representatives as always being pastors or church elders". Changing

NB some suggest **financing**. Cf. some missionaries' idea that the church views the hospital as an income source. One thought the church not only not tax the hospital "but better yet to actively support it financially, perhaps through scholarships for trainees or for capital improvements, etc. to increase the ministry's outreach and in appreciation for the benefits received."

**b) Finance**

- Input or output?

When asked who they thought should finance the hospital (in the Kenyan study) the following ideas were given (people could give more than one idea)

| Ideas as to who should contribute | Number suggesting this |
|---|---|
| Patient fees | 27 (50%) |
| Church | 26 (48%) |
| Government | 22 (40%) |
| Unspecified donations | 9 (16%) |
| Overseas | 12 (22%) |

**c) Involvement**

In Kenyan study 90% of those pastors not involved with hospitals (as chaplain or board members thought the following happen

- Members preaching –(minimal in my observation)
- Assessing attitudes of staff are "Christian" – discipline?
- Church regulations governing hospital
- Discipling – only chaplain

Both Board members and missionaries only mentioned the church running the hospital as the church's involvement. Only three staff mentioned finance by church as possibility and one preaching by church.

What is seen of church ownership

**d) Understanding of health care as part of Christian mission**

What is the biblical justification for medical mission – as perceived in Kenya study

Bible teachings mentioned as encouraging us to work in Christian hospitals

| Element mentioned | | Number mentioning it |
|---|---|---|
| Jesus' example - | mentioning one or more of compassion, healing holistic care | 32 (52.5%) |
| | mentioning Jesus healing alone | 24 (39.3%) |
| Commands to evangelise e.g. Mt 28:19, Acts 1:8 | | 9 (14.7%) |
| Told to care for sick in Matth 25 | | 6 (9.8%) |
| Good Samaritan parable | | 6 (9.8%) |
| Luke as doctor is example of Christian medical work | | 6 (9.8%) |

Thus there is seen to be a poor understanding of all the biblical texts which encourage us to be involved in holistic mission involved in Christian hospitals – perhaps not surprising but to be noted so that training can be undertaken.

**e) Vision**

"Is this possible in Africa?" was the comment of one missionary referring to vision statements etc as a very western concept imposed on Africa. But some missionaries would not be able to give a mission statement for their own work or the hospital in which they worked. Whether a vision statement is possible seems to depend on where hospital is. Does it have to be vision as we see it? Litein has vision as board to "have a model centre for high quality medical services." AICHM has its vision but not well understood "on the ground". Also reported by Asante in his study See bibliography.

**Do they have wrong motives?**

Respondents were asked what they thought the church would miss if the hospital had to close. The following table shows what the church (represented by pastors) thought and what other respondents thought.

| What the church would miss | All Pastors (n=19) | Remainder (n=42) |
|---|---|---|
| Medical care for people | 8 (42.1) | 10 (23.8%) |
| Witness | 6 (31.6%) | 14 (33.3%) |
| Credibility | 5 (26.3%) | 11 (26.2%) |
| Finance from tithes /jobs | 1 (5.3%) | 7 (16.7%) |

It is seen that finance is not considered (although in at least one community, the voluntary tithes of the staff were a significant source of income for the church in a community with little other employment). A marked divergence of opinion is seen. Ideas of what reputation for the hospital the board would wish to see are also very variable (See table below)
If people are questioned about how operating boards view the hospitals views of missionaries may be negative e.g. the following comments made in the AIM questionnaire: "the health facility has been seen by members of the board/committee as an income-

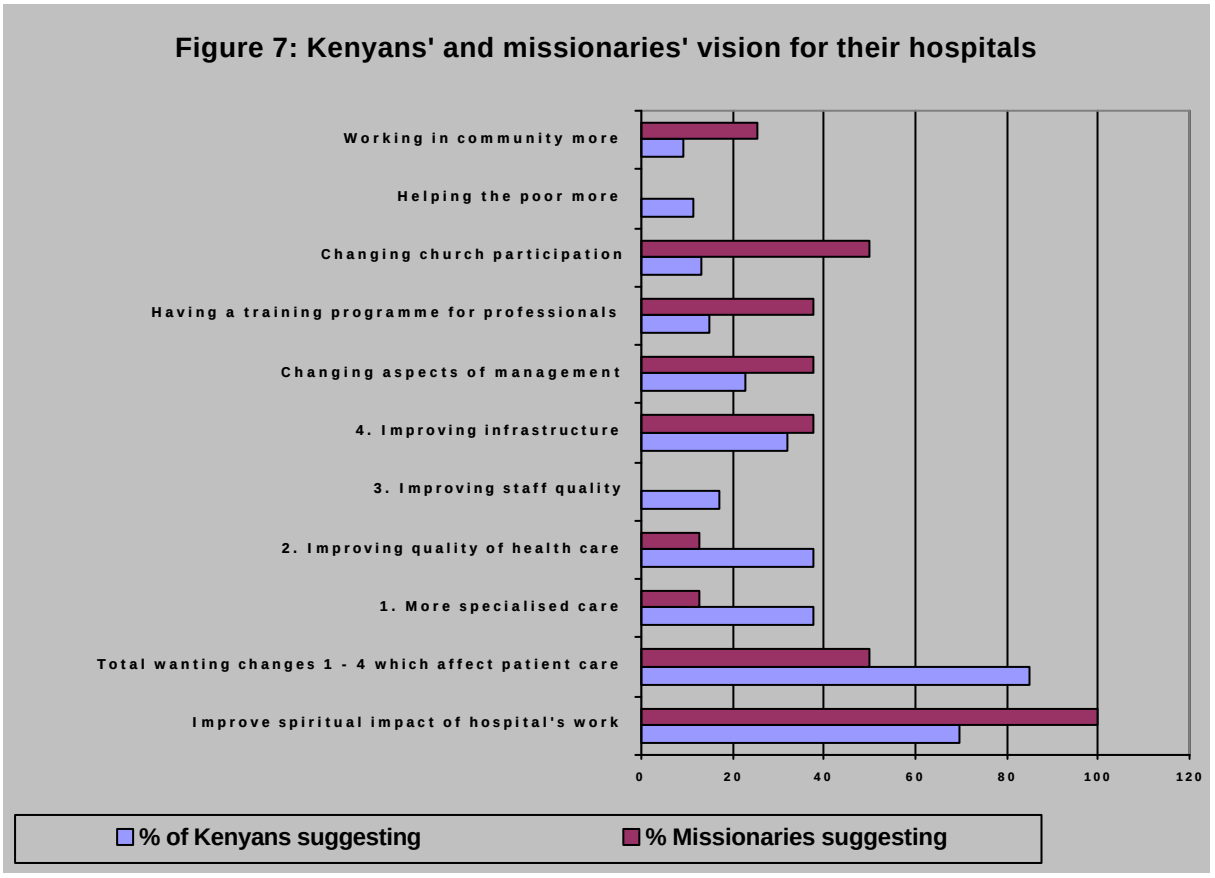
generating project for the church or the board members" and "We can't take for granted that every Christian naturally will have a vision of health ministry as service to the community" This may well be true but not only in Africa Some may consider the hospitals a source of "status or power".
The following table shows what people thought about how operating boards wanted the hospitals to be known.
The marked divergence in opinion between board members for Litein and Kapsowar are is noted
Note quality medicine or keeping up with competition. Word of God preached much less at Litein – perhaps in keeping with their vision.
Less certainty about board's views at Kapsowar may reflect poor communication

| The reputation the board want | | Board members mentioning (n=17) | Remainder of group (n=43) |
|---|---|---|---|
| Good quality medicine | Litein | 6 (100%) | 17 (70.8%) |
| | Kapsowar | 10 (90.9%) | 8 (33.3%) |
| Word of God preached | Litein | 1 (5.8%) | 6 (25%) |
| | Kapsowar | 7 (63.6%) | 6 (33.3%) |
| Better than competition | | 5 (31.2%) | 11 (25.6%) |
| Christian attitudes | | 4 (22.2%) | 11 (25.6%) |

**What Vision do they have?**

The following chart shows responses to a question about what respondents would like to see in their hospitals in the future.

**Figure 7: Kenyans' and missionaries' vision for their hospitals**



**Partnership**

As we call for hospitals to have a vision, will the national church decide on their own or in partnership with mission agencies? If they do decide, Will missionaries follow their lead and does this exclude management by professionals but how bring together church and professionals?

?

Are we committed to enabling "three self" local churches — self governing, self

| | Professional training | Spiritual training | Health Education |
|---|---|---|---|
| Board | 10 (66.7%) | 4 (26.7%) | 8 (53.3%) |
| Staff | 21 (70%) | 11 (36.7%) | 7 (23.3%) |
| Pastors | 7 (77.8%) | 3 (33.3%) | 4 (44.4%) |
| Missionaries | 5 (71.4%) | 3 (42.8%) | 2 (28.6%) |
| All respondents | 40 (72.7%) | 22 (40.7%) | 17 (30.9%) |

propagating and self-financing or do we want a say?

Partnership has been defined as "trust, mutual recognition and reciprocal interchange" and can occur but calls for partnership sometimes mask a desire by missionaries to retain authority, seeking equal rights to set agendas for the church's medical work. True partnership is hindered by "diverging agendas, insufficient emphasis on relationships and indiscriminate usage of old sponsorship methods"[2] with consequent problems of dependency and lack of spiritual freedom. If partnership does not exist or its parameters are not clear then unfruitful conflict can result.

**Training as Part of Effective Hospital Ministry**

Training is often considered primary in mission work. E.g. AIM missionaries agree that they should seek to minimise AIM personnel required to achieve goals but this begs a number of questions:-

- Is it cost-effective to make hospitals increase their payroll?
- Is it possible to provide full professional training? Some can't do so because of government requirements.
- What are our goals? Is it useless to only be helping others?
- Does it help reach the poor?
- "What strategies" can be used to "minimise mission personnel involved in Christian hospitals"?
- Training alone not sufficient – we need to persuade people to stay once trained and for more than the bond period.
- Are we training? – see study

Respondents in the Kenyan study were asked what training goes on in Christian hospitals. The following table shows what they thought.

[2] Brynjolfson "From Synthesis to synergy: the Iguassu think tanks" in Taylor (Ed.) G*lobal Missiology for the 21st Century: The Iguassu Dialogue* 2001:477-488 (:483) (Grand Rapids: Baker Academic) cf. Fountain 2002:10 who finds effective partnership is difficult without a common vision and Kirk, Andrew, J. (1999) *What is Mission? Theological Explorations* (London: Dartman, Longman and Todd)

NB not all respondents thought that training does go on, especially spiritual training and if you ask them what people would miss going to Government hospital, few mentioned fellowship. None mentioned training.

**Questions for discussion**

- Starting a new hospital – On what basis do we decide we should do so?
- How will Christian hospitals serve the poor and how will they fund the work?
- What are pressures to increase level of care and what level of care should we provide?
- What issues arise between Christian hospitals and the churches governing them and how can they be resolved?
- What are the main challenges you have faced in Christian hospitals today? How do we best meet these challenges?

Further details of the study in Kenya can be obtained from Ann Fursdon at annfursdon@ukonline.co.uk

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