GENERAL SYNOD

Health Care and the Church's Mission

Report by the Mission and Public Affairs Council

Introduction

1. Throughout the history of the Church, healing has been an integral part of the proclamation and application of the Gospel. The example set by Jesus in his ministry was reflected in the mission and ministry of the primitive Church as recorded in the Acts of the Apostles. Christian concern for physical and social wellbeing, as well as for spiritual transformation, was evident even in times of persecution under the Roman Empire. The foundation of hospitals throughout medieval Europe was almost uniformly centred on Christian institutions. The emergence of modern nation states resulted in greater governmental involvement in the delivery of healthcare, but Christian agencies, often in the form of voluntary or charitable bodies, continued to be at the forefront of highlighting and addressing health issues, especially among the poor and disadvantaged.

2. The establishment of the National Health Service, within a comprehensive vision of social welfare, owed much to the insight and energy of Archbishop William Temple and other Christian thinkers and activists.[1]

3. The NHS is currently undergoing the most thorough revision and reconstruction in its sixty year-old history. The NHS that emerges from this process will shape the delivery of healthcare in England for decades to come. It is, therefore, appropriate for the Church to look at the current and prospective state of healthcare delivery in England, focusing on particular areas of interest and concern that are pertinent to the Church's healing ministry and mission.

NHS Chaplaincy

4. In recent years, healthcare chaplaincy as an integral part of the NHS has come under increased critical scrutiny and even attack. In particular, it has been suggested that it is neither necessary nor desirable that spiritual care ought to be delivered by individuals who are associated with particular religious bodies or faith communities. It is argued by others that it is essential that chaplaincy continues to be supported and developed if truly comprehensive healthcare is to be delivered in the future.

5. NHS chaplains are healthcare professionals who, recognised and supported by their respective faith communities, are uniquely qualified and trained to deliver spiritual and religious care to patients, clients and staff.

6. The World Health Organisation understands spirituality as, '*an integrating component, holding together the physical, psychological and social components [of a person's life].*

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[1] The lifelong friendship and cooperation between Temple and William Beveridge is well known. Much of the vision which led, after the Second World War, to the creation of a welfare state and a National Health Service emerged from church-led consultations, such as the Malvern Conference of 1941, and Temple's own book, *Christianity and Social Order* (1942).

It is often perceived as being concerned with meaning and purpose and, for those nearing the end of life, this is commonly associated with a need for forgiveness, reconciliation and affirmation of worth'.[2] Spiritual care addresses these needs. Religious care addresses the needs of those whose spirituality is, to a greater or lesser extent, associated with a defined system of belief and practice, shared, in community, with others.

7. As it is incumbent upon the NHS to address all the healthcare requirements of patients and clients, spiritual and religious needs are significant factors, particularly in times of acute stress or when individuals and families face challenges associated with major or terminal illnesses. There is no defensible rationale for separating spiritual and religious care from other aspects of healthcare. This has been recognised by the Department of Health[3] and is reflected in many NHS Trusts' spiritual care policies[4]

8. Delivery of spiritual care is the responsibility of all professionals in a multi-disciplinary healthcare team, but on the grounds of care, efficiency and human rights, it is essential that chaplains continue to play a central frontline role in ensuring that appropriate spiritual and religious care are extended to all patients, clients and staff.

Chaplaincy Care

9. Many individuals, religious and non-religious alike, experience increased awareness of spiritual needs during times of illness or suffering. It is imperative that such needs are met. In situations where terminal illness is present and palliative care is paramount, meeting spiritual needs may acquire a particular intensity. In such circumstances, offering optimal spiritual care is a priority and to deny such care would amount to dereliction of duty on behalf of the NHS. In practice, this means that each NHS Trust (and, in the future, each Clinical Commissioning Group) must make adequate provision for spiritual care for all its patients and clients. This has recently been recognised by the National Institute for Health and Clinical Excellence (NICE), which has stated that spiritual and religious care ought to be commissioned as part of End of Life Care.[5]

10. The provision of spiritual care cannot be divorced from the provision of religious care. While it is true that some people may wish to have their spiritual needs addressed in a non-religious manner, for many others, their spiritual needs can only be properly addressed through the medium of religious care. In times of need and distress, for both patients and their families, it is essential that the most appropriate form of spiritual care is given and this, in many or even most cases, will involve religious care-giving. It is incumbent upon the NHS to ensure that such care is given.

11. While faith communities ought to be willing to cooperate with NHS Trusts in delivering such care, it remains the responsibility of the NHS to see that every patient is properly

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[2] *WHO Technical Report Series.* Geneva 1990; (No.804): pp 50-51.

[3] ''*all services, including spiritual ones, should be delivered appropriately to service users and NHS staff' NHS Chaplaincy: Meeting the religious and spiritual needs of patients and staff* : London 2003 p3.

[4] ''*The NHS is committed to holistic care. This means that physical, mental, social, spiritual and religious needs should be acknowledged and met. Today health care professionals recognise that these needs cannot be viewed in isolation because they make up the whole person. Therefore the multi disciplinary team should work together to ensure these needs are met' Harrogate NHS Trust Spiritual Care Policy*, Harrogate 2004, p1.

[5] National Institute for Health and Clinical Excellence, ' Implementation Programme: NICE support for commissioners and others using the quality standard for end of life care for adults, November 2011.

cared for. Given the large numbers of people who, each year, require spiritual or religious care, NHS chaplains are uniquely able to meet these needs. Chaplains are viewed as trained and qualified healthcare professionals and they enjoy the confidence of their faith communities; as NHS employees they are also available, as part of a multi-disciplinary team, to provide the cover and care required in hospitals, hospices and other settings.

Chaplaincy Effectiveness

12. Not only are NHS chaplains best equipped to provide spiritual and religious care, they are also the only practicable means by which such care can be delivered within the NHS. Spiritual care is not simply an 'added extra' to healthcare, any more than nursing care is an 'added extra' to medical care.

13. In publishing the results of a 2010 survey[6], the RCN acknowledged that many patients are '*missing out on important spiritual care*' with only 5% of nurses feeling that they could always meet the spiritual needs of patients. Ninety percent of nurses surveyed believed that '*providing spiritual care improves the overall quality of nursing care, and the vast majority (83%) believe spirituality is a fundamental aspect of nursing, even for patients with no religious beliefs*'. The importance of the chaplain's role, as part of a multi-disciplinary healthcare team working alongside nurses, could hardly be better illustrated.

14. Any suggestion that generic 'spiritual care-givers' might be utilised by the NHS is fraught with difficulties. To train and equip such 'spiritual care-givers' would require new financing, training, monitoring and management. It would not be viable simply to transfer chaplaincy resources to a new 'spiritual-care service', since spiritual care will not address the needs of those whose care must be approached through the medium of religious care. A Christian, for example, who requires the comfort and strength gained from receiving Holy Communion cannot have his or her needs addressed by a generic 'spiritual care-giver' who may or may not be a Christian and who may or may not believe in God.

15. While it is true that many local 'clergy' (of different faiths) will make every effort to provide some pastoral care to members of their congregations who are in hospital, this does not remove from the NHS its obligation to provide appropriate spiritual care. No other area of care is delegated to professional volunteers to deliver. If the NHS were to attempt to train and employ 'spiritual care-givers' and then to enter into a plethora of locally contracted agreements with various faith communities, the provision of spiritual care in the NHS would disappear into a maze of administrative chaos.

Human Rights and Healthcare Chaplaincy

16. Article 9 of The European Convention on Human Rights[7], enshrined in The Human Rights Act (1998), states:

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[6] http://www.rcn.org.uk/newsevents/press_releases/uk/patients_missing_out_on_spiritual_care,_say_nurses

[7] Council of Europe, The European Convention on Human Rights, Rome, 4 November 1950.

'Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.'

17. The UK government and its agents have obligations to respect, to protect and to promote these rights. Article 2 of 'The Declaration on the Rights and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms' states[8]:
'Each State has a prime responsibility and duty to protect, promote and implement all human rights and fundamental freedoms, inter alia, by adopting such steps as may be necessary to create all conditions necessary in the social, economic, political and other fields, as well as the legal guarantees required to ensure that all persons under its jurisdiction, individually and in association with others, are able to enjoy all those rights and freedoms in practice.'

18. This requires the NHS not only to allow freedom of religious belief and practice, but also to take all reasonable steps to *promote* such freedoms, enabling patients, clients and staff to express and to practise their beliefs. While these rights have to be set alongside other rights, such as those associated with privacy, the NHS has, nonetheless, an obligation to promote rights associated with religious belief and practice.

19. For many patients, religious practice cannot be merely a private affair, conducted in isolation from others in their faith community. There are many religious core practices that patients may need assistance to perform, including key rituals associated with their religion requiring the presence and participation of qualified and trained religious 'leaders'. The NHS has an obligation to respect, to protect and to promote such rights.

20. This cannot be done by merely stating that patients are permitted to make arrangements for members of their faith communities to visit them and to perform various religious functions. Very large numbers of patients are treated by the NHS each year and its own statistics[9] underline the continued need for chaplaincy services.

21. In 2009/10, there were 14,537,712 hospital admissions in England. An analysis of the 'Picker Inpatients surveys' between 2007 and 2009[10], indicates that, on average, 22% of hospital patients identified belief as being 'an issue', with 17.7% of patients wishing to practise their religion while in hospital. 2.1% of patients, however, reported that their beliefs were not fully respected and 2.9% were not able to practise their religion as they had wished. Using the 2009/10 NHS statistics, this translates into absolute figures of 3,198,297 patients for whom belief was 'an issue'. 2,573,175 patients wished to practise their religion while in hospital, but 305,291 patients did not have their beliefs fully respected and 421,594 patients were not able to practise their religion as they had wished.

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[8] United Nations, General Assembly resolution 53/144, 8th March 1999

[9] http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/hospital-activity-hospital-episode-statistics--hes

[10] Clayton, A, *Religious need in the NHS in England: The contribution of Picker Inpatient Surveys*, (unpublished) September 2010

22. This hospital population was served by some five hundred 'whole-time-equivalent' chaplains who made approximately one million patient-visits between them. Chaplains also attend to the needs of critically ill patients and neonates who were not surveyed, as well as to families and staff, and many serve on ethical committees or manage bereavement or other services. Given this workload, it is fair to say that the NHS may already be close to failing to fulfil its human rights obligations. Five hundred whole-time-equivalent chaplains is a tiny contingent, compared with the 140,897 doctors, 417,164 nurses and 44,661 managers employed in a National Health Service workforce that totals almost one and a half million.

NHS Reforms

23. It is doubtful that the founders of the NHS could have ever imagined that it would grow to encompass the vast range of health services currently available to the population; in the process, becoming the single largest employer in England supported by a complex administrative structure.

24. As medicine, surgery, pharmacology and other disciplines developed, the NHS assumed responsibility for delivering health and wellbeing to the nation. Interestingly, Beveridge's famous report which gave rise to the Welfare State and the NHS was followed by his second report, *Voluntary Action*. Beveridge had not expected state welfare to squeeze out local, voluntary and charitable provision but to work with them. In effect, however, as the NHS developed, a power-reliance axis developed between government and people with the State active in providing healthcare and the population tending to become passive in having its health needs met.

25. It has been argued that such a situation not only encouraged an abdication of personal and community responsibility, in deference to a centralised organ of the State; it also encouraged the State to become overbearing in its care for its citizens. In reaction to this, disquiet at the imbalance of power in the relationship between State and people has been expressed in revulsion against the 'Nanny State'.

26. Such a critique of the role of the NHS is, of course, controversial and open to question, but it provides part of the mental and visceral background to the current reform of the NHS[11]. The belief that an unreformed NHS has become not only unwieldy, but also potentially obstructive to the health and wellbeing of the nation did not emerge overnight; its seeds were sown in the centralising trends of the post-war period and watered in the counter-reaction that has gathered pace since the 1980s.

The Need for Change

27. For more than a decade, policy makers and health administrators have spoken almost constantly of 'drivers for change' in the ways in which healthcare ought to be delivered throughout the United Kingdom and elsewhere.[12] This term has been carefully chosen: it suggests that pressure to change is externally imposed and is beyond anyone's

[11] Cf. Page R.M., ' Clear Blue Water? The Conservative Party's Approach to Social Policy Since 1945', Paper presented at the Social Policy Association's Annual Conference, University of Lincoln (5th-7th July 2010).

[12] Cf. Piester, Henrik Noes; Andersen, Tine; Teglgaard Jakobsen, Søren., : 'Trends and drivers of change in the biomedical healthcare sector in Europe: Mapping report' Dublin 2007.

control. In truth, it also reflects significant developments in the range and means of delivering healthcare that cannot be ignored. Philosophical and intuitive unease at some of the ways in which the NHS has developed over the decades since its foundation, has been allied to these pragmatic ‘drivers’ to provide the rationale for the current programme of reform.

28. These ‘drivers for change’ include:

(a) Significant demographic changes, reflecting an increasing older population with greater care needs;

(b) Advances in medicine, surgery, pharmacology and technology, resulting in individuals living longer, with more complex care needs;

(c) Advances in telecommunication and ICT, enabling significant changes in the ways in which health services can be delivered;

(d) Increased patient and client sophistication with regard to health and wellbeing expectations and outcomes;

(e) An increasing evidence base demonstrating that the best outcomes are achieved from early intervention and prevention across the life spectrum;

(f) An increasing evidence base indicating that high quality outcomes in acute care are best delivered by centres of excellence;

(g) An increasing recognition that many aspects of care ought to be delivered outside institutions in order to produce the best outcomes, leading to a shift from institution-based care to community, service-based care.

The current financial climate and the UK budget deficit have formed the final piece in the jigsaw indicating that reform of the NHS is both necessary and timely.

29. Few would disagree that these ‘drivers for change’ ought to be addressed, but it is not self-evident that they are so overwhelming that they ought to dictate very radical NHS reform or to dictate the future shape of healthcare in England. It may, therefore, be better to speak of ‘pressures’ that indicate the need for change rather than ‘drivers’ that impose change. Choices remain to be made and it is the responsibility of the government to ensure that a correct balance is set between contrasting pressures.

30. In doing so, the government must seek to address a number of salient issues that sometimes appear to be set against one another. These include:

(a) The role of the Secretary of State as the person in ultimate executive control of the NHS, answerable to parliament, *and the need to promote operational independence of the NHS, free from party political control*;

(b) The statutory responsibility of commissioning bodies to promote a comprehensive health service as outlined in the NHS Constitution *and the need to ensure that, this includes spiritual and religious care with healthcare chaplains being recognised as being both healthcare professionals and recognised representatives of faith communities;*

(c) The development of greater patient and client choice, involvement and personal responsibility *and the need to provide improved patient and client education and advocacy so that reforms do not represent either empty rhetoric or an increased burden on vulnerable individuals;*

(d) Commissioning decisions being taken at a level close to patients and clients *and the need to see uniform standards of care across the nation;*

(e) The recognition that GP practices play a pivotal role in healthcare and ought to be at the centre of local commissioning *and the need to ensure that the expertise of other health professionals is given full consideration in decision-making*;

(f) Appropriate utilisation of the private and community and voluntary sectors in healthcare provision *and the need to safeguard NHS Trusts so that the local health ecology remains patient focussed rather than driven by sectional professional interests or profit seeking;*

(g) Greater financial control, resulting in better value for money, *and the need to ensure that commissioning decisions taken on the basis of improved health outcomes are not compromised by commercial considerations.*

31. Finding a workable balance in all of these areas will be difficult and complex, but it is essential that what emerges must reflect the best and enduring qualities of the NHS, calculated to secure the provision throughout the country of effective and efficient healthcare services provided free at the point of delivery and according to clinical need.

32. Finding a correct balance does not imply that the government ought simply to attempt to find 'middle ground'. What is required is a balance that best enables the NHS to serve individuals, families and communities with excellence and equity while acknowledging that the future of healthcare requires it to embrace new attitudes and new methods of delivery. Core values must remain the same, but the means by which these values may be best embodied is open to debate.

33. The government is to be commended in carrying out a genuine 'listening exercise' since it first proposed its far-ranging revision of the NHS in 2010. Subsequently, major improvements have been made to the government's original proposals. These include embedding in the Health and Social Care Bill a requirement for all commissioning bodies to promote the NHS Constitution with its requirement that a comprehensive health service is to be provided uniformly throughout England. Other notable changes include replacing GP Consortia with Clinical Commissioning Groups with a wider professional and community membership and a commitment not to allow providers to 'cherry pick' services to the detriment of hospital trusts.

34. The Church has played a full and active role in the government's consultation process and it is encouraging to note that some of our observations have been reflected in changes made to the original proposals.

35. There are still issues that continue to cause concern, including the need to secure the role of the Secretary of State for Health as the ultimate executive authority of the NHS, answerable to Parliament and the need to safeguard healthcare delivery in England against an unwarranted degree of privatisation or fragmentation.

36. The Church has an obligation to warn of the dangers of a wrong balance being struck in any of the areas above. It has a pivotal role to play in monitoring and assessing how reforms translate into practice. It also has an opportunity to continue its healing ministry in the future in a new environment. Through the Church's pastoral engagement with individuals, families and communities, through its involvement in healthcare chaplaincy and through its ongoing work in the community in advocacy,

health promotion and healthcare delivery, the Church is uniquely placed to contribute positively towards the creation of a society healthier in body, mind and spirit.

An International Dimension

37. Whilst the future of healthcare in Britain is, rightly, a major concern of the churches today, the mission of the church is always global and our concern for the promotion of healthcare to all peoples has been part of our historic and present engagement with peoples across the world. The global aspects of healthcare constitute an important reminder of the challenges that face many communities and of the relative privilege enjoyed by Western nations. Some additional material is offered as an Annex to this paper and may be found on the MPA website at: http://www.churchofengland.org/media/1383635/gs1857annexeb.pdf

38. The confines of a short Synod paper do not permit great detail of the activities of all the Anglican Mission Agencies in promoting healthcare. It is noteworthy, however, that USPG has recently made health one of the focal activities around which the society's Christian mission is orientated in the different countries in which it is active. Members are encouraged to look at the relevant pages of the USPG website: www.uspg.org.uk/project.php?id=339

39. Another recent development which brings an international dimension to the healthcare work of the church is the Anglican Communion Healthcare Network. One outcome of the 2008 Lambeth Conference was the establishment of this network for sharing healthcare resources and good practice models widely across the Communion. Its objective is to enable more effective transfer of learning and resources on health issues between member churches. The network is one way in which the structures of the Anglican Communion might be used in mission and development with health as a major focus. Members are encouraged to look at the Network's comprehensive website at: www.anglicanhealth.org/Default.aspx

40. USPG's work, and the AHN are two examples of the global significance of healthcare for the churches. Our interest as the Church of England should, we argue, combine a deep-rooted concern for the health of the people of our nation, and a lively interest in the most effective mechanisms for delivering physical, mental and spiritual care across the land, combined with a determination to contribute as far as we are able to the health and flourishing of all God's people. In this, we believe, we are following the example and the mind of Our Lord.

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