"I will lift up my eyes unto the pills."

Malcolm Muggeridge

Health *and the* Nation

In spite – or perhaps because – of a century of medical triumph health is still top of the British agenda. The NHS has become an icon of post-war Britain but seems to be in a state of perpetual crisis. Hardly a day passes without waiting lists, bed-blocking, performance league tables, or funding difficulties making the news.

Is there a distinctive Christian response to these issues? Does ignorance of the biomedical basis of disease render Biblical teaching irrelevant to modern healthcare? Or are there deeper principles which can be used to inform and instruct our thinking today?

Health and the Nation examines these issues and, by analysing and applying the 'divine logic' behind Biblical teaching, aims to offer a Christian perspective on health and healthcare in Britain today.

The Jubilee Centre

The Jubilee Centre exists to promote rigorous and high quality Biblical research into social, political and economic issues. Jubilee Centre Booklets endeavour to help Christians contribute to current debates by integrating this research with up-to-date social trends and offering a fresh Christian perspective on a range of important issues.

The Jubilee Centre

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The Jubilee Centre

Health *and the* Nation

A Biblical Perspective on Health and Healthcare in Britain Today

Nick Spencer

"Dear friend, I pray that you may enjoy good health..."

3 John 2

Appendices

Further Reading and Contacts

The Greatest Benefit to Mankind, Roy Porter, (London, Fontana Press, 1997)
Health: The Strength to be Human, ed. Andrew Fergusson (Leicester, Inter-Varsity Press, 1993)
Biblical Perspectives on Health and Healthcare Relationships, The Jubilee Centre, 1998
From Generation to Generation, Julia Burton-Jones (Jubilee Centre Publications, Cambridge, 1990)
The National Health Service, Charles Webster, (Oxford, OUP, 1998)
Christian Medical Fellowship (www.cmf.org.uk)
Christian Nurses and Midwives (www.cnm.org.uk)
Christian Therapists Network (www.ctn.org.uk)
National Health Service (www.nhs.uk)
British Medical Association (www.bma.org.uk)
Department of Health (www.doh.gov.uk)

About the Jubilee Centre

The Jubilee Centre was founded by Dr Michael Schluter in 1983 from a conviction that the Biblical social vision was relevant to the contemporary world. Its vision is to equip Christians to transform society through renewed relationships.

Relationships are the most precious resource in any society and ultimately it is the quality of relationships with God and within families and communities that hold society together and which provide the key to justice, happiness and well-being.

This vision initially led the Jubilee Centre into a number of campaigning roles, in partnership with others, on such issues as Sunday trading, family life and credit & debt. It also led to the launch of The Relationships Foundation in 1994 to engage in practical initiatives to reform society on issues such as criminal justice, health, unemployment, business practice, and peace building.

Over recent years The Jubilee Centre's focus has shifted away from campaigning towards promoting a coherent biblical social vision based on careful research, and founded on the belief that society may be transformed by Christians thinking and living biblically.

For further information about The Jubilee Centre's current projects, please contact:
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The Jubilee Centre also publishes the Cambridge Papers, a non-profit making quarterly which aims to contribute to debate on contemporary issues from a Christian perspective. Recent issues include discussion of cloning, taxation policy and multiculturalism. There is no subscription charge and if you wish to be added to the mailing list please contact Anne Gower at the above address or via e-mail annegower@jubilee.centre.clara.net

Health *and the* Nation

A Biblical Perspective on Health and Healthcare in Britain Today

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Preface

The people of Ancient Israel were encouraged to 'choose life'. This was not a matter of individual pietism or healthy lifestyle. It was a corporate commitment to covenantal obedience, a commitment to structure their political, economic and social life in ways that would bring blessing to all.

The Jubilee Centre was established in the belief that these commands, decrees and laws provide a paradigm for society that is relevant today. We are called to love our neighbour and to be salt and light. This is the basis of the Jubilee Centre's commitment to biblically informed and effective social reform.

The nature of global capitalism, the working of the criminal justice system, the pressures on family life, and the issues of social exclusion are just some of the issues which we have addressed over the years. This booklet is the first of a series which takes this research and applies it to contemporary issues. It is based on the tradition of 'double listening' – seeking to understand both the Word and the world. In this task we are able to draw on the experience of the many projects initiated by the Jubilee Centre.

The issues that we address share an important characteristic – relationships. Relationships are key to the well-being of both individuals and communities. The provision of public services such as health and education depend upon many relationships, such as those between teachers and pupils or between the wide range of organisations involved in care provision. Crime is both rooted in broken relationships and destroys relationships: an important aspect of justice is repairing those broken relationships.

The issues are also complex. Behind the headlines of public concern are difficult decisions about how best to improve public services, respond to crime or seek greater justice in our economic relationships. All Christians have a part to play in responding to these issues, whether in providing or receiving public services, in making policy or voting for those who do this on our behalf. It is important that this is an informed contribution, reflecting an understanding of the real nature of the issues and inspired by a biblical vision for society characterised by right relationships.

The Jubilee Centre seeks to equip Christians to transform society through renewed relationships. We hope and pray that this publication will serve that end.

MICHAEL SCHLUTER

Summary

Health stories grab headlines. Dramatic, joyful, moving, and of universal relevance, tales of personal tragedies, medical incompetence or funding crises touch each of us in a multitude of ways. The opening months of 2002 saw the alleged maltreatment of a 94-year-old dominate a Prime Minister's question time. They found the government calling down judgement on itself in the event of failing the NHS and witnessed British patients being exported whilst foreign medical teams were imported. Terms such as 'bedblocking' and 'postcode lottery' have passed into common parlance and the proposed bridging of the gap between private and public healthcare provision is fast becoming the acid test for the government's 'third way'.

How are Christians to react to this? Does the Bible offer any guidelines which might help individuals formulate their response? If so, what and how directive are they? Ignorance concerning the biomedical roots of disease made institutionalised healthcare provision an anachronism for ancient Israel but this is not to say that Old Testament law, for example, is therefore completely irrelevant. Scriptural preoccupation with the welfare of vulnerable members of society and the maintenance of sound relationships can help guide our understanding of the rights and responsibilities we owe to fellow citizens, and these in turn may be used as the framework on which an analysis of the NHS's woes may be structured.

This paper looks at the issues behind today's healthcare headlines and examines them through a scriptural lens. It begins by reviewing current thinking on health and healthcare provision, exploring the reasons why health is so newsworthy. A series of compelling factors from the demographic rebalancing of the population to the need to re-evaluate medicine's mandate has combined to make us a healthier nation but one with real concerns about the future of our health.

It then proceeds to examine the presuppositions which determine our very concept of health and to compare these with the Biblical idea of health, represented in the ideal of 'shalom' and epitomised in the life and work of Jesus Christ.

From this foundation of understanding health, it considers the state of the health service today and attempts to draw out some of the real choices and dilemmas that are often obscured by government White Papers and popular media coverage. Financial investment is naturally at the heart of these but can sometimes mask other pervasive questions. In our consumer society, what do we have a right to expect from a national health service? Should we view it like any

other commercial enterprise, evaluating it on criteria such as choice, rights and service, or is there another model for understanding its role within society? How far should we assume that health is a national and governmental responsibility and how far should it be local and even personal? Investment will always be central to any policy initiatives but without clear thinking investment becomes waste.

In the final chapter, I propose a tentative Biblical response to some of these questions. The Bible is in no way prescriptive in its position on these issues and should not be carelessly plundered for proof texts. Nevertheless, its concept of health and its concern for whole relationships, not least with the weakest members of society, can provide the foundations of a response.

The Bible's interconnected concept of health, linking physical, emotional, mental and spiritual well-being, points away from a purely biomedical approach which can lead to the devaluing of the caring professions and the fragmentation of healthcare provision. Similarly, an unconscious assimilation of the values of our consumer culture may establish impractical and deleterious expectations of the NHS and undervalue our own role in securing our health. The Biblical emphasis on covenantal relationships points to the two-way traffic of rights and responsibilities: perhaps the public should be as accountable to the NHS as it is to them?

Ultimately each individual has to make up his or her own mind on how they deal with healthcare professionals, what responsibility they assume for their own health, what they expect from the NHS, how and how much they believe should be spent on it, and who should be the main spending beneficiaries. Neither the Bible nor this booklet is dogmatic on any of these issues. Nevertheless, it is hoped that the analysis of current affairs and biblical teaching within this paper will equip Christians to think creatively and make considered decisions about health and healthcare in Britain today.

1. Everyone's Business: Health and the Nation

Chapter Summary

In spite – or perhaps because – of a century of medical triumph, health is still top of the British agenda with national crises and individual tragedies dominating popular media. The intimate issues involved and the ubiquity of public usage make the NHS everyone's business, and trends in demography, economics, and medicine, as well as attitudes to authority and consumerism, exacerbate existing concerns about the future of the health service. These anxieties are balanced by continuing medical advances, especially in the decoding of the human genome which promises a leap forward comparable to that of the antibiotic revolution fifty years ago. Resultant attitudes are often convoluted, combining a sense of disenchantment and trepidation with real hope for the future.

The triumph of medicine

We live in healthy times in the West. A baby born today has a 99.5% chance of surviving infancy and can expect to live to 2080. The great killers of history such as tuberculosis and typhus no longer plague our daily lives. Few people are driven to an early death by exhausting or unsafe labour. The body's organs are routinely treated and transplanted. Accurate and effective dietary advice is available to all.

Our ever lengthening lives are spent in regular contact with a myriad of healthcare professionals, from the midwife who delivers us to the carers who may be present at our death. Recent figures show that in the 24 months up to January 2001, 95% of the population had visited or had a close family member who had visited their GP.[1] If we don't use the health service ourselves, we almost certainly know someone who does.

This medicalisation of life is a comparatively recent phenomenon. One hundred years ago life expectancy at birth was 45 for boys and 49 for girls. There were approximately 140 infant deaths for every 1,000 births. The majority of the population had minimal access to healthcare and those who could afford treatment were hardly better off – doctors were rather better at diagnosis than treatment.[2]

For most people, serious illness meant death and much credit for the fact that today it no longer does must fall at the door of what Roy Porter called the "radically distinctive approaches to exploring the workings of the human body" that developed in the post-Renaissance West.[3]

Concern for our Health

At the same time as the likelihood of an early death or painful life has fallen our anxiety about both has risen.

We have recently become aware that whilst the battle with bacteria may have been won, the war is still on going. Abuse of antibiotics and the relentless course of bacterial evolution threaten a return to pre-penicillin days. The decoding of the human genome has opened up new horizons in preventative healthcare but has also popularised fears that each of us may be carrying inescapable personalised genetic timebombs. A decade of food scares has made us acutely conscious what we eat and drink. Asthma is on the rise and even though pollution levels in Britain are improving (and are infinitely better than before the 1956 Clean Air Act), we are alert to the very air we breathe.

Health and well-being magazines have proliferated over recent years, as have similar sections in national newspapers. Our concerns are often fanned into mild hysteria by media scare-mongering and we easily lose a sense of proportion. Concentrated outbreaks of measles may be noteworthy but hardly compare to the 200,000 who died in the UK alone in the influenza pandemic of 1918.

Our anxiety is due almost entirely to a better awareness of the causes of ill-health rather than greater risk of sickness or death. Nevertheless, even after a century of lengthening lifespans and better medical treatment, we are still pre-occupied with health.

The National Soap Opera

Nowhere is this better seen than in the British fascination with the National Health Service. Hardly a day passes without waiting lists, medical incompetence or a funding crisis making the front pages. In the first two months of 2002 alone we heard about NHS patients being treated abroad, 94-year-old Rose Addis being allegedly mistreated at home, the bed-blocking crisis that led to elderly patients being stranded on NHS trolleys, the increasing use of foreign nurses, and the short-term import of German healthcare teams. We heard that the British spend $1,000 less on health per person than the Germans, and $2,500 less than the Americans. We learned that in Britain we have 1.7 practising physicians per 1,000 population, compared to 2.5 in Australia and 3.3 in France. We have been treated to special reports on the NHS in virtually every national newspaper and to the BBC's special *'It's your NHS'* day.

This interest is clearly not a fad. The NHS funding debate is as old as the NHS itself, as is a sense of impending crisis: it is over 50 years since Aneurin Bevan

resigned over the charges for dentures, spectacles and prescriptions which effectively reneged on the service's founding promise of free health care at the point of delivery.

Moreover, the size of the organisation means that most people know someone who has worked for it and virtually everyone has used it. This universality of encounter allows everyone to draw on personal experiences in order to champion a particular view.

Perhaps most importantly, medical scandals make fantastic human interest stories. Over recent years, the tales which have emerged from the Bristol Royal Infirmary, Alder Hey in Liverpool and Dr Harold Shipman, to name only the most infamous of headlines, have occupied thousands of column inches, sold newspapers and fascinated readers. The NHS is a national soap opera, replete with a labyrinthine, heart-breaking plot and a cast of thousands, some of whom we seem to know personally.

Everyone's Business

It is not difficult to see why this is so: healthcare is one of the few issues that genuinely affects everyone, often in a multitude of different and intimate ways.

John Betjeman's confession in his autobiography, *Summoned by Bells*, that he greatly feared pain is one which most people would happily countersign. Everyone shrinks from physical discomfort. Ill-health can pull the rug of security from beneath our feet like nothing else, reducing our cosseted modern lives to a struggle for existence in moments. Nothing guarantees our immunity. Nobody remains healthy forever.

In addition, none of us exists in isolation. If we fear our own physical demise, we are equally scared for relatives and friends. As Betjeman's contemporary Philip Larkin accurately observed, "Courage…means not scaring others". One's health is a deeply emotional and relational issue, touching others just as it much as it does oneself.

Beyond this, it can be a profoundly spiritual or existential matter. Periods of ill-health are among the few times in our life when daily concerns fall away and we are faced with the long view. Questions that are crowded out by the minutiae of life demand answers. Am I simply 80kg of sophisticated meat or do I have some more profound identity? Should I cram my three score years and ten with pleasure or do I want to achieve something else? If so, what? As innumerable recovered patients and their relatives have testified, ill-health induces retrospection, reassessment and reformation like nothing else.

For these personal reasons healthcare is recognised as being central to our

national life. In a MORI poll into political attitudes in Britain conducted in January 2002, 40% of people said that they thought 'NHS/hospitals' was the most important issue facing Britain today. The real significance of this is only seen when one notes that the next most commonly mentioned issues, 'education' and 'law and order', were deemed most important by only 6% of people each.[4]

Health has, in fact, been the top spending priority in the public mind for 20 years. When first asked as part of the British Social Attitudes survey in 1983, health was rated first priority for extra spending by 37% of the population, a long way ahead of the next areas of education (24%) and help for industry (16%).

Although these NHS percentages have fluctuated over the years, reaching a maximum of 61% in 1989, health has always remained the top priority and was in the most recent wave of research judged as such by 55% of people. When the criterion was extended to include 2nd priorities, health was rated at 81%.[5] In the 12 months up to January 2001, 22% of people visited their GP, approximately four times as many as had had private medical treatment. During the same period, 23% of people had been an NHS hospital outpatient, 11% had been an inpatient, and 19% had visited a patient in an NHS hospital.[6] The NHS is everyone's business.

Given the size of the organisation this is hardly surprising. It employs around one million people in England alone and costs over £50 billion a year to run, a figure which is expected to rise significantly by 2005. In a typical week 1.4 million people will receive help in their home from the NHS and more than 800,000 will be treated in NHS hospital outpatient clinics. 700,000 will visit an NHS dentist for a check-up and the same number will be visited by a district nurse. Over 10,000 babies will be delivered and ambulances will make over 50,000 emergency journeys. NHS Direct nurses will receive around 25,000 calls from people seeking medical advice and pharmacists will dispense about 8.5 million items on NHS prescriptions. Surgeons will perform around 1,200 hip operations, 3,000 heart operations and 1,050 kidney operations.[7] With such enormity of scale it is not surprising that running operations are not perfectly smooth.

Fears for the Future

Our concern for the NHS is due to rather more than difficult running operations, however. Beyond fears of a return to the time of cholera, there are the rather more prosaic demographic challenges facing the UK in the next 30 years.

It is widely recognised that the British population is ageing and this affects the NHS in two critical ways: supply and demand. A higher *proportion* of older people

will leave a smaller number of tax payers to supply the funds. With the NHS already costing 5.6% of GDP, the approaching dependency ratio crisis will result in heavy strain on the economy and will demand further healthcare rationing.

On the other side, a higher *number* of older people will create greater demand. Technically this need not be the case, as it is *amount* of treatment needed that determines the level of demand and not the age at which one needs it. However, the reality is that as more people spend more time in their seventies, eighties and nineties, the amount of treatment needed is likely to increase.

The long term prospects are slightly less daunting, with an expected re-balancing of the dependency ratio after the baby boomer generation has passed away. However, this is at least forty years off and the NHS will have to endure more pressure before demographic trends begin to work in its favour.

Over and above these 'hard' demands on healthcare provision are pervasive 'soft', cultural ones. Society has a very different attitude to trust and authority in 2002 than it did in 1948 when the NHS was founded. Authority is questioned and scepticism is the accepted norm. Operational transparency is a necessity – anything that goes on behind closed doors is automatically suspect. Medics are no longer necessarily the authoritative and trustworthy figures they once were.

Britain in 2002 is also a consumer culture, with choice, rights and service dominating the lexicon and mindset in both private and public spheres. Health may have very little in common with consumer goods but the consumerist worldview is pervasive. As patients become customers and choice a birthright, the health service is under increasing pressure to deliver to the standard demanded by marketplace ideology. Failure to do so has resulted in the rapid growth of legal claims against the NHS, an immensely costly trend in terms of confidence and morale as well as finances.

In addition, society idolises health, beauty and appearance more than ever before. Good looks, good health and a good lifestyle are dominant aspirations and inability to achieve these is often perceived as a serious failure which is ultimately someone else's fault. As medicine infiltrates every sphere of life, a medical explanation and solution become increasingly expected. My problems become my body's problems, or my mind's problems, or my social problems. I am removed one step from them, as is my responsibility, and it becomes all the more reasonable for me to expect someone else to fix them for me. The result is, once again, greater stress on the health service.

All these factors combine to produce a subtle but insistent external pressure on the NHS and this pressure is compounded by the shifting internal dynamics of modern healthcare. The medical world is no longer as clear about its remit as it once was. The national improvement in health which was initially assumed would alleviate NHS costs has not come about. Where acute infectious diseases

such as TB or rheumatic fever have been (temporarily) defeated, 'lifestyle conditions' such as lung cancer or coronary heart disease have taken their place. This change in demand, accompanied by the ever growing capabilities of modern medicine, have caused something of an ideological crisis in medicine, casting questions over its mandate which had seemed so clear 50 years ago. How far should it seek to prevent 'lifestyle disorders'? How long should it keep terminally ill patients alive? How far should it treat non-physical disorders? Where, indeed, is the dividing line between a medical disorder and sense of personal disaffection?

Addressing Fears

The challenges facing the health service have provoked a number of approaches. The possibilities offered by the human genome project are at the base of the biomedical solutions. In the same way as the antibiotic revolution of the 1940s bred expectations in a generation, so has the genetic revolution of the 1990s. Anything may still be possible. If conditions can be identified, isolated and treated years before they would naturally appear, the pressures on curative medicine will be greatly alleviated. Sceptics, however, have pointed out that, in the same way as the medical advances of the 20th century resulted in postponed and lengthened periods of illness rather than their abolition, the genetic revolution may temporarily improve the quality of life without addressing the real problems facing the NHS.

A different grass roots approach to the healthcare problems can be seen in the peculiar rise of alternative medicine in the last 50 years. A minority activity in the immediate post-war period, doubts about the benefits of western medicine and the popularity of alternative lifestyles from the 1960s onwards led to the swift expansion of the alternative medicine profession. It is reckoned that the number of qualified, associated and unassociated complimentary practitioners exceeds the number of GPs in the UK today. Again, the sceptic's response is to dismiss out of hand the effectiveness of alternative medicine and suggest that this does nothing actually to help the health service.

The resulting picture is confused. A growing disaffection with the promises of earlier medical generations coupled with a quantifiable economic and demographic fear for the future is balanced against the promises of another great technological advance and popular exploration of wholly different approach. Between these poles of dystopian regression and utopian advance, people are increasingly inclined to pick and choose treatments according to the liberty and rights of a consumer society and are disappointed or disenchanted when customer service is substandard.

A Biblical Perspective

This paper examines these issues from a Biblical perspective. The Bible has no concentrated teaching on health and healthcare, being written in an age which was wholly ignorant of the biomedical causes of disease. However, the concern for human well-being that lies at the heart of the scriptures does include principles which can be used to assess healthcare policies.

There is no silver bullet to the problems facing the NHS in the UK, although various White Papers and political statements would often have the public believe otherwise. Instead there are a number of fundamental and often difficult choices which individuals and society need to recognise and address. Examining these through a biblical lens can help people to formulate and express their opinions on health and healthcare in Britain today. ■

Notes

1 *Trends in Attitudes to Health Care 1983 to 2000* (Table 3.38), Sonia Exley and Lindsey Jarvis, (National Centre for Social Research, 2002)
2 A Century of Change: Trends in UK Statistics since 1900, Joe Hicks and Grahame Allen, (House of Commons Research Paper, 1999)
3 *The Greatest Benefit to Mankind*, Roy Porter, (London, Fontana Press, 1997), p. 7
4 http://www.mori.com/polls/2002/t020128.shtml
5 *Trends in Attitudes to Health Care 1983 to 2000* (Table 2.1)
6 ibid. (Table 3.38)
7 http://www.nhs.uk/thenhsexplained/what_is_nhs.asp

2. Modern Perspectives on Health

Chapter Summary

In order to assess the National Health Service and offer a biblical perspective on its major problems, it is important to understand the parameters within which it works. The remit, structure and limitations of any health service will depend on the often implicit conception of health. Modern definitions span the spectrum from the biomedical 'absence of disease' to the holism of the World Health Organisation's "state of complete physical, mental and social well-being." Both poles of the spectrum have advantages and disadvantages relating to their precision and usefulness.

Modern definitions

The dictionary definition of the word health is very broad, ranging from the narrowly physical – "the condition in which [the body's] functions are duly and efficiently discharged" – to the broader and more holistic – "the general condition of the body…well-being, welfare, safety…spiritual, moral or mental soundness."[8]

Historically, most societies through most ages have understood health as the relationship between the individual and aspects of his 'world', be they stars, planets, rivers, forests, ancestors, spirits, other people, or gods. Ancient and primitive medicines were based on holistic worldviews in which man was inextricably and intimately bound up with creation, to the extent that imbalances in his constitution could be traced back to and addressed in often distant environmental phenomena.

The modern West, for various philosophical, religious and economic reasons, developed an atomistic approach to medicine which taught that health might be understood in terms of the human body alone. Anatomy became the foundation stone of modern medicine.

Modern definitions of health range between these two poles, with a reductionist, biomedical view at one end and an integrated holistic approach at the other. The former of these opinions traces its origins back to the anatomical revolution of the 16th century and the Cartesian separation of mind and body in the 17th. At its extreme, it sees the body as a machine, comprehensible solely in biological or chemical terms, and 'fixable' just as any other piece of equipment might be. According to this view, health is simply the absence of disease and healing is the sole provenance of medical specialists drawn from different spheres.

At the other extreme is the holistic perspective which takes the bigger picture

into view. Holism is, in some sense, a reaction against the more zealous forms of biomedical reductionism and tends to come in two varieties.

Individual holism understands disease as the dissonance between individual and environment. It looks to integrate spiritual, psychological and physiological elements and focuses on remedies which are perceived to work with the body's natural processes rather than against them.

The second type of holistic approach is that of environmental, social and economic holism. This usually complements the biomedical view but places the biological and chemical analysis in a wider perspective, recognising that the pathogenic explanation for illness can often be traced to sociological or environmental roots. This approach expresses a view of heath close to that of the World Health Organisation:

> *"Health is not merely the absence of disease, but a state of complete physical, mental and social well-being."*[9]

Evaluating Modern Definitions

Evaluating these different approaches to health reveals problems with each. There can be no questioning the organic reality of disease. The biomedical perspective has been highly successful, with its coup de grace coming in the later nineteenth century when it led to medicine's greatest single revolution: bacteriology.

However, a purely biomedical perspective can miss the wood for the trees, analysing (and spending considerable sums of money treating) effects rather than causes. Several reports published in early 2002 exemplify this. The British public is suffering increasingly from diabetes and coronary heart disease due to greater levels of obesity. Similarly, young men and women are increasingly prone to liver disease and cirrhosis, due to alcohol abuse. In each of these cases, a purely biomedical approach would treat patients for heart failure or liver disease and would fail to recognise the social issues that are causing these problems in the first place.

In addition to this, the biomedical perspective can lead to the alienation and depersonalisation of patient and his or her removal from the whole healing process. The consequences of this can be both harmful and comical and were well satirised in Monty Python's film *The Meaning of Life* where a pregnant woman undergoing labour is wheeled through the hospital corridors at speed. Gasping through the pain she asks the doctor what she should do, only to receive the angry reply, "Nothing, you're not qualified." It is this sense of alienation that gave rise to the patient-as-a-person movement in the early 1900s, which stressed that the patient was not simply a disease and that "a sympathetic, caring manner was therapeutic in itself."[10]

Criticisms of holism have often been more vocal. First and foremost with regard to individual holism, there are significant concerns about its clinical effectiveness. Many members of the medical profession are happy to dismiss this approach to disease as mere quackery.

Criticism of societal holism has been less vociferous, if for no other reason than its proven track record. As Ian McColl has written:

> *"It often comes as a surprise for some medical students that the health of a nation is more dependent on public health and social issues that the clinical activities of doctors. The reduction in tuberculosis over this [i.e. the twentieth] century in this country has much more to do with nutrition and housing than medicines."*[11]

Nevertheless, societal holism has been challenged for forcing medicine into areas which do not concern it. The criticism seems churlish until one thinks of the practicalities of any health service, the constant pressure on the medical profession and the need to define and fund specific roles.

It can be seen, therefore, that whilst biomedical and holistic views are both useful and successful, both have shortfalls for different reasons. For most people a purely biomedical perspective feels too narrow. Many people have had the experience of being physically healthy and yet feeling empty, depressed, or that there is something wrong. Although the modern trend is for a biomedical approach to answer these feelings by providing a drug for every ailment, psychological as well as physical, this is widely recognised as a inadequate solution – costly, endless, ineffectual, and ultimately profoundly dehumanising. Conversely, a holistic approach, whether individual or societal, is often of questionable merit, open to subjective corruption, and potentially unworkable in the limited public health forum. To quote Stephen Pattison:

> *"I am tempted to suggest that wholeness is a concept which is only really used by those of us who are so far removed from the real fight for health and healing in daily life that we can claim to see the world in terms of ideal universal patterns rather than in terms of the very unsatisfactory specifics provided by the worm's-eye view."*[12]. ■

Notes

8 Oxford English Dictionary
9 *Health: The Strength to be Human,* ed. Andrew Fergusson (Leicester, Inter-Varsity Press, 1993), p. 17.
10 Porter, p. 682-686
11 'National Priorities for Health', Ian McColl, in *Our National Life,* ed. Allister Vale (London, Monarch Books, 1998), p. 142
12 Fergusson, p. 27

3. The Biblical View of Health

Chapter Summary

In spite of the centrality of healing in Jesus' ministry the Bible contains no concentrated teaching on health and healthcare. Nevertheless, the health of the individual and of society is central to its concerns and attitudes to both can be drawn out from the use of the word 'shalom' in the Old Testament and from the life and work of Jesus in the new. The biblical understanding views physical health as vital – the body is no prison of the soul but an intrinsic and good part of God's creation – but integrates it with emotional, relational and spiritual well-being, each element of which is intimately connected with the others.

Health and Shalom

The closest equivalent to the English world 'health' in the Old Testament is 'shalom'. Often translated 'peace', its meaning covers a wide range of facets, and in this sense it is similar to the word 'health' in its broadest definition. It is a holistic term which incorporates physical, mental, emotional, and spiritual wholeness and, when used of a community, societal and relational wholeness. Various authorities define it as "wholeness, well-being, vigour and vitality in all dimensions of human life" or "pleasure and happiness, peace and well-being…overtones of justice…to live appropriately and to have harmony and balance in every aspect of one's life and relationships."[13] It stands in direct contrast to physical disease, disability, deformity, idolatry, social injustice, and death.

Alongside this broad definition, are the implications that 'shalom' is never fully attainable. Brokenness and infirmity were not part of the original design for life but have become endemic in the Fall, leaving all of creation in need of renewal and restoration. Many commentators see Jesus' healings as heralding the inbreaking of God's Kingdom, with its promise of restoration and wholeness but the 'now but not yet' nature of this realised eschatology leaves the world and its peoples still suffering from a lack of shalom.

The interpretation of shalom has at times veered towards a purely spiritual understanding of the word but it is important to emphasise that it means more than simply spiritual well-being. There is a distinct physical aspect to the concept and an emphasis on its material implications. It is equated at various points in the Old Testament with physical strength, longevity, vitality, and survival.

The inclination in Hebrew culture was to use concrete nouns for abstract concepts and this can be seen in the various metaphors for health. The words for

'bones' signify life and strength. Serving as the body's framework, bones are the seat of health and vigour, and accordingly 'breaking', 'rottenness' and 'dryness' of bones are frequently employed as metaphors for sickness.

Bones had their parallel in the Hebrew concept of flesh which was often used to indicate human weakness, but wrongly interpreted in later Greek-influenced cultures as attesting to a loathing of physicality and bodily incarnation. In the Hebrew world, health was unquestionably corporeal.

In addition to this physical meaning, the word also had a developed social meaning, as one would expect from a society in which physical ill-health had significant social and relational implications. Shalom is as much about an individual's ability to discharge social duties as it is his or her particular physical state.

Health and Jesus

This holistic view of health is also found in the New Testament and is seen supremely in the figure of Jesus from whom we gain our fullest picture of what it is to be human.

The picture seen in Jesus is a multi-dimensional one, in which humans are seen as having a variety of facets and features. Andrew Fergusson identifies a number of these aspects[14]:

- the incarnation emphasises the Hebrew concept of the importance of the body and counters dualistic Greek understanding of true life as that of the disembodied soul, which is trapped, albeit temporarily, in the prison of the body. The centrality of the physical healings in his ministry[15], the evidence for his bodily resurrection[16] and Paul's subsequent emphasis on this for all believers further stress the importance of the body to the biblical concept of humanness.[17]
- the cardinal importance of Jesus' relationship with his father as demonstrated on numerous occasions in the gospels stresses the spiritual dimension to complete humanness.[18] This is supported by an acute awareness of spiritual life and spiritual warfare throughout his ministry.[19]
- although never central to the focus of the gospels, the evangelists are clear that Jesus lived a real emotional life. He cries, rejoices, celebrates, sighs in despair, and fumes with anger. Emotions were clearly intrinsic to his existence and are not to be undervalued in our concept of health for being too personal or subjective.[20]

- Jesus' relational life is central to the gospels. Among the earliest tasks of his ministry is the assembly of a group of friends on whose backs the kingdom-annunciation would one day fall. So occupied is he with other people that for solitude he is forced to seek out solitary places at awkward times, and even then when this is thwarted and his desire for privacy is denied him, his concern is still for others. His friendship and intimacy with other humans is fundamental to his message and disturbing to those who have drawn conscious or unconscious lines between community groups.[21]

This theological anthropology derived from the life of Jesus should act as a guide to our concept of health, showing how an individual's physical well-being needs to be integrated alongside a sound emotional, spiritual and relational condition in order for them to be truly healthy.

A Biblical Perspective

The implication of this unity is that each element can and will affect each other. Anyone who has ever been physically ill knows how much energy is demanded. Physical sickness can crush emotions, damage relationships and wreck a spiritual life. Similarly, the idea of being sick through worry or with stress is one with which many people are familiar.

Biblical teaching recognises a clear link between a healthy relationship with God and one's shalom. Central to the law is the concept of loving God and loving one's neighbour, and obedience to these dictums was recognised as conducive to shalom. Such compliance would ensure justice, mutual self-respect, a care for the environment, and an inward peace and security guaranteed by God himself.

The converse was also true, although to a more limited extent. Links between sin and disturbed shalom are clearly established, seen through individuals breaking commandments, pursuing their own ends, fracturing relationships with their community, overlooking social justice, and disregarding creation.

Throughout the Old and New Testaments, along with much of the ancient world, there is an assumption that sickness was punishment for sin. It can be seen in Job's companions just as it can in the disciples' question about the blind man in John chapter 9.[22] This theory was maintained and indeed was often treated as a medical axiom throughout the subsequent history of Christendom.[23]

However, whilst the Bible does give specific instances of ill-health as a punishment for disobedience, it is also clear that there is no intrinsic link between the two. The very premise of the book of Job is based on the erroneous beliefs of Job's companions. Similarly, Jesus tells his disciples that the man's blindness in John 9 was not due to his or his parent's sin, just as the murdered Galileans mentioned

in Luke chapter 13 did not suffer because they were worse sinners than anyone else.[24] Sickness need not imply sin just as obedience to God's law is no guarantee of health. The fallen nature of the world disrupts any direct causal link between the two. Moreover, God's demand for our love is unconditional and nowhere contingent on the promise of an easy or healthy life.

Scripture offers one final important perspective on the concept of health, although it is one which is found predominantly in the New Testament. With the coming of Jesus, health is put in perspective of eternity. Although central to Jesus' ministry, health is never of ultimate importance, with Jesus' (and the apostles') willingness to embrace suffering for the sake of the kingdom of God overriding, often very painfully, the concerns of immediate health.

In conclusion, it can be said that the Bible views health as a gift from God and hence as something which is good but not the ultimate good. The biblical view of health, described as shalom and epitomised in Jesus, is wider than the modern biomedical one but includes it. Its health is holistic in the manner of the WHO definition mentioned above but differs in several areas:

- it incorporates spiritual values;
- it is conscious of the reality of sin;
- it acknowledges a 'beyond suffering', recognising that suffering, whilst it should be addressed with all urgency, need not be the last word and *can* be redemptive.

Implications of the Biblical Definition of Health

This definition should have implications for our own health attitudes and behaviour.

Firstly, it is a basic axiom of all scripture that life is good. This life is a holistic one, encompassing physical, emotional, mental, and spiritual well-being. It is a concept which is a long way from the Platonic or the ascetic doctrine of the body as prison from which the soul should flee for full satisfaction. Abstinence is therefore not to be cherished in its own right, as it is in effect a denial of God's gift. Whilst it may serve the purpose of refocusing one from God's gifts to God's self, it is not an end in itself. Physical life and physical health are to be enjoyed.

Secondly, however, Biblical teaching is clear that physical health, whilst important, is not everything. There is more to life than physical well-being. Suffering can be redemptive. Death is not the final word. Whilst these are very hard statements to accept when one is in physical pain, they should offer hope to people for whom suffering is an objective, even daily reality.

Thirdly, the holistic concept of health found in the both Old and New Testaments provides a pointer to our own lifestyles. We are unlikely to attain full health if we exercise well but are overworked. Again, a physically healthy lifestyle is unlikely to amount to full health if one's relationships are corrupt and worrying, or if one lives with burdensome guilt or a restless fear of death.

Fourthly, we need to accept responsibility for our own physical health. Although, as we shall explore below, Biblical teaching focuses on our responsibility for eachother, this is not a substitute for responsibility for ourselves. It is an abuse of God's gift of life and our position within the community to engage in physically and socially irresponsible behaviour.

Fifthly, being intrinsically relational beings, we are profoundly linked to and involved with the health and well-beings of other people. We have a responsibility to others and as such the provision of a public health service based on the holistic biblical concept of health rather than a narrowly biomedical conception is, in as far as possible, a Christian duty. ■

Notes

13 Fergusson, p. 25; Dictionary of Christian Ethics and Pastoral Theology
14 Fergusson, pp. 19-25
15 cf. Matthew 8:2-4, Mark 2.3-12, Luke 13.11-13, John 5.1-9, etc
16 cf. John 20.23
17 cf. 1 Corinthians 15.3-8
18 cf. Matthew 6.1, Mark 1.35, Luke 10.21-22, John 13-17, etc
19 cf. Matthew 12.28, Mark 5.8, Luke 8.26-33, John 11.21, etc
20 cf. John 11.35, Matthew 21.12-13, Mark 7.34, etc
21 cf. Mark 1.14-20, Mark 6.32-34, Mark 7.34, etc
22 cf. Job 34.37, John 92.
23 Porter, pp. 86-87
24 cf. Luke 13.2

4. Healthcare today

Chapter Summary

The overarching media picture of the NHS is of an institution consistently failing in its objectives. Whilst mistakes are undeniable and public concern is high, the immense size and intricate structure of the organisation, and the satisfaction levels of constituent parts (as opposed to of the whole) suggest that it is doing better than is sometimes believed. Moreover, examination of other national healthcare services shows that no system is perfect. Nevertheless, long term concerns are well founded, with issues such as levels of investment, the ageing population, the consumer rights culture in which it operates, and the degree of local autonomy all being central to is future.

The Health of the Health Service

The public impression of the NHS is of an institution in a critical, if not terminal condition. It lurches from one crisis to another, suffers from regular bouts of incompetence or malpractice, and is crippled by funding shortfalls and low morale.

Inevitably much of this can be ascribed to media hype. Given the ubiquity of public involvement, the urgency of the issues under debate (the issues facing the Inland Revenue are, for example, very important but not quite such a matter of life and death) and the innate human interest of many of the stories, it is hardly surprising that newspaper editors choose to lead with salacious, scandalous or heart-breaking tales of woe. Bad news sells.

Nevertheless, studies by the National Centre for Social Research quietly confirm the problems screamed by the headlines. Public satisfaction with the NHS fluctuates significantly on a year-by-year basis, often reflecting particular news stories and media agendas. It reached nadirs in 1990 and 1996, when the percentage of people who were dissatisfied was 10 and 14 points respectively greater than the proportion of those who were satisfied.[25]

Since the second of those dates, satisfaction levels have improved, although the most recent wave of data (2000) shows a very fine balance with 3% more satisfied than dissatisfied.[26] This seems likely to tip towards the negative after the stories of recent months: one of the few memorable images of a rather lacklustre general election in 2001 was Sharon Storer berating Tony Blair outside a hospital in Birmingham over the government's healthcare failings.

The vast size and complex structures of the NHS mean that this overall satisfaction figure masks several layers of detail. Public satisfaction with GPs is

generally high, with 76% satisfied vs. 15% dissatisfied, as is the level for dentists (62% satisfied vs. 19% dissatisfied). Similarly, although far from perfect, hospital inpatient and outpatient services are also more positively than negatively received (the difference being 37% and 34% more satisfied and than dissatisfied respectively).[27] It is clear that we are far more willing to criticise the NHS *as a whole* than its constituent parts.

It is also worth noting that every national healthcare system has problems. US citizens may spend on average $3,950 on health per person per year (compared to $1,418 in UK) but 15% have no public or private insurance and therefore have access to only a limited health service. Moreover, it is estimated that over two million Americans lost their health coverage in 2001 alone due to rising unemployment and insurance costs.[28]

Even the French system, rated by the World Health Organisation as the best in the world, has weaknesses. It is highly expensive, with excessive administration costs, little incentive to ration treatment (a fact partly responsible for the high use of anti-depressants in France) and an unwieldy bureaucracy which generates over a billion claim forms a year. It may be a first rate system without waiting lists in which patients can choose doctors, but its disproportionate cost contributes to France's high unemployment.[29]

This comparison should counsel against the despair which media reports of NHS failures sometimes encourage. Nevertheless, the fact that many of the satisfaction figures have fallen in the last ten years combined with the long-term demographic and cultural pressures outlined above provide some explanation of our general impression that the NHS is teetering on its last legs.

Seeking to address the problems from the patients' point of view, the Government initiated a consultation exercise intended to evaluate the main faults of the service as perceived by the public. The main areas people wanted improving were found to be:

- More and better paid staff – more doctors, more nurses, more therapists and scientists
- Reduced waiting times – reductions in waiting overall, for appointments and on trolleys and in casualty
- New ways of working – including 'bringing back matron'
- Care centred on patients – action on cancelled operations, more convenient services
- Higher quality of care – especially for cancer and heart disease
- Better facilities – more cleanliness, better food, getting the basics right
- Better conditions for NHS staff – reward and recognition for the work NHS staff do

- Better local services – improvements in local hospitals and surgeries
- Ending the postcode lottery – high quality treatment assured wherever people live
- More prevention – better help and information on healthy living.

It is worth comparing these results with those of the BBC's *'It's your NHS'* poll. Viewers and listeners were asked to vote for one of a pre-selected list of options which was narrowed down as the day went on. Although there were a number of similarities between these results and those of the government's consultation exercise, such as staff remuneration, waiting lists and hospital conditions, there were also some significant differences not least at the head of the list:

Option	Votes
Free long term care for elderly	73,402
More pay for NHS staff	28,434
Reduced wait for heart/cancer cure	17,292
Improve A&E	15,639
Cleaner hospitals	11,067
See GP within 48 hours**	5,537
Drugs regardless of cost**	4,930
More for mental health**	4,255
Free eye care*	2,141
Reduced wait for other care* (i.e. not heart/cancer)	1,835
More cancer screening*	1,825
More medical research*	536

* *voting closed at 1pm*
** *voting closed at 6pm*

The government's consultation period resulted in the White Paper detailing the 10 year NHS plan which was announced to the House of Commons in July 2000. Promising to "go with the grain of efforts by NHS staff," it guaranteed significant investment, including 7,000 extra beds in hospitals and intermediate care, 7,500 more consultants and 2,000 more GPs, 100 new hospitals, 500 new one-stop primary care centres and 20,000 extra nurses. This investment was to be accompanied by reform which focused on localisation, patient power, a more joined-up approach to healthcare provision, and a specific focus on elderly patients.

The White Paper's propositions were largely welcomed but did not, of course, settle the debate. This is ongoing and although extremely complex in detail, does include a limited number of difficult, overarching choices.

The Heart of the Matter

Payment

Financial problems have plagued the NHS from before it was founded. Rather than being created *ex nihilo* at the end of the Second World War it inherited the assorted arrangements of various public authorities and voluntary agencies. Financial structures were harmonised in the new organisation which was founded on the basic principle that healthcare should be available to all, free at point of delivery and provided on the basis of need rather than ability to pay.

A similar principle had been behind the medical philanthropy of William Marsden who opened a dispensary for advice and medicines in 1828 at which treatment was free of charge and "the only passport…poverty and disease." The overwhelming demand for Marsden's service (which became the Royal Free Hospital) led to brink of bankruptcy in 1920 at which point the organisation was forced to ask patients to pay whatever they could towards their treatment.

Demand outstripped the capacity for supply, the institution almost collapsed under the weight of people's need and was forced to re-evaluate its financial ideology. 80 years later the story is strangely similar. Although some founders believed that an improvement in the nation's health would result in the NHS paying for itself, it was quickly recognised that it would in fact face the same problems as Marsden's enterprise. Aneurin Bevan, the driving force behind its foundation, saw as much when he said, "we shall never have all we need…expectations will always exceed capacity."

The early introduction of prescription charges and dental treatment fees was the first attempt to combat the runaway costs, the most radical of which was the introduction of the internal market in the early 1990s. This broke up the monolithic bureaucracy which had run all aspects of the NHS, creating 'purchasers' (health authorities and some family doctors) who were given budgets to buy healthcare from 'providers' (ambulance services, hospitals and other organisations that provided care for the mentally ill, people with learning disabilities and the elderly).

Responses to the internal market were mixed. It was widely recognised as improving cost consciousness and trimming a great deal of fat. However, it was also criticised for encouraging the duplication of services, increasing the traditionally low administration costs and creating internal tension by pitting medical objectives against financial ones.

The validity or otherwise of these criticisms cannot be discussed here except to say that in recent years rather than dismantle the internal market Labour has instead concentrated on developing relationships with the private sector in order to guarantee funding through private finance initiatives.

This has been a bumpy road, drawing criticism from the socialist left who see the government selling the NHS's founding principles down the river, and from free-market right who view this 'third way' as a pragmatic tinkering at the edges when a wholesale re-evaluation of the funding ideology is demanded.

It has at least, however, brought to fore the principal question in the whole financial debate – how and how much should we pay for a national health service? Our response to this invariably dictates our answers to a range of other, more detailed questions: What proportion of GDP should be directed towards healthcare? What is the right balance between public and private expenditure? Should funding come through centrally raised income taxation? Or via national insurance? And should it be hypothecated?

The question also leads to another, less obviously financial but equally critical to our thinking about the health service: What does the NHS mean to the British public? Is it an organisation whose sole aim is to achieve the optimum physical health of the nation by whatever means possible? Or is it something more than that, "an institutional expression of British solidarity, decency and responsibility", something which Nigel Lawson called in his memoirs, "the closest thing the English have to a religion."[30]

Consumer Expectations

Sorting out the financial supply for the National Health Service (even supposing such a thing were possible) would not solve its problems. The demand-side issues are equally pressing and even more varied.

Consumer culture is all-pervasive and even though we are aware that our GP is very different from our average high street department store, we tend not to have different models for dealing with each, using concepts of rights, convenience and service for both. Each of these has implications for our attitude to and the structure of the health service.

How far do consumer rights extend to healthcare? Guarantees are written into consumer goods and our idea of what we have a right to, having paid our price is reasonably clear. The lines are rather more blurred when the same questions are asked of medical treatment. Our payment is neither immediate at the point of sale nor exact to the price tag. Moreover, according to founding principles, it should be an irrelevance.

The 'goods' received are usually intangible, incomprehensible to the user, and measurement of their performance is difficult and subjective. They are infinitely more complex and ultimately almost guaranteed to fail us. In such a complex and intricate transaction, what rights do we have? Should I, for example, *expect* a hip replacement within 6 months, 2 years or even at all? And depending on my

answer to that what, if any, guarantee of operational success should I expect? At what point should I demand compensation for 'failure'? And given the NHS's budgetary constraints, how much compensation is appropriate?

The same hard questions apply to the issue of convenience, although there are more clearly defined choices here. In an age where e-commerce has brought a million shops into my living room and in which retailers are eagerly restructuring business strategies to minimise the customer inconvenience of home delivery, what sort of convenience can we expect from our healthcare providers. Do we want to be able to see our GP in 48 hours or to have time to talk to him or her properly? How do we choose between having a short waiting time in advance of a hospital appointment, no waiting time when in hospital or a good length of time with the right consultant at the appointment? However much money is poured into the NHS it is extremely unlikely that everyone will be able to have all three. Priorities must be outlined.

There are similar issues concerning the 'customer service' we receive in our healthcare. Our attitude to medical service will be subtly determined by our attitudes to health. If it is simply a physical condition, the caring professions become at best of secondary importance, at worst an irrelevance. The distribution of new funding between equipment, doctors and nurses will be influenced by the perceived relative worth of each. How much time and attention do we expect from medical professionals? When do we expect to see a consultant, a GP or a nurse, or when might a telephone or video-screen diagnosis suffice?

Attitude to Elderly People

As already mentioned, the demographic shift facing the UK over the next twenty years presents significant problems for the health service. The over 65s who comprised around 10% of the population when the NHS was founded will make up 19% in 2020.

Not only will this create extra strain on the health service but it will demand a re-alignment of political motives. This was seen in the result of the BBC NHS poll in which by far the most popular option was free long-term care for the elderly.

That much is clear and not a dilemma. The BBC poll, however, failed to ask further questions concerning which other services should be downgraded to accommodate this top priority. The reality is that free long-term care for the elderly cannot simply be paid for from the existing budget without significant extra funding or considerable internal rationing. It is important that genuine long term care for the elderly is not lost sight of when the focus shifts from a pre-selected BBC poll to the realities of the financial landscape.

Degree of Localisation

The National Health Service's 'post-code lottery' has been much reported over recent years. The differing standards of hospitals in adjacent areas can lead to (the perception of) a multi-tiered health service whose only criteria is where you happen to live.

This sounds deeply unfair and yet it highlights another key question – how far should autonomy be devolved to a local level? Are we happy to encourage and live with local diversity or should there be an emphasis on national standards? How far should a national health service be a nationally *uniform* health service?

Role of Governmental Intervention

A final key question pertains to the role of government. How far should the state play an educational role in health care? There is a notable antipathy towards the so-called 'nanny-state' in Britain and yet a simultaneous recognition that an enormous weight would be lifted from the NHS's shoulders if people's eating, drinking, smoking, and sexual habits were in greater accordance with medical advice. In a free country, how far should the state intervene in the health-affecting behaviour of citizens, particularly when it is also responsible for administering healthcare? ■

Notes

25 *Trends in Attitudes to Health Care 1983 to 2000* (Table 3.4)
26 ibid. (Table 3.4)
27 ibid. (Table 2.2)
28 Beth Egan, *Comparing Health Systems*, Prospect, April 2002
29 ibid.
30 ibid.

5. A Biblical Response

Chapter Summary

As observed, Biblical teaching has no panacea for the issues facing the NHS and one must guard against the temptation to quarry the Bible crudely for easy proof-texts. Nevertheless, the recognition of physical health as a vital element within full 'shalom' and the emphasis on the importance of relationships are both useful lenses through which key issues may be assessed. Against the consumer model of choice, rights and service received for money spent, the Biblical principle of covenant provides a helpful framework, with the recognition that both state/organisation and patient group/individual have rights and responsibilities and that the relationship between national healthcare and the public should be two-rather than one-way. Biblical teaching also counsels against the tendency to devalue the more demanding individuals, the often-mentioned fatherless, widow and alien who are unable to support themselves – particularly important advice given recent trends in immigration, family break-up and population ageing.

The Basis of a Biblical response

Christians are part of a new community in a renewed relationship with God. This relationship has important ethical implications and there will, at times, be distinctive ways in which Christians are called to address social issues such as health and healthcare, at both an individual and a corporate level.

The Old Testament records how Israel was called to be a priestly nation, bringing light to the rest of the world. A number of writers have stressed the importance of social justice within this call and argued that Israel may be regarded as a paradigm nation, a case study of how God's values can be institutionalised in society.[31] As a paradigm it is, of course, specific to its time and place and an example to be applied rather than a blueprint to follow. It is, therefore, important to understand the 'divine logic' behind its foundational laws in order to grasp the essential characteristics of what a biblical society might look like.

The values which derive from this process can be used to inform and influence the Christian response to the debate over healthcare. Issues such as equity in provision, the dignity of the patient, the use of power in large organisations, the extent of our responsibility for own health and the health of others can and should be informed by careful theological reflection, something which organisations such as Christian Medical Fellowship have been encouraging

for many years. By exploring and analysing the example of Israel, in the light of the New Testament, relevant and helpful principles may be educed as a basis for a Christian response.

Healthcare in the Bible

The Bible contains no concept of institutionalised healthcare. Although certain inter-testamental writings praise the art of the physic and Luke was respected as a medic, the lack of any biological understanding of disease rendered an institutional health service, as we would recognise it, impossible.[32]

Nevertheless, as has been observed, the Bible is concerned for the well-being of the individual within his or her community, and the Old Testament laws, rather than being arbitrary acts of authority, were intended to institutionalise justice and love in such a way as to foster shalom across society.

Primitive health practices do appear to be at the root of some of the Levitical laws. The commands to eat meat within a short time of cooking it[33], not to eat carrion eaters or pork[34] and to wash thoroughly after touching a carcass[35] are all good medical practices in a hot climate. Similarly, other commands discourage eating carcasses[36], touching dead bodies[37], and require the quarantining of people with infectious skin diseases[38], the incineration of unclean food and material[39], and the burying of human excreta away from people's homes[40]. Again, these are all sound medical principles.

However, although a concern for hygiene and health are intrinsic to some of the commands one should not see a primitive biomedical conception as central to the laws. As Darling has pointed out in his essay 'The Levitical Code: Hygiene or Holiness?', "the Mosaic code on uncleanness, as given in the Pentateuch, was primarily ceremonial and only at times of practical use in the prevention of disease, though there are certain basic points of hygiene associated with the ritual."[41] There is also a theology of holiness fundamental to the laws, which recognises death and the uncleanliness associated with it as the antithesis of the life exemplified in God.

It should be clear, therefore, that modern models of national healthcare are essentially an anachronism for a pre-modern society like ancient Israel. Nevertheless, whilst having nothing to say on the bio-medical processes central to any modern health service, the law does suggest a number of principles on which a healthcare system might be structured.

Biblical Principles for the Health Service

A Holistic Conception of Health

The biblical conception of health, shalom, incorporates but exceeds the purely physical sense of the modern English word. Healthy human nature is, in the Biblical view, undoubtedly physical but it is also mental, relational and spiritual. People exist in relationship to themselves, to the environment, to others, and to God. Full health demands a secure and well-balanced condition in each of these.

There are implications here for several areas of healthcare. Whilst the treatment of physical symptoms will always remain central to a modern healthcare system, patients should not be reduced simply to wounds or diseases. As psycho-physical entities, in as far as possible, people should be involved in their own healing process, rather than just being 'mended' by a qualified 'body mechanic'.

At the same time, it is important to place appropriate value on the caring professions which have in the past been somewhat subordinated to the bio-medical areas of healthcare. In terms of hours contact, most patients will spend a far greater time being cared for than being physically 'mended'.

The Importance of Relationships

Fundamental to the entire Biblical metanarrative, central to the Old Testament law and of foundational concern within Jesus' ministry, relationships are intrinsic to the health of the individual, the organisation and society. A person's physical fitness or a company's economic health are of minimal importance if unpleasant personal relationships make life embattled and lonely, or a workplace tense and stressful.

The size and structure of the NHS make personal relationships key to its effective operation and although the balance sheet will be the top priority in any government's mind, the effects that any financial or structural changes have on internal relationships need to be considered carefully. The introduction of the internal market, for example, whilst successfully trimming operational fat is considered to have introduced a degree of internal friction which damaged working relationships.

Although the fact is often ignored in public and private enterprise, broken relationships can be the fatal flaw in any organisational reform, undermining supposed short-term cost benefits and destroying the reasons which underpin long-term success by attracting committed staff and inspiring hard work. Relationships matter and in a organisation with over a million employees, they matter a great deal.

This importance of harmonising relationships extends to those between healthcare professionals and the public. The kind of relationship the public expects to have with the NHS will influence the rationing of services. High expectations combined with social fragmentation can set patient groups in competition with one another and compound NHS pressure. As an antidote, public discrimination between 'needs' and 'wants' alleviates strain by engaging the NHS in a dialogue of mutual obligation.

A further example of this may be seen in the importance of *positive* feedback. The persistent silver lining amidst the storm clouds of NHS crises and scandals has been the constantly positive impression of the individuals who work in the service. The vast majority of doctors and nurses are lauded by those who encounter them and it is a sad but predictable fact that the column inches occupied by tales of a few corrupt and inept individuals far exceed those on the hard-working and responsible majority. To that end, the implementation of a system which allowed and encouraged positive feedback from patients (as opposed the equivalent of a customer complaints line) might have a beneficial effect on the low morale of many healthcare workers.

A Biblical Response to Key NHS Issues

As outlined in an earlier chapter, the National Health Services faces a number of fundamental problems. These include questions over finance, responsibility, rights and expectations, Biblical responses to which are outlined below.

National Responsibility

One of the principles behind the Deuteronomic law was to represent Israel as a paradigm of love and care which would appeal to and attract other nations. The metaphor of fraternity repeatedly used in the Old Testament to describe Israel indicates the strength of the bond and therefore of the responsibility between people.[42] The whole nation was to live in obedience to God's commandments, loving God and one another, and taking care to follow guidelines "so that [they] may enjoy long life."[43] Whilst the immediate provision of care in Ancient Israel would have been the community, the law clearly contains a concern for the state of the nation and the example it was to provide to other nations.

The inference is that in a modern society there is a national responsibility to ensure equitable access and healthcare for all. This is especially the case for those like the widows, foreigners and orphans often mentioned in the law who, due to the absence of an immediate support network, may be a particularly heavy burden on the state.

The Biblical inclination towards a decentralised state may also provide some guidelines for healthcare provision. Although this was an attitude born of the awareness that heavily concentrated power is easily abused (a shrewd caution but one which is, to a large extent, addressed in the democratic process), it suggests that a degree of localisation is acceptable and not against the Biblical principles, providing that it does not foster runaway inequalities which fragment the national example of love, care and justice.

Individual Responsibility

At the same time as the nation (and the locality) have a responsibility for health, so does the individual. The autonomy and free will which is so fundamental to Biblical anthropology demands that each person is accountable for him or herself. Living in a intricate web of relationships does not exempt one from self-responsibility. The choice between a blessing and a curse is central to Old Testament law.[44]

This is a critical message for an age where over-indulgence is seen as wholly acceptable. The fact that the (perhaps temporary) defeat of so many of history's chronic diseases in the UK has been followed by the upsurge in 'lifestyle diseases' is a tragedy of modern life. We should not ignore the fundamental link between cause and effect just because we are increasingly able to treat effects.

This requires us to ask some searching questions of our own motivations. Are we sufficiently aware of the fact that God created us *bodily* creatures in order to look after those bodies? Do we take our responsibilities to our 'brothers' sufficiently seriously to be prepared to prioritise their needs over our wants? Are we prepared to care for the vulnerable and marginalized in our lives even though it may be an uneconomical use of our time or energy?

Perhaps the most fundamental question is whether we view problems as primarily the state's to which we as individuals contribute money, or ours to which the state contributes help. The answer to this question will vary according to the situation: care for relatives who are poorly will demand a totally different balance to the need for cancer treatment. However, a friend's or relative's capacity to 'make up' the emotional, psychological and spiritual needs of a patient fits well with the deficit left by the expertise of bio-medical professionals. The Biblical attitude to human autonomy and the responsibilities it entails counsels against our inclination to off-load liabilities, whilst at the same time being clear that we should also "bear one another's burdens."[45]

Expectations: Consumerism and Covenant

Directly linked to the question of responsibility is the issue of expectation. The foundational belief of consumerism is that you can have anything you want if you

can afford it and this alone highlights why free-market principles are of limited use as a model for healthcare provision. True health is difficult to recognise, difficult to realise and impossible to buy. Moreover, it involves rather more than a one-off transaction, demanding the 'consumer's' long-term, full-time and high-intensity commitment just as much as it does the 'provider's' efficient and professional use of resources.

Biblical models of covenant vary considerably according to situation and participants.[46] However, the dominant model which provides the basic biblical paradigm is between God and his people and this can be a fruitful way of thinking about the link between public and health service.

There are, of course, many ways in which the covenant model is singularly inappropriate for any modern application, resting as it does on God's grace and mankind's obedience. Nevertheless, the emphasis within various covenants on openness, loyalty, obligation, trust, and assurance are instructive.[47]

An open admission that public healthcare cannot achieve the consumerist utopia of unimpeachable immediacy, convenience and quality is a preliminary necessity (as is the need to weather the predictable lambasting for 'willingness to accept second best' that such admissions provoke). An ensuing recognition that obligation is a two-way process which demands trust and commitment from both parties also acts as an antidote to the immensely destructive "everything, now" ethos of unbridled consumerism that threatens to pressurise further the NHS.

The Role of Good Governance

This individual responsibility is closely linked to the role of government. Both Peter and Paul wrote positively of the role of governors, who should be respected for governing diligently whilst being scrutinised at the same time.[48]

The question of how far obedience to a government is still demanded when political legislation is demonstrably anti-Christian is rather more complex but in this instance the active promotion of healthy lifestyles is less problematic. Advice on healthy eating and drinking is not controversial. Smoking legislation is slightly more so. Unfortunately political intervention on sexual, marital and other relational behaviour has become mired in controversy and governments are now hesitant to promote certain lifestyles and offer advice, partly because the causal links are more questionable and partly because over recent years the subject has become a minefield of lobbying and single interest groups.

Nevertheless, in as far as it is possible, those in authority do have a role to play in fostering the shalom of the community through advice, punitive taxation, provision of healthy food and even enforcement.[49] Public vigilance is required to test the actions and validity of the government and to ensure that diligent governance doesn't become autocratic manipulation but this is not the same as

shouting "Nanny State!" at any preventative action taken by the government with an eye to alleviating the pressures on the NHS.

Care for the Elderly and the Prospect of 'Joined-up' Healthcare

Respect for the elderly is a favourite theme throughout the Bible. The Decalogue demands honour for parents[50], Leviticus requires Israelites to "rise in the presence of the aged [and] show respect for the elderly"[51], Proverbs sees old age as a "crown of splendour"[52], and Zechariah describes "men and women of ripe old age [sitting] in the streets of Jerusalem" whilst young children play around them as integral to God's dwelling in the healed city.[53]

Such positive images and precise commands for care and protection prove a welcome antidote to the inclination to see the elderly as burdensome. They also re-emphasise the Christian worldview that human beings have an intrinsic worth which is not contingent on their physical strength or economic viability. These are pragmatically challenging yet vital truths to absorb in the face of an unprecedented demographic shift in British society.

One of the ways this thinking can be incorporated into policy making today is in the closer integration of social services and the NHS, the 'joined-up healthcare' outlined in the government's NHS plan. Internal working friction, rigid boundaries between professions and a non-holistic conception of health all contribute to a fragmented healthcare system where a patient whose needs span a range of different specialisms ends up being poorly or inefficiently treated.

Moreover, it is often the more lonely and vulnerable patients who suffer from this fragmentation, being unable themselves and having no-one to help them navigate a composite healthcare structure, and giving rise to the unfortunately named "bed-blocking" phenomenon.

It is important, however, to incorporate this approach alongside the thinking about responsibility. A joined-up healthcare service is not on its own an adequate answer which will guarantee the safe passage of elderly patients through the healthcare system. Responsibility lies just as much with relatives, friends, communities and churches to care for the elderly in domestic and public spheres.

Paying for the NHS

No Biblical teaching stipulates either how or how much a nation should pay for its healthcare. There is no overriding principle which dictates that healthcare provision should be funded publicly, privately or by some combination of the two.

For this reason, a biblical response to this issue of NHS funding cannot dictate the supply mechanism or appropriate spending figures. Instead, the principle of being responsible for one another, the need to care for those who have problems

caring for themselves, and the ideal of being a national example of shalom point towards an approach which should be used to challenge ideas about the level and type of care we should provide rather than actually dictate the method by which it is achieved. In this way, the responsibility of financial judgement goes through an ideological analysis before being passed on to those capable of making a technical evaluation of spending efficiency, patient needs, or adequacy of care.

An example of this may be seen in a response to the Government's desire to achieve "a concordat with private healthcare providers" which would end "the stand off between the private sector and the NHS that is not in the interests of NHS patients."[54] This is part of New Labour's pragmatism in which ideological principles which impede public service provision are swept aside in favour of a "whatever works" approach.

A biblical response to this may applaud the principle of circumventing obstructive ideologies but highlight a number of areas where evidence needs to be carefully examined. For example:

- Is the principle driven by a verifiable knowledge or a vague belief that patients will receive better treatment?
- Is it driven by a recognition that localisation provides better patient care or by a silent desire to absolve central government of responsibilities?
- Does it treat the symptoms of an ailing service rather than its causes?
- Does the use of private healthcare constitute a serious long-term solution or is it simply a temporary alleviation of financial strains which will prove dangerous or economically inefficient in the long run, as with the costly example of Railtrack?

There are no definitive Christian responses to any of these questions. Theology cannot unilaterally dictate specific policies which, in William Temple's words, "always depend on technical decisions concerning the actual relations of cause and effect in the political and economic world."[55]

However, by understanding the issues behind the headlines, assessing the relevant biblical principles and asking the appropriate questions, Christians can engage with current policy issues in a way which draws on and develops their faith.

A Final Word

There is one further element which a biblical perspective on health can offer a modern society but which would never find its way into any Government White Paper. The Christian gospel offers a 'long distance' perspective on health. Historically this has sadly and quite wrongly been taken by many as a disincentive

for action, as it is today by elements of the American religious right on environmental issues. The Christian view requires the simultaneous grasp of the facts that the 'here and now' is hugely important and not to be discarded as a temporary or disposable state but also that it is the gift and therefore ultimately subordinate to and less important than the giver.

In a fallen world, perfect health is an unrealisable goal, and at least as much a human responsibility as a human right. Moreover, health is not a reward for obeying God who should be loved for who he is. Ultimately, we require the faith of loyalty to God, in sickness and in health. ■

Notes

31 see, for example, Chris Wright, *Living as the People of God* (IVP, 1983)
32 cf. Ecclesiasticus 38:1-15, which begins, "Honour the physician with the honour due to him/For healing comes from the Most High"
33 cf. Leviticus 7:15-18, 19:6-7
34 cf. Leviticus 11:7, 11:13-19
35 cf. Leviticus 11:40
36 cf. Leviticus 17:15-16
37 cf. Leviticus 11:39
38 cf. Leviticus 13:1-46
39 cf. Leviticus 4:11-12, 7:19
40 cf. Deuteronomy 23:12-13
41 'The Levitical Code: Hygiene or Holiness', A. Darling, in *Medicine and the Bible*, ed. B. Palmer (Paternoster Press, 1986), pp. 85-101
42 cf. Deuteronomy 15:7, 15:11, 17:15, etc
43 cf. Deuteronomy 6:2
44 cf. Deuteronomy 11:26
45 cf. Galatians 6:2
46 cf. between friends, 1 Samuel 20:16-17; between states, 1 Kings 5:12; in marriage, Malachi 2:14
47 cf. Genesis 17, Exodus 19-24, Jeremiah 31:31-34
48 cf. Romans 13:1-5, 1 Peter 2:13-17
49 The NHS plan includes an emphasis on preventative measures such as the stepping up of smoking cessation services and free provision of fruit in schools for 4-6 year olds. Examples of enforcement include the compulsory vaccination for measles in the US or the 1985 Water (Fluoridation) Act.
50 cf. Exodus 20:12
51 cf. Leviticus 19:32
52 cf. Proverbs 16:31
53 cf. Zechariah 8:1-4
54 Prime Minister to House of Commons, 27 July 2000
55 *Christianity and the Social Order*, William Temple (London, Shepheard Walwyn, 1976), p. 40