RETHINKING MEDICAL MISSIONARY WORK

Investigation by Christian Medical Commission

GENEVA (NC)—The Christian Medical Commission (CMC) of the World Council of Churches is examining what medical missionaries have wrought in the developing countries and is asking if the results are worth the work and the funds put in to them.

The assessment is that there are many hospitals, insufficient health care, and unwise investment.

There are 2,000 church-related hospitals in the world. But the institutionalized care is genrally in population centres for the few who can afford it, at the cost of little or no care for the great majority of the population spread through the country.

The CMC holds that this is uneconomical as well as us-Christian.

COST-BENEFIT ANALYSIS

It is not easy to bring cost-benefit analysis methods into missionary work, but the CMC director, Dr. James C. McGilvray, finds it imperative, and he is urging medical missionaries in the developing countries to examine their operations and find the ways to apply their resources and their efforts towords health care for those who need it most.

"Our resources are limited and we are responsible to use them in a way that will bring the greatest benefit to all," he says.

Ninety-five percent of the Churches resources in medical work have gone into instituti onalized curative programmes, Dr. McGilvray said. "This is the most obvious and most dramatic response to health needs. However we are now seriously questinning whether it is the most efffctive response."

Biomedical technology which requires expensive hospitals and equipment for its implementation, can have only a limited impact on the total health need, the CMC believes. But the fact "that we have limited effectiveness in this area does not seem to deter us from continuing with this enormous and at times unavailing effort- building ever more and ever larger institutions."

Thus in Korea a majority of the hospitals were established by American Churches and are still supported by them. An attempt is being made to provided the highest level of medical care, with speciality departments and up-to-date dingnostic and therapeutic equipment. But technology is costly and the budgets have quadrupled in 10 years, where as days of hospitalization have only doubled.

The result is that they are pricing themselves beyond the range of the majority of the Korean population.

HOSPITALS OR HEALTH-CARE

Since the CMC has no medical programmes of its own, it is working with others to develop experimental programmes to demonstrate new methods of delivering health care which reach out into the community and are economically viable.

"We have been doing a disservice to the developing countries by ex-porting a hospital centered approach to health care as being the normative basis for planning," Dr. McGilvray says.

"Do we really do an injustice to the individual when we apply cost-benefit analysis to the delivery of health care? Is he really sacrificed on the altar of effectiveness, as some would claim?

"Whether out interest be in clinical medicine or in preventive medicine in episodic treatment or comprehensive care, we must always remember that we are faced with the terriblem of costing(putting a money value on) human life. We used to think that this was a dilemma to be faced only by the senior officers of armed forces in combat. Whether we like it or not, we now face the same problem."

COST IN LIVES

The costing problem, as seen by Dr. William H. George, director of the Smallpox Eradication programme at the National Communicable Disease Centre in Atlanta, Georgia, goes like this:

"For example, a medical centre can become a mecca of quality medical care--but what is the price? If $ 100 would save a life, we are easily content to say the cost of saving a life is $ 100. But if that $ 100 had been instead investead invested in providing safe water supplies or better nutrition and if it could have saved 10 lives instead of one, then the cost of saving one life is not simply $ 100 it is $ 100 plus nine deaths."

As the CMC director sees it, "the doctors in our church-related hospitals, which are usually undermanned and deprived and deprived of adquated hospitals, must face this choice--either to see a few and give them adequate care and attention, or to see all who claim their time and give them three or four minutes at the most, knowing full well that this is less than adequate for effective diagnosis and treatment."

Achieving the best solution, according to Dr. McGilvray, require cost-benefit analyiss, a willingness to bridge the frontiers between disciplines, and an openness to discard some old assumptions if the and result is to bring the optimum of health care to persones in need.

Many medical mission leaders are urging mergers. Although church-related institutions have often been pioneers in medical service, and no one denies the quality of their work, many of their institutions today are outmoded and suffering multiple problems: steeply rising costs, limited staff, inadequate administrative systems and obsolescence. In addition, they often function in isolation, not coordmating their efforts with governments or anyone else.

On the other hand, governments in the developing countries, often with meagre resources, are making plans for providing universal health care and these plans are being made without taking into account the facilities of the Churches.

MERGERS WITH GOVERNMENT SERVICES

The CMC is out to promote the merging of mission facilities and experience with government plans and programmes.

In several countries mergers have already taking place. At the request of the government of Papua-New Guinea, the CMC is working on a plan to integrate health services with Catholic and Protestant agencies, which now operate 40% of the existing health services(Though the Roman Catholic is not a member of the World Council of Churches, there is Cntholic participation in the CMC).

Botswana has also asked for a CMC consultant to help the government and missions there to find the way to join their resources for more eccnomical and effective medical care services.

Increasing pressure on the missions is coming from many governments in the developing Third World to coordinate missionary medical facilities into national health plans, Dr. McGilvray says. "I expect this trend to become wide-spread in many lands within the next few years."

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