HEALTHY LIVING CENTRES
The churches: a resource for health and wholeness?

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INTRODUCTION

Malcolm Rigler's piece is a courageous testimony reflecting the continuous development and change present in the organisation and delivery of health care today. His reflections focus on the significant movement away from an approach to health dominated by the *medical model* towards embracing a perspective that has been defined as a *social model* of health which recognises the limitations of the medical model. It is the purpose of this paper to explore the relationship between the medical and social models of health and ask what lessons might be learned from Malcolm Rigler's insights and his challenge to the Churches to become involved in Healthy Living Centres.

The Medical and Social Models of Health

The clearest influence on the understanding of professional training for health care (particularly for doctors but also for others, not least clergy) is the notion of health as 'an absence of disease'. This notion is often taken for granted in official medical publications and has dominated western thinking about health during the past two centuries. This is often termed the *medical model* and is linked to the rise during the last century of the scientific investigation of disease by a growing body of specialist doctors and researchers, and to the emergence of health work as a formal professionalised area of expertise. Within this view, health is seen as both the absence of disease and as functional fitness. Health services are geared mainly towards treating sick and disabled people and a high value is put on the provision of specialist medical services, in mainly institutionalised settings. Within the medical model doctors and other qualified experts diagnose disease and sanction and supervise the withdrawal of patients from productive labour. The function of the Health Service as an institution and agency is remedial and curative, almost a 'repair shop' mentality. Disease and sickness are explained within a biological framework that emphasises the physical nature of disease. In the treatment of illness it takes a biologically reductionist view of the person. A high value is put on using qualitative scientific methods of research and on scientific knowledge. This is the model of health within which Malcolm Rigler was trained and has been responding to and reacting against during his professional career.

In 1974 the World Health Organisation defined health in the following way: 'Health is not merely the absence of disease and damage to internal organs of the body, but a state of complete physical, mental, spiritual and social wellbeing.' This definition builds a positive vision of health as comprehensive well-being, in which preoccupation with disease is replaced by a recognition of the framework of individual health. It reflects a critical evaluation of the medical model by researchers both inside and outside medicine, and

questions how far diseases can be objective categories and measurable entities, rather than reflecting mental and social categorisations, a wide range of factors. This is the social *model of* health.

A definitive or even indicative account of factors that have shaped medicine in the United Kingdom has yet to be written, but it may be worthwhile within this discussion to reflect on some of the influences that have shaped modern medicine, drawing out insights in Dr Rigler's piece. There appears to be some considerable sense of crisis in medicine today as it continues to attract suspicion and criticism. This crisis is also apparent within more critically reflective practitioners like Malcolm Rigler. Of course it needs to be set against the innovative and life-changing effects that medicine has had over the last 50 years. Amongst these innovations include the discovery and development of penicillin, antibiotics, steroids, transplants and other surgery. Medical science and research have transformed our understanding of the human body and consequently our ability to conquer disease. Medicine therefore has grown in significance and power over this period and has transformed our lives. Society in turn has invested an enormous amount in medicine as a social utility and good, given it finance and imagined that science will save us.

Despite this, however, medicine continues to be fundamentally challenged by a number of groups and individuals. Some researchers have shown that medicine is not all that effective compared to other agencies and can sometimes do positive harm. Thus life expectancy has increased this century because of improved living standards and not necessarily the development of medical expertise alone. Further, there has been a cultural challenge by many individual lay people and pressure groups in our pluralistic culture who have come to think that there is a wider and more valued health care market than has been supposed, and that even more widely available conventional medicine might fail to promote health. There have been professional challenges by other groups, such as nurses, who argue that they can do things that make for health better than doctors and for less money. There has also been an organisational challenge by successive governments which have been tempted to tame medical power and to ensure the effective use of money and resources in an organisational shift of power from the doctor to the general manager. Some of this has been modified with a new Labour Government and its White Paper, but at local level there are indications that there continues to be a power struggle.

The World Health Organisation has had a very important influence as it has been able to build up a wider picture of medicine's recent history, and the problems and difficulties which face it in the next Millennium. Statistics show a dual (and paradoxical) challenge to human society that has given increased significance to medicine. The world's population has doubled because of medicine's interventions and preventions, while at the same time medicine has acquired the ability to prevent a population explosion through the introduction of the contraceptive pill. There has been a therapeutic resolution which, however, has coincided with the reality that medicine has been more open to criticism and has also had to deal with setbacks and failures. Research, for example on cancer or Alzheimer's disease, creeps along very slowly and HIV has posed considerable challenges

to the ability of medicine to deal with disease, especially in African countries. Culturally, society seems divided between affirming medicine as a profession with prestige and power, and questioning whether medicine is in fact able to be all-conquering and in command of disease.

The development of medical sociology in the 1950s has challenged the professional dominance of medicine for the way it has defined notions of' health and sickness within particular modes of social control and the production of social norms. Sociologists like Roy Porter have questioned the power base of the profession and argue that medicine has become a prisoner of its own success. This surely compels medicine to re-think what its aims and objectives are, and Malcolm Rigler is keen to do so in co-operation with others.

It is also interesting to note the politicisation of medicine. The British health care system, which has been moulded by the values, cultural norms and care system in 1948, was, perhaps in part, a design to complement Britain's big power status, and a part of the British empirical and utilitarian tradition. The nineteenth-century industrial and urban legacy and two World Wars left Britain with a determination to expand education and to improve health, as essential parts of an improved quality of life. The health and welfare services offered opportunities for a redistribution of wealth and a reduction of inequality. Still today we struggle with this challenge. Although the National Health Service absorbs so much state funding, the proportion of the national expenditure has always been low. Perhaps, therefore, from the very establishment of the Health Service, medicine was never allowed to succeed in meeting the expectations directed towards it.

The critique of the medical model of health continues apace. However, both politics and medicine have failed to address the paradox that improved health in the population has led to an increased craving for medicine. Does medicine collude with the general public's expectation that all can be cured in a *can do, must do* approach to medical issues? Can medicine fulfil the increased demand of medical consumerism, where life is extended for the sake of it, and expectations are advanced to a point where they are unrealisable? In America some corpses remain frozen awaiting technology to revive them! The present approach places a cash limit on health resources and this will continue to force medicine to re-define what its goals are. In this process of re-definition, medicine will have to explore the interrelationship between money, power, knowledge and practice if it is to retain its influence.

Over the past 20 years this critique of the medical model of health has gradually moved opinion towards what has been defined as a *social model* of health. This emphasises the environmental causes of health and disease, and in particular makes the connection between individuals and their environment as a dynamic interaction. Many health researchers have argued that the business of improving health needs to address all these four fields: human biology, life-style, environment and health care organisation. This emphasises the wider natural, social, economic and political setting within which health or

disease is experienced. This is the model which Malcolm Rigler seeks to develop and work within.

It is important, however, to appreciate the fundamental changes that have taken place within the organisation and provision of health care in Britain. There have been significant moves forward with the Labour Government's policy on health. Some of these changes have been driven by the necessity to look carefully at the ways in which money is spent on health, but they have also been influenced by developments in clinical practice, shorter lengths of stay in hospital, the provision of more care and treatment in the community and people's developing interest in their own health needs. For many years the focus of health care as an agency and institution has been on hospitals, with the agencies of primary care in the community regarded as satellites of these powerful institutions and GPs often regarded as failed hospital doctors. What is significant today is that primary health care in the community is increasingly becoming the focus for improving health as the social model of health begins to affect the culture, agencies and institutions of health care. It is against this background of improving and developing primary care that the Churches need to explore the appropriate models of health care work, moving away from the traditional emphasis on hospitals as the primary location. This has given rise to a concept described in Government policy as Healthy Living Centres, to which we now turn.

Healthy Living Centres

The Government's notion of Healthy Living Centres is an attempt to develop the future of care through providing new models of people-centred health promotion. They aim to create the synergy which will build confident and knowledgeable communities which are empowered to participate in both identifying health issues and helping mould and provide services. Undergirding these Centres is an holistic approach to public health and personal community care. The Government wants to find ways of delivering health services particularly to those who have limited access to them. This approach to delivering health care is both inter-professional and multidisciplinary as it aims to include a range of complementary services to wellbeing and related services which can contribute to healthy communities (for example parent and child programmes and the creative arts). There is a long and creative history of the relationship between Christianity and art.

Healthy Living Centres mark a shift from the medical to the social model of health and a movement for the National Health Service to become a ‘primary care-led' service. This movement moves away from the focus on medicine simply as a means of treating sickness to one where wellness is equally important, and this includes both physical and mental well-being and care for the environment. There is a new emphasis, therefore, on promoting health positively. This emerges from a recognition that the causes of illness are many and varied and therefore demand a multi-disciplinary approach to treatment and multi-agency co-operation and partnership. It also emerges from the belief that the most effective responses to illness and wellness are likely to be equally disparate and to come from a

variety of sources - drugs being seen as increasingly insufficient and often inappropriate. More and more frequently doctors are looking to alternatives to drugs and might prescribe exercise regimes, massage therapy, acupuncture or even creative arts to bring about wellness. Different professions bring different approaches and Healthy Living Centres will attempt to bring together, in a co-ordinated way, the necessary changes for the development of these varied roles, not least those of GPs.

There is now a broad recognition that communities should have a clear, active role in the Health Service. Indeed, some advocate changing the term ‘patient' to ‘participant'. Increasingly health services users are being encouraged to participate in decisions about themselves and move away from being mere recipients of a top-down delivery system. User involvement means entering into a process of ongoing dialogue with communities to ensure that Healthy Living Centres reflect the needs of those communities, and to bring about empowerment of local people. The Healthy Living Centres concept is innovative. They are likely to emerge in disparate settings, each meeting different sets of needs as appropriate to their community. These settings will not necessarily currently be entirely health-based. It is likely that alternatives to traditional health services will be on offer. It seems that the style will reflect the necessity of reaching the whole community. A community café or pre-school provision are as likely to be components of Healthy Living Centres as are clinics and surgeries.

The new Government's belief in the virtues of partnership is both refreshing and welcome. It remains to be seen whether the Churches can respond to this invitation to forge new partnerships for health and wholeness of individuals within communities. Another remaining issue concerns the nature of spiritual input and how far the Church's traditional ministry can innovate around thinking about and responding to non-physical and spiritual needs.

Conclusions and Ways Forward

Exploring the meanings around our stories.

One of the lessons to be learned from Malcolm Rigler's article is the need for the Churches to develop a culture which listens to human experience as sensitively and creatively as possible. It is important to understand how individual and political agendas interact and shape views and perspectives. Malcolm Rigler's vulnerability has liberated him to dynamic and energetic creativity in developing the Withymoor Village Surgery. The key to unlocking change is an honest realisation of the limitations and difficulties of medicine both as it is currently taught and as it is practised. Can the Churches match this sensitivity?

A spirituality and theology for health?

In the development of an approach to health care which is primary health care led and embraces whole-person care, the Churches would do well to explore their thinking and practice around spirituality and health care. In what ways might the Churches be a resource for meeting people's spiritual needs around health and well-being? Can church buildings be adapted to be used for resourceful and purposeful engagement with well-being? The need for quiet places in the community for stressed people to talk is a possible resource opportunity. Do Christian communities have the imagination and adaptability to share in developments along these lines?

Education and inter-professional learning

Malcolm Rigler stands in the Birmingham tradition which has pioneered medical/religious dialogue. This has had a practical effect on how pastoral theology is taught and has shaped medical practice in a number of key centres in the West Midlands. This dialogue needs to find new energy within which it can move forward in both theory and practice, re-discovering areas of common ground and forging the Church as an active link and partner for health.

What are the theological principles in developing new agencies and institutions of health care? What dimensions of thinking might the Churches reflect upon as they look at health and healing at a local level? The theological principles follow and undergird thinking about Healthy Living Centres and the social model of health. This insists on the inter-connectedness between the various aspects of the person and between human beings and their environment. Where the medical model of health predominates, the hospital institutions especially, are likely to employ a narrow concept of health and disease that can often fail to explore and respond to the reality of these interconnections. Concern for health is part of God's beneficent purpose of human fulfilment, expressed traditionally in the idea of the creation of the human race in the divine image. It is manifested through his grace in the gifts and abilities he has given to people to enable ill-health to be prevented and the sick to be restored. Within this context the concern for health involves tolerating uncertainty, taking risks and making mistakes which are to be regarded as stepping-stones in our shared search for wholeness. The Church has a particular perspective on this search, involving a readiness to work with concepts such as sin and salvation, despair and hope, to take seriously both malevolence and benevolence, doom and rescue; and to know the difference between human arrogance and creatureliness. The Christian's life of faith creates a constant bias towards seeing persons as wholes rather than as, for example, purely physical organisms or just a collection of organs.

We have noted that health and disease are parts of social process with moral, ethical and financial aspects If society is to pay due attention to this process and these dimensions in considering how best to promote well-being in the community, there is room for the Church to play its part, not least in exploring what it means to be human and to find health in and through community. Perhaps above all it can contribute by holding steady this width of considerations in the face of persistent tendencies to narrow the range of factors that are allowed to play their part. In the social organisation of health problems, doctors in particular need to address the challenges posed by health and disease by sharing power, both with their colleagues and with their patients. The users of health care services need to be offered knowledge, skills and support to enable them to take an active interest in their own health and well-being. And the fostering of Christian communities, in the form of congregations and other groupings, offers a social environment where, it is to be hoped people may find acceptance and opportunity for growth.

I believe that Churches can and should have a role to play in all this. There are important historical and contemporary connections to be made between religion and medicine in both primary and secondary care. Churches should be exploring closer working relationships with primary health care teams, health promotion units and possibly GP practices. The Church can make a contribution to providing other services to aid the health of the community, such as befrienders, skilled listeners, babysitters, help with transportation and legal work. Such integration affirms the importance of convictions about our deepest needs where health care is concerned. It acknowledges that the search for wholeness requires a wider model than that provided conventionally by the health services alone, one that involves an inner journey as well as the use of the techniques of medicine. This work, therefore, is about building healthier alliances to encourage people, both individuals and groups, to have an informed voice and reflective wisdom about their care.

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