

Health, Wellbeing and Faith in Birmingham

Briefing/position paper for the health strand of the November Conference

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Introduction

The history, institutions, beliefs and practices that comprise contemporary Western health and social care are intricately entwined with, and shaped by, religious and faith groups and their ideas and practices. From allopathic medicine to the development of nurses, hospitals and hospices, faith groups and their ideas have been important in structuring health institutions and motivating those who work in them. Sometimes, however, these same groups and ideas have obstructed or questioned developments in health care, eg, anaesthetics, immunisation, contraception. At the same time, faith and religion are ill-understood in the context of a secular state¹ that 'does not do God'. While personal and communal faith is formally respected and tolerated as a private choice, there is much suspicion and ignorance about the place of faith in public policies and institutions. Generally, within the state and its organisations, there is an over-simplistic view of religion and faith groups and their ends and purposes. A level of discomfort and illiteracy about religion can also lead to a certain kind of animosity, especially towards independent religious groups.

In this briefing paper, we point up some of the opportunities and tensions that might emerge as state health care institutions focussed around delivering allopathic, biomedically-based care do, and might, interact with faith groups and ideas in Birmingham. Inevitably, we raise many questions in the interests of trying to create a practical and research agenda that might engage faith groups, health care institutions and practitioners, and academic researchers from a variety of disciplines in future. While there are important opportunities for collaboration and mutual

¹ In this paper 'state' refers to the conglomeration of institutions and organisations, local and national, that are ultimately responsible to the electorate. In the Birmingham context, the City Council, the NHS Primary Care Trusts, hospitals, clinics and other services are all parts of the state, broadly understood and are required by law to commit to policies of not discriminating against workers on the grounds of faith, ethnicity, gender, etc.

learning here, the challenges inherent in the interests of these different perspectives and groups should not be underestimated.

Health and wellbeing issues in Birmingham – today and tomorrow

Government policy in health care is to move towards less reliance on hospitals and to make more use of community based services. Moreover, improving the health of populations and maintaining their independence from needing care services is a key aspiration. This runs counter to how Birmingham has traditionally run health and social care services. There has been a reliance on large scale hospital based services with high cost social care services available to those in most need, with little emphasis on prevention. A 43% real terms increase in NHS expenditure between 2006 and 2009² has not resulted necessarily in greater productivity across the UK. HM Treasury estimates public sector's proportion of the UK economy is going to reduce after 2010, and the government of the day may choose to reduce it yet further³. Government policy aspirations for health and social care can be summarised in three words:

- Partnerships – agencies working together to deliver improved outcomes for local communities
- Performance – standards of performance expected from government including greater efficiency
- Participation – real participation by communities and residents in what services are provided or purchased by the public purse, and real participation by community and third sector agencies as well as the private sector in delivering these. Some faith communities participate as providers. Others feel participation as citizens is tokenistic when it comes to taking their faith seriously.

Against a changing national context of reducing finance and desire for greater efficiency, many people in Birmingham still die at a younger age, and live more of that shorter life in disability and ill-health than the England average⁴. This is especially so for men. We experience a significant burden of inequalities in health (differences in health outcomes such as cancer or heart disease where there is a clear social gradient, with the poorest almost always being worst off in health terms),

² Source: Institute of Fiscal Studies and HM Treasury

³ Source: The Economist

⁴ Source: Birmingham's Joint Strategic Needs Assessment – Health Profile 2009

which requires concentrated and concerted action across the short, medium and longer term.

- We have higher rates of premature death from men especially, than the England average.
- We have very high rates of death in children within the first 28 days and first year of life compared to England.
- A higher proportion of our residents live more of their lives in pain or disability than the England average.

Much of this illness is twenty, or even forty, years in the making. Lifestyles associated with high fat diets, poor general nutrition, smoking and so on eventually take their toll and have very high costs for care.

Looking ahead to 2020, we will see some worrying health challenges unless we take steps to change the lifestyles of our residents and the frameworks of our services.

- If outward migration continues, the social care and health care workforce may be reduced at a time when the older population traditionally in need of care is increasing.
- The BME older population is expected to double in size, and new migrant communities will continue to bring new care needs and health issues
- We will see a resurgence in infectious diseases like Tuberculosis
- We will see an increase in severe liver disease from people who are currently in their 20s and binge drinking, especially women
- As the proportion of the population which is obese increases, the numbers needing health and social care for diabetes, heart disease, disabling stroke and other complications will increase.
- People living unhealthily now – not just smokers - will become ill through stroke, cancer, diabetes, heart disease and other long term conditions.
- We may see more people living alone and needing care

An emphasis on prevention is needed, and a sustained effort at delivering this, or the City may bankrupt itself and become unable financially to meet the health needs of its population. It is clear that we must reduce the rising numbers of people who are preventably ill.

Issues and questions for consideration in thinking about the relationship between state and faith organisations in relation to health and health care in Birmingham

Birmingham is a city richly endowed with religious communities and traditions, formal and informal, large and minute, influential and powerless. The largest formal religious groupings with which people identify themselves are Christianity and Islam, but Sikhism, Hinduism, Buddhism and most major world traditions, including paganism, are represented here. And the city is well known for its association with the tiny religious community, Quakerism.

- *When we talk about faith communities, which community or communities are we thinking about? All, some, a very few? What do we know about the various faith communities in Birmingham?*

Some faith communities are highly organised, some loosely so. Some local communities draw on their localities for members while others draw people in from near and far. There are communities that work closely together with other similar communities and may be federated with them. They may have clear leaders, even hierarchies and clerical castes. But there are faith communities that are very congregational and localised in focus and organisation and it may be difficult to identify any wider links or networks to which they belong or are accountable. It may be difficult to identify clear leaders who can act or speak on their behalf.

- *To which faith communities should health policy makers and health workers relate, and how might they do this? How might they appropriately identify organisation and structure? Is it only highly organised, federated and clearly hierarchically led communities that should be included in the purview of health promotion and provision? Which members or which communities should be consulted about policies and practices? How representative might they be? These are important questions if, for example, consultation is to be effective and fair; faith communities often feel it is not.*

Many, if not all, religious traditions and practices tend to have a keen interest in promoting the health and wellbeing of their members and this interest may also extend to non-members and the wider community. But the motivational understanding of health and illness that underlies this concern is often rooted in very broad and comprehensive world views and understandings that will often include distinctive beliefs, practices, symbols and rituals that inform the whole of life and go far beyond merely fighting disease. In many religious traditions, disease, suffering, wellbeing and happiness are often situated within a distinctive belief in some kind of higher purpose, will or transcendence that informs and directs the whole of life.

Promoting health and fighting illness is usually a part of religious beliefs and practices, but illness and suffering may also have their place and meaning within a religious world view that is inimical to the philosophy of disease elimination and worldly happiness promoted within health care.

- *Are simplistic assumptions made about the understandings of disease and suffering in religious communities? How do specific understandings and beliefs about health and illness impinge on the provision of health and health care? To what extent might these inhibit or be compatible with understandings and practices within the provision of health and medical care? Is faith and belief a help or a hindrance in the struggle against illness and suffering, or does it have distinctive things to offer? What is the value of religious healing attitudes in a context where biomedicine is taken to be normative?*

Many faith communities not only have distinctive beliefs and understandings of health and illness, they also have a range of practices that promote care and wellbeing. These range from prayer, laying on of hands, provision of amulets and substances, to counselling, provision of care, housing, and social activities. Some of these activities may be very similar to those conducted by secular voluntary or charitable groups and seem uncontroversial and reasonable, but others are likely to be distinctive and may be thought to be problematic and at best a-rational and possibly inimical to Western biomedical means of treating people. Some practices might even be thought dangerous, useless or unacceptable.

- *To what extent should faith groups be seen as voluntary organisations that are basically compatible adjuncts to the secular health and welfare state? How should distinctive religious healing and care practices be valued? Is there any scope for mutual learning between religious and secular practices of healing and care? Or should the state only engage with faith groups insofar as they are willing to abandon their distinctive agenda and fit in uncritically with the norms of secular society and state provision of biomedically based medicine and care?*

For the last 40 years, the state-funded health and social care system has tried to move care and medical provision more towards communities and localities. More recently, it has tried to develop a greater plurality of providers and kinds of care. In this context, faith communities look like important intermediate voluntary organisations and providers that can help the state system reach the parts of society that might be hard to reach.

- *Is it appropriate that faith communities should be regarded as major partners in, or providers of, health and social care, and vectors of health promotion as defined by the state? What are the implications of this kind of partnership both for the state (including the local state) and for faith communities? How*

might both be affected and changed, for better and for worse? What kinds of care and provision is it appropriate for faith communities to be involved in, and in what ways? How far should they have a voice in determining the nature and extent of health and social care provision? Are they to be regarded merely as vehicles for provision or as independent agents that have their own ideas and autonomy? To what extent might they be critics of the ideas and practices of the state? And is there any danger that faith communities that look mainly to collaboration with state institutions might a) find themselves taking on far too much responsibility for the care of their members and others while the state retreats, and/or b) find themselves looking upwards towards the state for direction and funding to the extent that they fail to look outwards and laterally to their own members and communities?

One of the attractive things about faith communities from the perspective of those outside them who try to organise health care is that in a fast changing modern world, they may appear to be coherent, relatively strong structures that relate closely to localities and natural communities. They can be bound together by common interests, ideas and theologies that provide a relatively clear sense of meaning purpose and understanding. Within this, understandings of care, illness and healing may be equally clear and coherent.

- *Is there a danger, perhaps, that faith communities can be too inward looking and so clear about the values and value of their own way of doing things that people with particular needs may not be encouraged to access health care ideas and practices outside these communities? Might it be that faith communities, like the state, can become concerned only with their own perspectives and practices, failing to engage in real dialogue and co-operation with other kinds of health and social care provision?*

Faith communities and religious interests are represented in 'secular' state, health and social institutions not only by historical influences and structures but also by chaplaincies, and perhaps most importantly by adherents who work as policy makers and care deliverers. Often, the motivation these individuals have will be at least partially motivated by faith commitments and ideas.

- *What is the proper place of faith in health care practice and for health care practitioners? Are there/should there be significant differences in the ways that people of faith might relate to people within and outside their faith communities within their work? Should health care institutions be overtly places of pluralism of faith practice and thought? Or should the services on offer be firmly separated from faith ideas and practices, i.e., formally secular and agnostic? What is gained/lost by this stance? What place, if any, should faith considerations, insights, and practices have in structuring health care practices and institutions?*

Conclusion and Questions for discussion

It seems clear that Faith has an important set of roles in health and wellbeing. For people of faith, their health and wellbeing are often mediated through, and understood in, the light of that faith's principles and practices. Have we truly as both faith communities and health agencies understood this and addressed its implications?

Finally, the role of faith in the public sector world of health care is problematic. There is always a tension in a large public service available to everyone in meeting very individual needs and concerns. But do we have the balance in that tension right when Birmingham is, perhaps more than other cities, a city where faith is alive and kicking?

We invite you to consider the following questions:

- How is the health and wellbeing system making space for religious groups and mediated kinds of thought and care?
- What obstacles exist to more contributions and collaboration?
- Are there specifically religious views on health and care that should be accommodated in the thinking and planning on health and wellbeing?
- What are the challenges, opportunities, pitfalls for collaboration and dialogue?
- Do we have, or do we even need, a theological vision and critique?
- What opportunities exist for research and enquiry between faith, state and academic groups in Birmingham that might throw light on the issues raised in this paper and upon the practical provision of care?