Do they have a future?
asks **Gordon McFarlane**

Africa's Church Hospitals

Most missionary ventures have contained elements of medical work. The latter half of the nineteenth century saw the introduction of missions that were specifically medically orientated. Over the last century and more, in the West, the role of the church in providing medical care has been taken over by governments and by private companies, with the responsibility for health gradually moving from the individual through churches and charitable organisations to the state. This pattern has been repeated in many developing countries, with the state seeking to provide health care. In the process some have taken over hospitals previously run by churches or missions.

This article seeks to examine the plight of hospitals in Africa that are still under church or mission control. While it draws on nine years experience in Africa, I believe lessons can be applied to developing countries throughout the world.

That a tremendous amount of good is being done through church-based health care programmes cannot be denied, but there are questions that demand answers. To whom is the care given? Can the poor afford the fees payable at many Church Hospitals? What is the cost to the church?

Government-run Healthcare

In many countries in Africa, government-provided healthcare is far from ideal. Admission may be almost free but relatives often have to buy drugs or surgical supplies before treatment can commence or an operation be carried out. Nursing staff may be poorly motivated. Doctors are often hard to find, spending much of their time in private practice to the detriment of their non-paying patients. For the poorer nations of Africa, taking over church hospitals has not been a great success. Some have even been handed back.

There are, however, a number of positive aspects to provision of healthcare by governments. Care may not be ideal but there is little restriction on access. More than one missionary doctor with a call to serve the poor has moved from a church hospital to government-provided healthcare.

Who is served by church hospitals?

Over the last decade, financing of church hospitals has become increasingly difficult. The plight of Eastern Bloc countries has diverted the attention of donor agencies and mission supporters away from African nations. Structural

Above. Church ministers and elders spend much valuable time attending hospital committee meetings

Top. National resident house officer being trained in basic surgery

A Theological Education by Extension leaders' training day - vital for the future of the church

MEDICAL MISSION IS A PROPER CHRISTIAN RESPONSE TO OVERWHELMING NEED BUT THERE IS NO BIBLICAL JUSTIFICATION TO REGARD THESE INSTITUTIONS AS ESSENTIAL ELEMENTS OF MISSION

readjustment has left many Africans less well off and many cannot afford to pay for health care, while the cost of healthcare is escalating. Unions are pushing for better wages for unskilled staff; professionals are demanding better recognition for their skills; and the cost of medicines and equipment is increasing, but government subsidies to church-run hospitals have dwindled.

The result is that the rapidly escalating cost of healthcare has to be recovered from user fees and these fees have risen to a point where church hospitals are serving only the middle-income groups. The poor, towards whom the church is supposed to feel a greater responsibility, are excluded. In order to stay financially viable, some church hospitals have had to turn patients away or postpone elective operations until the full fee is paid in advance - hardly a witness to the surrounding community.

The cost to the church

African church leaders, however, are very keen to maintain their church hospitals. They believe they provide a good opportunity for witness to many who otherwise may not come near the church. There may be other reasons for their enthusiasm, too. They are a status symbol in the often fierce interdenominational competition. Relatives can find jobs. Some see their church hospitals as potential income generation projects for the church. Financial corruption is a serious temptation, too.

More serious yet is the effect that ownership of a large institution such as a hospital may have on the life of the local and national church. Ministers with ten or more churches can be called upon to sit on management committees, health boards, attend courses and seminars relevant to the work of the institution, or get involved in sorting out staffing and disciplinary matters. Church leaders with little or no training are often called on to make decisions affecting 500 staff, a health care system for 500,000 people and an annual budget of over 1.4 million pounds sterling.

The overall effect is that much valuable time is spent in looking after huge status symbols that threaten to engulf the local church. Ministers and elders are called to attend to the spiritual growth of the church, not manage health institutions for which they have little or no training. Involvement of ministers and elders in healthcare is a time-consuming distraction for many and a fatal temptation for others.

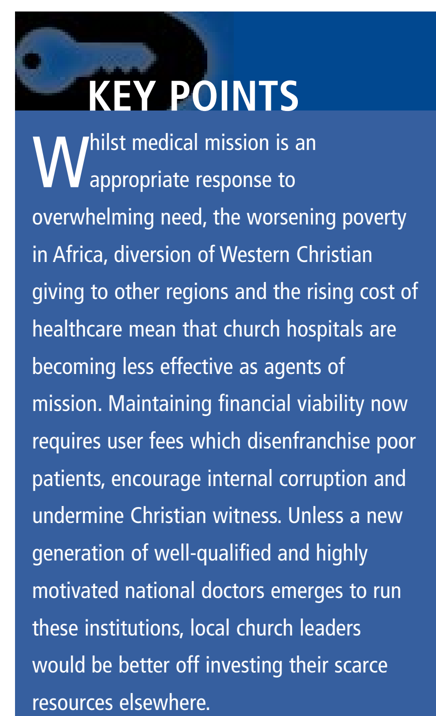
The way forward

For those who have not worked overseas, many of these facts may come as a surprise. What is the way forward? As disciples of Jesus we have been commissioned to preach, baptise and teach (Matthew 28:19, Mark 16:15-18, Luke 24:46-9, John 20:21, Acts 1:8). Medical mission is a proper Christian response to overwhelming need but there is no biblical justification to regard these institutions as essential elements of mission nor to perpetuate them when they may be having a negative impact on the life and witness of the church.

Unless a new generation of well-qualified and highly-motivated national doctors and managers come forward to work in and run these hospitals, the future looks bleak. In countries where there is little or no government subsidy, they must either close or lose their image as charitable Christian institutions. Recent moves towards income-generating activities within church hospitals and community-based health insurance have failed to provide a solution for those in the lowest income bracket. (McFarlane GA, Sammon A. A prepaid healthcare scheme in rural Africa. *Tropical Doctor* (in press)).

It is vital that the African churches come to realistic solutions that will divest the church of the huge burden of responsibility that Western medical missionaries have left them with. The greatest impact that the Western-based mission organisations can currently have is in discipleship courses, TEE courses (Theological Education by Extension), and formal theological education to help churches and individual Christians to deepen their spiritual lives.

Graham McFarlane was a Medical Missionary in Africa



KEY POINTS

Whilst medical mission is an appropriate response to overwhelming need, the worsening poverty in Africa, diversion of Western Christian giving to other regions and the rising cost of healthcare mean that church hospitals are becoming less effective as agents of mission. Maintaining financial viability now requires user fees which disenfranchise poor patients, encourage internal corruption and undermine Christian witness. Unless a new generation of well-qualified and highly motivated national doctors emerges to run these institutions, local church leaders would be better off investing their scarce resources elsewhere.