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TWO MODELS OF HEALTH CARE, THEIR PROBLEMS AND PROSPECTS; RUSSIAN AND AMERICAN
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A Look At Health Care In Russia and Some Comparisons

> "Prior to the fall of the Soviet Union, the Russian people were used to getting free health care-even though the condition of that care was marginal at best. To receive health care, the majority of the people normally go to the "polyclinic" in their own living area or to the clinic in the factory where they work. This local clinic was supposed to be able to supply everything a worker needed for health care."
> Bill Shepard (a private business consultant, formerly with MAP [Medical Assistance Program] and Board Member with St. Zenia's Foundation) Observations of Medical Conditions of Russia,1992." p. 1.

The picture of health care in Russia in the summer of 1992 is indeed a picture of tragedy. My intention is to go through phases of analysis of the problem and then move to some proposed alternatives. My data and opinions have come from at least four different sources. First, beginning in January 1992 I have been able to spend six months in review of material for this presentation. As a part of the analysis of the present situation I heard three major addresses from professors and a journalist who have taken their own first hand look at what has been happening in Eastern bloc countries, particularly the former USSR, with a view as to how this impacts upon Russia.

Second, I have talked with consultants who are viewing the unfolding of events in the former USSR. The question is how can we of the community of faith make responses to these unprecedented needs? The United Methodist Board of Global Ministries, especially staff members Bob Harman, Cathi Lyons and consultant David Hilton, MD, have shared

their reflections with me. Also representatives from the St. Zenia's Foundation, a non-profit group from America's eastern seaboard including Jim McReynolds, an Episcopal priest, Bill Shepard, Jr. and Larry Kennedy, business consultants who have traveled to Russia and provided me with a situational analysis from their perspectives.

Third one of the most stimulating and disconcerting analyses has come from Murray Feshbach a demographer from Georgetown University and his co-author, Alfred Friendly, Jr., a former Moscow Bureau Chief for Newsweek magazine. Their 376 page work Ecocide in the USSR-Health and Nature Under Siege contains 1147 references including a number of in-country interviews as well as official documentation from the former Ministry of Health in Moscow. This publication was released late April 1992. I have also explored numerous journal and newspaper articles. Lastly, I traveled to Russia for 16 days at the end of May 1992 for my own first hand look and listening. This has provided the most stimulating, partly confusing, and definitely challenging periods of my professional life. I will dedicate a great deal of my future in making responses to these needs.

What I Viewed First Hand

My journeys in Russia took me to Moscow, St. Petersburg and the countryside. I was invited to lecture in Moscow by the Russian Academy of Sciences, Institute of Psychology. The School of Academic Psychology was my receiving host. This school is preparing professional counselors/psychotherapists to offer mental health services enlightened by a Christian perspective. Along with presenting seven lectures in Moscow, I presented a lecture on Family Systems Theory to the Institute of Pedagogy for social workers in St. Petersburg.

In addition to the interaction with the faculties and the 50 students, I had opportunities for three major consultations. In St. Petersburg I met with seven psychiatrists at Psychiatric Hospital Number 6. There we discussed and consulted concerning their emerging Alcohol Rehabilitation program. There will be a four way linkage including a partnership with the St. Zenia Hospital, Psychiatric Hospital Number Six with its newly emerging Alcohol Rehabilitation Program and the St. Petersburg Theological Academy with its student body of 600 seminary students and the St. Zenia's Foundation. The latter has already begun providing equipment, supplies, and consultation.

Father Vladamir Sorokin is the Rector of the Seminary and he was able to persuade the Russian government to return a building which the government confiscated during the early stages of the Communist Revolution. It has been a gynecological hospital and has now been converted to a 50 bed gerontological hospital. This is an entirely new venture for the Russian Orthodox Church to assume the responsibility for the management and support of a charity hospital. Under Communism these kinds of acts of mercy were illegal as the State was to meet the needs of its citizens.

Two other very moving consultations took place in Moscow. I visited still another alcohol rehabilitation hospital (Narcology Hospital) on the outskirts of Moscow. Many other Russian hospitals are reported to be lacking in cleanliness. However this one is extremely clean. The Director of Psychotherapy presented me with a special request. He wants help in getting social workers trained as a part of their treatment team. In another Moscow consultation within a mile of the Kremlin I met with seven professionals responsible for orphanage

placed and foster home placed children. The figure which is alarming is that there are an estimated 1.1 million children in the above two categories in the former Soviet Union. The particular agency which I visited was monitoring the needs and programs for 15,000 children. We do have some well functioning children's homes under United Methodist management which may be able to offer some guidance in program development.

Some Major Questions

Now, I want to turn to two questions:

(1) What is the current situation concerning health care in Russia?

(2) What responses can be made by the community of faith?

Situation of Russian Health Care-Summer 1992

There are two disasters which overshadow health care in Russia. First, there is an ecological disaster of unprecedented proportions which has been three quarters of a century in developing. Second, the military-industrial complex has consumed from one-third to one-half of their Gross National Product over the last half century. Currently Russia spends about three percent of GNP on health care, while the United States of America spends about twelve percent of GNP. (Tragically, about 37,000,000 Americans, or about 15 percent of the population, have no health insurance and are left with many unmet basic health care needs. This problem must have a solution. Likewise, we need to curb rising health care costs which are projected to reach seventeen per cent of the GNP by the year 2000.)

The ecological disaster in Russia is of major proportion as relates to health. Problems as they are experienced include high levels

of pesticides in the food and water supplies and heavy industrially based air pollution. Both water and air supplies have been compromised. In the then USSR- nearly three-fourths of the surface water was classified as polluted in 1989 (Feshbach and Friendly p. 114).

By contrast, a survey conducted by the U.S. Environmental Protection Agency found 10 percent of the rivers, streams, and bays of America to be significantly polluted. (This is too high a figure to be tolerated and we are enacting Federal Legislation around this issue). In Russia, the problem has come through investing too much in promoting urban industrial and rural farm output and too little in protecting people and other aspects of nature. The pollutions which threaten Russian health include both chemical and bacterial threats to life and well-being.

These factors have a direct bearing on the health of the Russian people. Tragically, it shows up is in high infant mortality. In the United States the infant mortality rate is in the range of 10 deaths per 1,000 live births overall with an African-American death rate of 19 per 1,000. The state acknowledged figure of infant mortality in Russia is 23 per 1,000. However, an American demographer, Murray Feshbach, has done further exploration and he puts the figure for infant death rate in Russia at 33 per 1,000 in Russia. In some of the other Republics the infant mortality figure rises as high as 50 per 1,000.

The death rate is exacerbated by the shortage of medical supplies. The re-using of needles and syringes has become its own kind of "Typhoid Mary" in the transmission of disease. Feshbach has characterized the process as an "injection epidemic." For example in one of the Central Asian Republics, a child in his/her first year of life may get 200-400

injections. In the West, since we have access to medicines in liquid and/or powder form, a child may get only from three to five injections in the first year of life. It is reported that a child with relatively uncomplicated upper-respiratory illness may get up to 38 injections in one visit.

Problems and Possibilities in Health Care Delivery

Feshbach and Friendly report that according to their sources in the Soviet Ministry of Health that about 200,000 babies died in 1989 with more than one in four being a victim of improper medical care. There is infanticide with children of limited birth weight and noted congenital handicapping conditions.

There are numerous problems related to health care delivery in Russia. There is reason for concern about the a problematic quality of medical education. The Russians do not have the equivalent MCAT screening examination for admission into medical school. Some aspiring students "buy their way" into medical school; others have been admitted based on ability to muster political influence without appropriate regard for qualifications. If one has a "problemed preparation" in any profession one will have a "problemed delivery of services."

Lets review some of the positive aspects of Russian health care, for example the "polyclinics" as cited in the opening paragraph. It is estimated that the former Soviet Union had about 36,000 polyclinics. These were developed to serve about 280,000,000 people. There are over 140,000,000 people in Russia and just over 50,000.000 people in Ukraine to be served. Many more problems are present in the more remote Republics where issues of pollution, the shortage of medical supplies, lack of appropriate places for referral, and infant mortality are

greatest. To envision the kind of distribution the polyclinics have in the former USSR they compare in number to the United Methodist churches or Post Offices in the USA (approximately 37,000 of each). According to Doctor David Hilton the distribution of the polyclinics in the Russian population is about ideal (probably better than distribution of first line primary care in the United States.)

What do the polyclinics do and how are they staffed? David Hilton, a physician who consults with the United Methodist Board of Global Missions and formerly was associate director of the Christian Medical Commission, World Council of Churches, reports of his visits to rural Russian polyclinics. They are staffed with the equivalent of an American physician's assistant or a nurse practitioner. They become the first line of contact between health care and the Russian public. However, the polyclinics are hampered by the shortage of supplies and the difficulty of getting patients to tertiary care centers when needed. This certainly mitigates against quality of service either on site or as a place for referral.

There are three basic issues which need to be faced in staffing polyclinic/primary care type enterprises. First, there is the matter of the level of training, especially in diagnosis. Second, there is a matter of facilities and supplies. No running water, no hot water to sterilize equipment, and lack of disposable needles and syringes, as well as the lack of suture materials and other pharmaceutical supplies highlight a real problem. Third, the lack of transportation to a tertiary care hospital when needed creates its own problems. For Americans, we would add a fourth problem and that would be the

perception and reality of liability claims arising from malfunctioning of health care delivery. We are extremely conscious about mal-practice.

The rural hospitals and the polyclinics face the same problems as an initial place for referral. Some of the greatest deficiencies of all Russian health care are reported to be in the rural hospitals. It is from them that we get reports of surgeries such as appendectomies being performed with razor blades, with no hot water, and without adequate sewage disposal. Patients have had bathroom facilities on the ratio of one bathroom for thirty patients in some of the metropolitan area hospitals.

Some Perspectives on Staffing

Let's look at the number of physicians in Russia and the former Soviet Union. They have reported twice as many physicians (4,124 per 1,000,000 population) as the United States (2,035 per 1,000,000) or respectively 1 per 250 and 1 per 500 of the population. At the same time the USSR reported twice the number of hospital beds--USSR 12.8 per thousand versus 5.9 per thousand in USA. By comparison the United Kingdom and Canada have fewer physicians and more hospital beds per capita than the United States.

There is a glaring deficiency in family practice physicians in Russia. As a discipline this specialty is very much needed but almost non-existent. This points to what seems to be an over reliance on lesser trained staff at the polyclinics and over reliance on specialists in urban hospitals. It is difficult to reconcile the extremely low pay scale for physicians. Several reports have indicated that bus drivers make more money (220 rubles per month) than physicians (110 rubles per month). In terms of gender mix the ratio of female to male physicians

is much higher in Russia than in many parts of the world. In review of the basic thrust in medicine there appears to be a focus more on the science of medicine and doing research than on practicing the art of medicine. They do take pride in scientific quests. It is still not clear how the ratio of physicians to population precludes having the quality of health care which is desired.

Those of us who have visited Russian lately have found what seems to be a very high level of motivation in physicians; however this is juxtaposed with lowering morale conditions. Because of low pay there has been a threat of a general health care workers strike throughout Russia. I found a high level of motivation among those working in alcohol rehabilitation and among those working in child welfare around issues of foster placement and orphanage placement. If they have increase of supplies, pay, and needed consultation I would expect a decided upward shift in morale.

As I tried to account for the problems encountered in social reforms in the past half dozen years I developed the thesis that President Gorbachev got into trouble when he began his 1986 campaign against alcoholism by closing State owned liquor stores. This caused considerable backlash and a great number of the population began reacting. This was only a precursor to the economic disaster that followed.

In terms of medical schools physicians in the USSR graduate from one of 86 medical schools. Chris Hena, MD, MPH from Liberia is one such product where the intention was to make her a convert to Communism. Instead her evangelical faith (as she identified with an underground Protestant Church movement) was strengthened. This created considerable

problems for her as the KGB developed an extensive file on her. She once was disenrolled from Medical School for her faith stance. She chose to receive treatment for breast cancer in both Sweden and the United States, averting care in Russia. She now works for the Board of Global Ministry in Moscow. Before the recent changes in Russia which led to the August 1991 coup they had recruited third world persons to attend their medical schools and then return to spread Communism. Due to the economic crisis this practice has ceased. (There are 126 medical schools in the United States by comparison. As well the United States has a larger number of foreign medical school graduates.)

While at Psychiatric Hospital Number 6 in St. Petersburg, I wondered if Ivan Pavlov, for whom their Medical Institute was named, would approve of their interest in existential psychotherapy and the use of Alcoholics Anonymous principles in working in alcohol rehabilitation. The answer was, to my surprise: "In the heavens they are quite tolerant of new ideas." It is difficult for even those heavily influenced by Atheism in higher education to refrain from using biblical metaphors. Some of the physicians identify the problem to include the issues of economics, low morale, and a need for a spiritual perspective and resources to cope with both present and future needs.

One of the problems in Russian health care which is also a social tragedy is the way abortions are used as a method of birth control. It is estimated that one of four abortions in the world is performed in the former USSR. They have the highest ratio of abortions of any country in the world averaging four per female of child bearing age. Some women have up to ten abortions in their lifetime. For many this is the only choice they have in family planning. Also, some physicians have

performed abortions after normal working hours as a form of "moon-lighting" to increase their very low state supported salaries. Reports are that they are unlikely to discuss alternative methods of family planning with their patients.

This leads us into still another problem area which impacts upon surgeries, injections, and abortions. This is the scarcities of pharmaceutical supplies as has been mentioned above. In the past some of these supplies have come from former Eastern bloc countries who now want hard currencies for their transactions. Also, the equipment which have helped produce pharmaceuticals are so dated that it is difficult to keep in production.

The Plague of Pollution

A corollary to this has been the dumping of pharmaceutical wastes into streams which has given basis for Feshbach's and Friendly's rationale for their work entitled Ecocide in the USSR. Just how bad is the pollution that is linked to health issues? The Ministry of Health reported the 18 to 20 fold jump in poisoning deaths of Soviet farm workers in 1988 and 1989 over the levels from 1976 to 1985. Diseases which are reflected in workers in rural areas include increases in anemia, tuberculosis, viral hepatitis and acute upper respiratory tract infections. These are linked to the intensity of pesticide use in agricultural production. The major cities of Russia are characterized as being in "multiple pollutant danger."

What Can We Do?

Let's turn to some responses that interested persons from the World Community can make. First, insure that when medications and other supplies are provided that instructions are provided for their usage.

It can be very counterproductive to have drugs shipped which recipients as well as physicians do not understand how to use. Second, we can aid in medical education. One form of this could be to provide continuing education events for health care workers in Russia.

Also, we can benefit greatly by medical and other health care exchange programs. We can learn from their strengths. It can be affirming for the Russians to invite them to teach us about the function of the polyclinics. We, in the United States, and like some from other countries desperately need to know more about a structure that would reach our entire population no matter how remote or congested in urban areas. One such exchange in Bioethics has already happened with Robert Veatch, PHD, a United Methodist Bioethicist and currently the Director of the Kennedy Institute of Ethics, Georgetown University, Washington,D. C. He and three or four colleagues spent two weeks (in 1989), in consultation in what was then the USSR. We need to continue to promote exchanges of professional information.

Initiatives like the one in progress by the United Methodist Board of Global Ministry can be developed. Large Methodist hospitals, located in Memphis, TN; Indianapolis, IN; and Houston, TX, among others, have been identified to develop partnership programs with Russian hospitals. I expect to continue work in psychologists' and social workers' training especially as these persons aid in the development of alcohol rehabilitation programs. Ecumenical functions like the work of the St. Zenia's Foundation linking with St. Zenia's Hospital (Gerontology) and the St. Petersburg Theological Academy, a Russian Orthodox major seminary, offer the prospects for cooperative ventures.

The Russian Orthodox Church can teach us a lot with their 1,000 year history with Spirituality. This has been very sustaining for them during periods of oppression. We can offer them ways to engage in compassionate forms of ministry. This is a view espoused by Professor Thomas C. Oden of the Theological School, Drew University, Madison, New Jersey. He has been invited twice to lecture at Moscow State University. In his consultation with our Board of Global Ministry he has recommended that we promote support Compassionate Ministries as well as for us to attempt support of the Russian Orthodox Church.

One of the kinds of support would be to assist them in providing supplies and printing for religious education materials. His belief is that Wesleyan ecclesiology lends itself to both approaches. (I am also aware that five "high steeple" American Church pastors are pledging $100,000 each for their own version basically Southern and Evangelical type of evangelism). They are joining the parade of "church planters" in Russia and other CIS. We are seeing the moderate and conservative approaches to the Church's mission being lived out in different types of Americans going to Russia.

Among other things we need patience as their own sense of pride/self determination dictates that they be able to feel ownership for what they will be offering in their own health care delivery system even though we are providing, hopefully, short-time support. Practical Theology as a discipline guides us in ways of providing pastoral care. In our Wesleyan tradition we can present some time proven models and offer to adapt them to the Russian context.

Already they are reopening Russian Orthodox churches on hospital grounds. An example is at Hospital Number One in Moscow as well as the

newly chartered St. Zenia's Hospital adjacent to the theological seminary in St. Petersburg. I have already discussed the issue of pastoral care training (Practical Theology at the Theological Academy in St. Petersburg and with Father Victor Petluchenko on the Staff of Bishop Alexis II, the Patriarch of all Russian Orthodox Churches at their headquarters at St. Daniel's Monastery in Moscow. This issue is worthy of follow up. There is a place for a lot of creativity in partnership arrangements.

Bob Harman of our Board of Global Ministry has recently (late June 1992) attended a week long program sponsored by the World Council of Churches in Moscow. The topic was Religious Education. Father Victor reflected with me that for 74 years their priests could do only liturgy. Until recently they were forbidden even to do anointing of the sick in hospitals. Father Victor outlined three current needs: (a) Better preaching, (b) Help in religious education, and (c) Help in developing community building programs (i.e. fellowship dinners and small groups in the congregation). It took me 100 days and much persistence to finally get an audience with the office of External Church Relations at the Office of the Patriach, Alexis II. We Must be prepared to listen to their needs and not merely to attempt to superimpose our agenda on them. I can be and am very critical of approaching the Russian health care problems and needs with paternalism. They have been the society under suffering.

In the area of Social Ethics we can help them particularly in Medical Ethics. Resource personnel such as Doctor Robert Veatch of the Kennedy Institute, as cited above, need to be made available. There is a way through a program called IREX International of Princeton, New

Jersey, to compete for grants to send American scientists to work on a joint program with a Russian scientist.

Expenses will be paid for up to a two week period. Also the National Institutes of Mental Health at Bethesda, Maryland, can sponsor an American scientist who is invited to collaborate with a Russian scientist on a particular project for example in alcohol rehabilitation or care of institutionalized children. The point I make is there is a place for considerable creativity in planning an extension of our Wesleyan heritage and acquired skills in Russia and other parts of the Commonwealth of Independent States.

Conclusion: I want to share observations of a colleague and fellow health care consultant, Bill Shepard as cited above:

> During an interview with the "Chief Doctor" of the largest hospital in St. Petersburg (Leningrad), the doctor painfully explained to me that her total annual budget allocation from the State would barely cover the general operational expenses. Nothing was left for equipment, medicines or individual care!
> Larger regional polyclinics (hospitals) may now acquire supplemental funding by providing additional medical services to the general population and by joining with industries to provide the "promised" health care for a local factory. The more people a hospital or clinic sees, the more money it will receive from the state. This has a negative impact on the quality of care because patients are released prematurely in order to make room for new cases. This has the most serious impact on the seriously ill and aged.
> Until perestroika, communist leaders boasted of a health care system that was not only adequate to meet the country's needs, but was also one that was able to forge breakthroughs in some types of high risk surgery and cures, such as diseases of eyes and bones. Russian health officials are now reporting the conditions accurately and are warning that the country will soon run out of already scarce medicines.
> Doctors, nurses, pharmacists and grim citizens leaving clinics and pharmacies without their prescribed medicine, say shortages that began several years ago are now chronic. Medical supplies--cotton or bandages. disinfectants for hospital rooms and surgical equipment - are also in very short supply.
> Frustrated doctors and nurses are being forced to limit the use of antibiotics and painkillers to life-or-death cases and to scavenge for hard-to-find necessities. Of major concern is the lack of

> medicine for heart and diabetes patients whose require steady, long-term dosages. Ordinary medicines are routinely unavailable.
> Unless aid comes quickly, the Russian government has warned that thousands of ill people will die. "Medicines are in catastrophically short supply," reported a government controlled report just before the August coup. "Not only are our pharmacies empty, hospitals lack even basic supplies and medicines for surgical operations...The situation is near catastrophic."

Please note: Because of time limitations I have not given major attention to other CIS including Ukraine. In Ukraine and nearby Republics, including Russia, the Chernobyl disaster is affecting the birth rate due to the psychological despair. Also the ecological disaster affects the soil and water supply and will for years to come. They do need international help and interventions. Dr. David Hilton has been appraising this issue for the Board of Global Ministry. I will welcome a response from this working group on future directions in these areas of concern.

A Look At Health Care in the United States:

> The health care system in America today does not respond at all to some 12 to 15 percent of our population. This fact constitutes a terrible moral burden. And because that same system satisfies its own uncontrolled needs at the expense of every other sector of American society it creates a terrible economic burden for society as well. We need to change that system. We need to change it thoroughly, and we need to do it soon." C. Everett Koop "Health Care in the United States--The Social Issues," Second Opinion, Vol.13, 1990, p.12.

The story of health care in the United States is a story of triumph and tragedy. For some the triumph is there when a person or family can receive optimal health care. For others, particularly the estimated 37,000,000 , or roughly 15 percent, who are uninsured of America's 252,000,000 citizens it is tragedy. We face a major problem of mal-distribution of resources on one hand to over-utilization on the other hand.

Certainly, the past decade has witnessed a decided shift into high technology and the rise of "For Profit" hospitals. The high tech can be illustrated by a new MRI (magnetic resonance imager) costing $2,000,000 installed. A $200,000 a year radiologist interprets the pictures. A normal charge by hospitals is $1,000 for an MRI scan. The findings are helpful from pictures of one's brain, spinal cord, or joints. However, physicians need clearer results on chests and abdomens so they turn to a $1,000,000 CAT (computerized axial tomographer) scanner. This must be housed in a separate building.)

The ante has recently been upped for a $5,000,000 PET (Position emission tomography) The scanner requires its own cyclotran to produce a radioactive gas that the patient inhales (or a liquid injected into the patient's veins. It s estimated that insurance companies will be paying $2,500 per test. There are only about 40 of the PET scanners in use in America USA has 2,000 MRIs. By contrast, Canada has 15.

Robert Brook who is director of health sciences research for the Rand Corporation estimates that as much as one-third of America's spending is unnecessary. Some typical costs for open heart surgery are $40,000 for a coronary artery bypass graft, $50,000 for heart valve replacement, and $100,000 for a heart transplant. Healthcare costs in auto manufacturing is equal to the projected company profits or roughly one dollar per hour of labor ($2,000 per year per worker). It is estimated that the cost of health care in the Boston area (cite of renowned medical school) is twice that of New Haven with no noticeable difference in overall health of the citizens. There are roughly 375,000 babies born each year having been exposed to illegal drugs. Some of

these children require as much as $200,000 in intensive care in the first months of their lives.

Stepping Back--Trying To Be Objective

My task is to provide an analysis of what appears to be the problems and prospects of the model of health care delivery as I perceive it in the United States. Sometimes it is difficult to be self critical and therefore we miss opportunities for constructive change. The President of Methodist Hospitals of Memphis, Gary Shorb is a hospital administrator who is willing to be critical including presenting a problem which he sees happening in American health care. In offering a critique, Shorb wrote a guest column for the Memphis Commercial-Appeal newspaper in January 1992. Shorb was reflecting 100 days after spending a week consulting on health care delivery in Moscow.

His "Tale of Two Health Care Systems" was very candid in identifying some problem and some possible areas in both cities--Memphis and Moscow. (Methodist Hospitals Memphis is a part of a three hospital network with a total of 13 hospitals located in the three annual conference areas that own the Methodist Health System (MHS)--Memphis Conference, North Arkansas Conference, and Mississippi Conference. MHS has 3,000 beds including a tertiary care hospital in Memphis and in Jackson, Mississippi. It has an annual budget of $700,000,000 and has 8,000 associates/employees). His major thesis is that America's health care delivery system must undergo some major changes.

Troubles in America's Health Care Delivery

One of the greatest phrases wrestled with in Bioethics/Medical Ethics, recently being developed from Social Ethics is: "Allocation of scarce resources." Whether it is one of the three major think tanks in

Bioethics--Hastings Center (New York), Kennedy Institute for Bioethics (Washington, D.C.), the Parkridge Center (Chicago), or at major universities/graduate schools like Southern Methodist University, the University of Virginia, Notre Dame University or the Graduate Theological Union (San Francisco) there is much activity around critiquing our health care programs and their delivery. We must find better ways to allocate our resources especially for the poor.

We do not have workable formulas for how our resources are to be allocated. In the decade of the 80s in America third party payments, Diagnostic Related Groups (DRGs), HMOs (Health Maintenance Organizations), PPOs (Prospective Payment Organizations), and HCFA (Health Care Financing Administration of U.S. Health and Human Services Department), have created problems as well as possibilities. As a part of the problem the above function are presenting accounting and economic nightmares. Likewise, some of the above have interfaced with landmark Bioethics related cases like Karen Ann Quinlan, Nancy Cruzan, and Baby Doe and have expanded the imageries in our moral and ethical nightmares around health care delivery. These images may appear to be either unreal and surreal at times.

In the private sector of health care we have a three-tiered system according to Dr. C. Everett Koop our former surgeon General. They are: private pay, third party insurance, and pay through government programs of MEDICARE and MEDICAID. Our public health resources are not adequate to meet the needs of persons not covered by third party payments. As a result we have a vast underserved population. Poverty and violence, two major social problems are definitely linked to health care issues. They make their demands for a response which is in keeping with our Wesleyan

tradition. Poverty often is cyclical, weaving its web across generations. Often it is linked with lower educational achievement, and lower job skills which precludes having adequate resources for health care. Persons may not qualify for MEDICAID. Their sub-standard wages preclude care for themselves and their children.

In responding to these issues physicians express that they are trained to deal with medical issues and not social issues. We have a way of passing the issues on like a hot potato and frequently express our expectations that the government (federal? state? or local?) ought to do it. The problems of health care delivery are magnified by inadequate attention to prevention in health care. We need proactive programs in health promotion.

John Wesley in the richness of our heritage took on medical needs and social needs as well as responding to spiritual needs. I remember Bishop Leroy Hodapp preaching in the pulpit of his former Indianapolis parish during the 1980 United Methodist General Conference. His topic was "Where Are You John Wesley When We Need You?" At this 1992 Oxford Institute we need to hear the question: "Where Are You (Leadership) in the Wesleyan Tradition When We Need You?" This question is especially pertinent around the issue of the allocation of resources in the lands and lives of people whom all of us here represent. I would be pleased if each member of this Working Group would decide that she/he could begin to do something about health care needs either local or global especially as the needs cast their shadows on our social principles and seek recognition for solution.

Our bioethics colleagues have called us to re-examine also the work of John Rawls at Harvard University in: A Theory of Justice.

Now two decades later we are still pondering the meaning of distributive justice when it comes to the question of allocation of resources for health care. Some split second judgment calls on the part of physicians can either save lives or bankrupt people and sometimes both at the same time. We are being called to make more responsible choices in the allocation of our health care resources.

"Do Not Resuscitate" had broad implications when written as a medical order. It may create dilemmas in the treatment staff. It may cause division of family members. Determination of brain death may have broad implications when there are organs which could be donated depending on certain conditions such as the absence of neoplasms or drug toxicity in the injured person. We have physicians and transplant coordinators on beeper call as we also have bioethicists and chaplains as spiritual advisors on call. Culturally, we tend to deny death and try to avoid death at all costs. When and how are the right decisions to be made and the right consolation and moral support to be given?

Do We As Wesleyans Behave Any Differently in Health Care?

The question of behaving differently is extended to whether we develop policies different from our counterparts in public hospitals, in other non-profit hospitals, and/or in for profit hospitals? The questioner is Dr. Robert Veatch a Medical Ethicist and United Methodist layperson. The case in point is the Medical Records Department. In our Protestant tradition we advocate the priesthood of all believers and our access to the Word of God. Do we insure that knowledge of what goes into one's medical record belongs to the person about whom it has been written? It has taken federal legislation to open up access to information to us the people. Paternalism has been dying a slow death.

Are we doing any better at allocation of resources? At our hospital system where I work we report that we provide up to $20,000,000 per year in unfunded care. Does that make any difference in an overall national expenditure of $700,000,000,000 per year for health care? Are we able to live out any sense of stewardship? It does make a difference in both primary care and tertiary care for those in need. I am convinced that we fall far short in health promotion and educating for change to more healthy life styles.

Some moneys have to be available for replacement of facilities and equipment. Who monitors how we are living out our responsibilities in stewardship? Hospitals may attempt to shun low paying or no paying patients. What are the ethical implications for "dumping" of patients to another facility or refusing treatment? What happens when the "bottom line" and the "golden rule" are in conflict? We have reason to expect that a health care facility--hospital or nursing home managed from a Wesleyan perspective will live out its life in a different way than a "For Profit" institution would.

All is not Rosy

In my consultation with David Hilton, MD a former United Methodist Medical Missionary in Nigeria, (14 years) former care provider for Florida's Seminole Indians (Native Americans for six years) and more recently in Geneva with the World Council of churches he highlights three areas of his concerns in health care. They are (a) Hospitals seeking to make a profit (b) Physicians and other providers who assess and collect high fees for services, and (c) Insurance Companies seeking to make a profit. What I wonder as Russia, discussed earlier in this paper, moves toward a market economy will they begin, or have they

already begun, replicating some of our mistakes in health care delivery? How can we in the Wesleyan tradition be more available to them or to persons in the two-thirds world by offering responsible alternatives? We do not need to export our mistakes in health care delivery but to work with them in partnership by offering responsible alternative? What we will have to guard against is a tendency to try domination and paternalism when we are offering consultation.

There are two problems seen from both ends of the spectrum. One has to do with salaries and perks at upper levels of management. (For instance in one local hospital the CEO/top administrator at an area non-profit hospital received more than $200,000 in annual compensation. At the same time no hospital supported pastoral care is provided because they had not done a "needs analyses." Top management in "For Profit" hospitals exceeds this figure times over as they are compensated in stock as well as salary much in the model of General Motors. Another area is the layering of management. Corporate structures also dictate perks for upper levels of management. At the other end of the pay scales are people who are working for wages near the poverty level especially in environmental services/housekeeping, laundry, and food services. How do we reconcile even with the formula to not have more than a twenty (CEO) to one (lowest paid employee) salary ratio?

Gary Shorb, President of Methodist Hospitals of Memphis in his "A Tale of Two Health Care Systems" offers the following observation:

"Caught up in meeting HCFA (Health Care Financing Administration), JCAHO (Joint Commission for Accreditation of Health Care Organizations), PRO (Peer Review Organization), State health department and countless other organizations' regulations, we're constantly documenting for

payment and liability reasons, rather than out of concern for patient care. Obviously the U.S. health care system is serving the bureaucracy instead of the patient. And that's the wrong focus."

Shrob cites a Harvard University study published in May 1991 cited that bureaucratic paper work accounts for 24 cents of every dollar spent on health care in America. As cited above our health system has a 700,000,000 budget.

If this formula prevails this would mean that nearly one-fourth or over $170,000,000 of the annual budget is going for paperwork. Shorb contrasts the Russian health care system as having little documentation and therefore a lot lower administrative costs. In hospitals corporate/staff attorneys guide and supervise risk management which is an effort to prevent litigation and this process becomes a high ticket item. At middle levels of management we develop extensive reports to protect us from liability claims when some of this time could be better spent in direct patient care. We may need to reform our liability laws.

I am not advocating that we return to the simplicity of John Wesley's Friday Medical Clinics. I do appeal for a dedication to providing health care for the under-served in our population. Health care delivery is far more sophisticated as we approach the twenty-first century. CAT SCANS, PET SCANS, and MRIs are high ticket items. By comparison in 1989 America had many times over these "exotic" kinds of diagnostic equipment versus the technology being available for even basic care in Russia.

At the end of June 1992 the press carried an article from Nashville, Tennessee, about "rationing health care." The study was done by an independent accounting firm Deloitte and Touche at the

company's own expense. Those of us who share strong theological and ethical perspectives need very much to be a part of this discussion. Persons, like Pamela Couture, a Practical Theologian at Emory University's Candler School of Theology, are taking up issues like how Public Policy is shaped which in turn affects health care for the poor. We need more competent analysis and then Wesleyan inspired action. Somehow Christian Ethical Theory and Practical Theology must join forces for effective "systems care" which is needed for our physical, psycho-social, and spiritual care. These fields have separated the pastoral and the prophetic for too long. I appreciate J. Phillip Wogaman's treatment of the value and place of Pastoral Care in his: Making Moral Decisions.

Sometimes change happens out of crisis. The Patient Self-determination Act was drafted by Missouri's Senator John Danforth's staff and became public law on December 1, 1991. Briefly stated, a person age 18 or older who is admitted to an American health care facility is to be asked within forty-eight hours if they have a Living Will and a Durable Power of Attorney. (These are documents which churches can help parishioners to prepare before illness comes.) For those who elect to have these documents prepared they will be able to let their own wishes be known so they can determine if they want extraordinary intervention should their illness come to its final stages. This allows for a person to act in a proactive manner and even to authorize organ and tissue donation which is greatly needed as an act of altruism and stewardship.

Let's go back to one of our original questions: What can we of the community of faith do about the problems? I know we are dealing

with an American problem of health care. It may have some transfer of learning to other countries, cultures and contexts.

1. We can seek to promote healthy and holy living. Studies have linked church attendance and accompanying supportive activities are seen as having positive effects on health. Our Wesleyan tradition is certainly on our side here in holy living and holy dying. We need to offer assistance in defining quality of life.

2. We can use our influence to be advocates for the poor. We need to aid the passage of just laws including some form of universal health insurance. Both Russia and America need to redirect spending from the Cold War to health care, safe housing, and a cleaner environment. People of faith need to be in dialogue when the public, as has been the case in Oregon works on formulas of Adjusted Life Index as ways to allocate resources. (Adjusted Life Index is a way of assessing quality of life as a part of risk benefit analysis based upon an assessment of quality of life anticipated based in part upon age and degrees of illness).

3. We need to help our communities at large and community of faith in particular to deal with issues around death and dying, organ and tissue donation, grief, addictions, violence and poverty. There is much that can be done in development of appropriate attitudes and assistance in positive behavioral changes.

4. We need improvements in the education of seminarians and continuing education of our clergy. A vital clergy role is persuasion of people. This must be preceded by having better means of analyzing the problem. The first step is a consciousness raising as to the kinds and

depths of problems which are in need of transformation in our culture and are within our grasp to do something about.

We need some major paradigm shifts about viewing local needs and global needs. Proposed action on issues of ecology and public health is needed to move us beyond complacency and toward mutual interdependence of all living creatures. Racism, sexism, and ageism affects all who are either victims, or perpetrators of pain. There is a definite linkage of these personal and social problems which in turn impact upon the health of our citizens.

Community Responses

I want to cite responses to health care needs for the poor which are being made out of the Wesleyan tradition in two American Metropolitan areas. In Washington, D.C., the Columbia Road Health Center along with Christ House serve as models. First, Janelle Goetchus, MD, a United Methodist layperson and Family Practice Physician began working at the Community of Hope in the later 1970s. Tom Neece a clergy from the Church of the Nazarene (of the Wesleyan tradition) founded the Community of Hope in response to unmet health needs in inner city Washington, D.C. That center is housed on 14th Street next door to buildings destroyed during the riots which followed the death of Dr. Martin Luther King, Jr. in April 1968. (Now David Hilfiker, M.D. is the Medical Director of this Center as well as living with his family at St. Joseph's House where he also serves adult male patients who have AIDS).

After a few years following their beginning in Washington, D.C. in 1976 Janelle and her husband, the Reverend Allen Goetchus, and their children moved less than two miles away and founded the Columbia Road Health Center and Christ House. They live in an intentional community

with a total of eight adults. Christ House is a forty bed Infirmary for homeless men. (The estimate is that forty percent of homeless men are also alcoholic). Columbia Road Health Center provides primary care to the poor including political refugees from Central America. These persons need health care as well as sanctuary.

What is noted is that Janelle Goetchus and staff also provide care for about 1,400 hundred people in homeless shelters. Allen Goetchus provides Pastoral Care and Counseling services. These agencies, Columbia Road Health Center, Christ House (affiliated also with the ecumenical Church of the Savior), and the Community of Hope work with grants including moneys from U.S. Department of Health and Human Services and the District of Columbia Government. A sad statistic is that more than thirty percent of the homeless people of all ages have diagnosable mental illness disorders including thousands of children who struggle for mere survival. In a visit with them in early 1992 I learned that only a four hour per week block of time is given pro bono by a psychiatrist to respond to the mental health needs of a number of these people who were released from St. Elizabeth's Hospital, a federal institution, with a short supply of medications in hand. We need advocacy for the mentally ill.

Second, I want to cite a model program in Memphis, Tennessee called The Church Health Center. Scott Morris, MDIV. MD is a Yale Divinity School graduate, a graduate of Emory University Medical School, is a board certified Family Practice Physician, and United Methodist clergy serving also as a Minister of Health at a local United Methodist Church. Also, they are training health promoters for many volunteer from inner city churches. They help in early detection of health

problems. They provide primary care services for the working poor. In the first five years of operation they have served more than 11,000 who have no health care insurance. This program is highly acclaimed and supported as an ecumenical human service enterprise. Also they have been given recognition from the Medical and Dental Societies, (from which they get dozens of volunteers) as well as from State Government in Tennessee. Hospitals, churches, and civic groups continue their support of this worthy model. Both of these cities are fortunate to have Wesleyan inspired health care and spiritual leadership.

If we are going to serve the poor in the tradition of our Wesleyan heritage we need to reclaim the vision of this historic Anglican priest who founded the Methodist Society. I saw it work when I served two years in Morocco, North Africa, when three women of vision provided primary care as Anglican Medical Missionaries. I've seen it work while I served in Appalacia with the primary health care providers at the Red Bird Mission in rural Kentucky. I've seen it work in Washington, D.C. I'm seeing it work for many people whose roots and relatives are in the Mississippi Delta but they (the present patients) have migrated to Memphis, Tennessee, and are served by the Church Health Center. A vision and resources make things happen.

Conclusion

There are both similarities and differences in the Russian and American models of health care. In both countries these are some positive and negative aspects. We do need to take seriously what Russia has done in taking some level of care to all citizens. Tragically 37,000,000 or roughly 15% of Americans do not have access to health care in any insurance program. We excel in high tech and for the most part

try to get both spiritual care and bioethics concerns as major points of emphasis in Medical School related hospitals as well as in Christian and Jewish owned facilities. America has devoted about $875,000,000 to AIDS research this year including an increase of three per cent by recent national budget vote. We must, as must Russia, re-channel military-industrial complex moneys and personnel resources into health care and programs which promote both social and spiritual well-being. We cannot separate these from our concerns of the needs of the body and mind. Mental health programs and well being of children need far more emphases than either country has given. Partnership programs create unprecedented challenges and need to be pursued with great dedication.

Readings Relevant to Social Change and Health Care (Including Social Ethics and Practical Theology)

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The Reverend O. Ray Fitzgerald PHD is a native of Washington, Indiana. He is a member of the California-Pacific United Methodist Annual Conference. He holds Masters degrees in Philosophical Theology and Clinical Psychology. He holds Doctor of Philosophy degrees from Boston University in Pastoral Theology and from The American University in Psychology. He is a Diplomate in the American Association of Pastoral Counselors and also in the American Board of Professional Psychology. He is a Licensed Psychologist and Marriage and Family Therapist.

For the past three decades he has worked in health care in a variety of hospitals and Medical Centers. His consultations in health care have taken him to Morocco, the Philippines, and more recently to Russia. His teaching and research in Religion and Health has been at the University of Kentucky and has held Adjunct Professorships in Pastoral Theology at the Graduate Theological Union in Berkeley, California, Wesley Theological Seminary in Washington, D.C. and Asbury Theological Seminary in Wilmore, Kentucky. He has served as a Board Member of the United Methodist Health and Welfare Association representing 450 institutions and as Co-Chair of the Ethics Committee. He has lectured for the Russian Academy of Sciences Institute of Psychology in Moscow and for the Pedagogical Institute in St. Petersburg, Russia. For the past seven years he has served as Director of Clinical Pastoral Education, Methodist Health Systems, Memphis, Tennessee. This is a 13 hospital 3,000 bed network with a budget of $700,000,000. Currently he is active on the Tennessee Family Action Network (TEAM) sponsored by Senator and Vice Presidential Candidate Al

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