Religion and the National Health Service
A report for Barking and Dagenham Primary Care Trust

by Dr Patrick Brown, Paul Bickley and Paul Woolley

This report has been produced for Barking and Dagenham Primary Care Trust by Theos, the public theology think tank. Theos undertakes research and provides commentary on issues relating to faith and belief in society. In addition to its independently driven work, Theos provides research, analysis and advice to individuals and organisations across the private, public and not-for-profit sectors.
Contents

Introduction 3

Chapter 1: Healthcare Chaplaincy 9

Chapter 2: Religion and patient experience and outcomes 18

Chapter 3: Religion and public health 32

Chapter 4: The ‘faith sector’ and healthcare service 43

Conclusion 59

Bibliography 64
Introduction

This report has been commissioned by Barking and Dagenham Primary Care Trust (PCT). Its purpose is to explore how faith might impact on healthcare. In the light of the growing importance of faith in the public square (see next section) can healthcare professionals practically engage with religion and religious institutions with a view to improving health and wellbeing? The report examines a number of key themes that are especially relevant to this question, namely chaplaincy, patient experience, public health, and the commissioning of non-public sector providers for health care. It concludes by suggesting that there are opportunities for engagement between healthcare practitioners and religious institutions which could enhance the work of the National Health Service.

The report has been produced by Theos, the public theology think tank. Theos undertakes research and provides commentary on issues relating to faith and belief in society. In addition to its independently driven work, Theos provides research, analysis and advice to individuals and organisations across the private, public and not-for-profit sectors.

Religion and society

In 2003, Alistair Campbell, Tony Blair’s former Head of Communications, sparked controversy when he claimed, “We don’t do God”. The statement captured what was, at least until recently, the prevailing understanding of faith and public life, that being that religion is a private issue, publically irrelevant in a society undergoing a process of inevitable secularisation. Campbell’s comments reflected a longstanding nervousness among public figures; talking

*An authoritative definition of ‘religion’ is beyond the scope of this paper. For the purposes of this report, religion can be considered to be a set of beliefs and practices, often centred upon specific supernatural and moral claims about reality, the cosmos, and human nature, and often codified as prayer, ritual, religious law or practice. In short, religion is a lived reality, a world-view, a way of both seeing and living in the world. World-views provide answers to ultimate questions concerning identity, existence and purpose.
about religion in connection with public issues was at best ineffective, at worst a vote loser or a malign attempt to obscure real motivations.

These assumptions are being widely challenged today. Indeed, society is arguably undergoing a process not so much of continuing secularisation, but rather one of de-secularisation. The philosopher, Julian Baggini, has rightly observed that “When the UK Prime Minister’s spokesperson remarked in 2003 that ‘We don’t do God’ what was striking was that until that point it went without saying that politicians don’t overtly discuss religion. The need to rule god-talk out was a symptom that it was coming back in”

In 1968, writing in the *New York Times*, the sociologist, Peter Berger, wrote “[By] the twenty-first century, religious believers are likely to be found only in small sects, huddled together to resist a worldwide secular culture”. However, in his *The Desecularisation of the World* in 1999 Berger admitted that he had been wrong: “the assumption that we live in a secularised world is false: The world today, with some exceptions … is as furiously religious as it ever was, and in some places more so than ever”.

Religion is back on the public agenda and there are a variety of reasons why public bodies, including health services, should begin to take account of religious life and institutions. Before we look at these, it is worth considering some of the implications of the return of religion on a broader canvas.

**The fall and rise of civil society**

‘Civil society’ is “the space between rulers and ruled populated by independent, voluntary and charitable organisations”. Although displaced somewhat by the growth of state activity that accompanied the advent of the welfare state, the past decade has seen a renewed interest in the capacity of voluntary action, charitable initiative and social enterprise to deliver what the welfare state cannot: a thriving common life.

Recent political interest in the idea of civil society is somewhat unsurprising, not least because it seems, on some levels at least, to be somewhat
diminished. According to the Citizenship in Britain study conducted by Charles Pattie, Patrick Seyd and Paul Whiteley, Britain is “divided between a well connected group of citizens with prosperous lives and high levels of civic engagement and other groups whose networks, associational life and involvement in very limited”\textsuperscript{5}. A similar study for the London School of Economics found that “formal participation in voluntary organisations and political engagement are [sic] increasingly concentrated on the middle and upper classes” and that “levels of generalised social trust have levelled out and remain low.” In short, “Britain may have experienced a decline in ‘social capital’ strikingly similar to that of the United States”\textsuperscript{6}.

Yet those individuals who regarded themselves as belonging to a particular religion often exhibit atypical characteristics. Such people record comparatively high levels of interpersonal trust, of trust in the police, of respect for the law and of a citizen’s duty to vote. They also recorded higher than average levels of group membership, of engagement in informal activities, of political participation and of time ‘donation’\textsuperscript{7}. In short, faith can sustain and underpin civil society.

**Well-being**

In his speech to the Labour Party conference on 3 October 1995 Tony Blair said, “We enjoy a thousand material advantages over any previous generation, and yet we suffer a depth of insecurity and spiritual doubt they never knew.” Indeed, it is widely reported that people in Britain, particularly the young, are some of the most unhappy in the developed world\textsuperscript{8}. In light of this, there is an emerging interest in issues of human well-being or ‘happiness’ as the objective of public policy. Numerous studies have recorded the importance of religious faith as significant for human well-being.

Richard Layard of the London School of Economics has argued that: “One of the most robust findings of happiness research is that people who believe in God are happier”\textsuperscript{9}. Similarly, the Prime Minister’s Strategy Unit has observed that “Religious people report higher levels of life satisfaction. Research, mostly into Christianity, has found a correlation between life satisfaction measures
and religious certainty, strength of one’s relationship with the divine, prayer experiences and devotional and participatory aspects of religiosity. Both the effect of religious belief *per se* and the social benefits provided by participation in religious activities have independent effects upon life satisfaction\(^{10}\).

**The politics of identity**

As Nick Spencer has argued, the historic symbolic pillars of Britishness that have been central to national identity for centuries – union, empire, monarchy and Protestant Christianity – have collapsed. This, combined with large scale migration, has meant that people increasingly are defining themselves according to their religious faith, rather than national, social or economic criteria \(^{11}\).

In *The Dignity of Difference* Sir Jonathan Sacks explains this development: “What this overlooked ... is that homo sapiens is not only, or even primarily, a maximising animal, choosing rationally between options. We are uniquely a meaning-asking animal. Our most fundamental questions are ‘Who am I?’ and ‘To which narrative do I belong?’ The great hope of the liberal imagination, that politics could be superseded with economics, replacing public good with private choice, was bound to fail because economics as such offers no answer to the big questions of ‘Who?’ and ‘Why?’. Religion does, and that is its power in the contemporary world. The politics of ideology may have died, but it has been replaced not by “the end of history” but by the politics of identity”\(^{12}\).

Unprecedented levels of migration exacerbate the conundrum of developing a coherent British identity. For example, in 2007 a report by the Von Hügel Institute, entitled *The Ground of Justice*, examined how Catholic migration into the UK has caused the Catholic community to undergo a shift in its ethnic make up: according to one agency director interviewed by the authors, over 2000 people arrive at Victoria coach station from Central and Eastern Europe every week\(^{13}\). Many of them bring strong religious convictions with them.

**The public and legal recognition of religion**
As religion has been rediscovered as an important aspect of human experience in respect of the above, the state has increasingly offered legal protection for religious practice. Anti discrimination legislation enshrines in law the right of an individual to religious observance, ensuring that everyone in the UK has the right to ‘…hold [their] own religious beliefs or other philosophical beliefs similar to religion’\textsuperscript{14}. Similarly, the Employment Equality (Religion or Belief) Regulations 2003 have ensured that religion is acknowledged as an integral part of life and the individual’s right to practice or participate in religion is protected by law\textsuperscript{15}. Moreover, Part 2 of the Equality Act 2006 makes it unlawful for a public body to discriminate on the grounds of religion or belief through “providing goods, facilities or services of an inferior quality to those that would normally be provided, or in a less favourable manner or on less favourable terms than would normally be the case”\textsuperscript{16}. It is arguable, however, that the religion and belief equality strand is the least well developed and that there is a scarcity of guidance and resources available to healthcare providers on this subject\textsuperscript{17}.

Overview

In the light of the above, what are the implications for Primary Care Trusts like Barking and Dagenham PCT?

This report considers the arguments and evidence around four aspects of healthcare for which religion may be considered important or even fundamental. Chapter 1 examines the role of hospital chaplains and evidence that some NHS Trusts consider them to have little importance. The report then reviews evidence that they still have a significant part to play in the quality of patient experiences. Chapter 2 picks up the concept of patient experience and considers the role of faith as a means of coping with illness and as a source of good health. Both of these aspects have important implications for healthcare professionals, not least those working in public health/health promotion. Chapter 3 considers the roles and possibilities of faith groups in promoting healthy living, particularly amongst certain vulnerable sectors of the community. The fourth and final main chapter builds on these possibilities to
consider the advantages and limitations of involving the ‘faith-sector’ in the provision of health care services.


8 The anxiety epidemic: Why are children so unhappy? The Independent, 11 March 2008


11 Spencer, Nick, Doing God: A Future for Faith in the Public Square, Theos, 2006, p. 60


1 Healthcare chaplaincy

Summary
This chapter considers the role of chaplaincy in the National Health Service. It reviews recent quantitative research, carried out by Theos, which indicates that chaplaincy services have suffered substantial cuts in recent years, and argues that this can be attributed, on the one hand, to budgetary stringencies and, on the other, to the difficulty that chaplains have had in articulating their role in demonstrating why chaplaincies should be publicly funded. The difficulty that religious communities have had in making the case for healthcare chaplaincy has been exacerbated by the changing social context – with increased religious pluralism and a heavily scientific and ‘medicalised’ understanding of illness and the role of healthcare institutions. The chapter then goes on to consider how the role of chaplaincy has been described in the modern context and briefly explores the question of how, in the light of commitments to ensure that all NHS services are evidence based, their efficacy might be properly demonstrated.

1.1 Background
It has been estimated that there are currently around 400 full-time chaplains and 3,000 part-time chaplains serving in NHS Trusts in the United Kingdom. Their role, which is considered in more depth below, is wide-ranging, and extends beyond the traditional image of bed visits and the administration of sacraments for patients to looking after the spiritual needs of staff and relatives and, in the words of the Archbishop of Canterbury, functioning as confidantes of the hospital executive and NHS Trust. Typical day to day activities might include grief and loss care, crisis intervention, communication with caregivers, facilitation of staff communication, conflict resolution, referral and linkage to internal and external resources, and staff support relative to personal crises or work stress. They operate in a variety of evolving healthcare contexts - community-based mental health work, day-case work, Primary Care Trusts, out-patient clinics and, most recently, free-
standing NHS and independent sector treatment centres. Some churches are even seeking to introduce chaplains into GP surgeries at their own expense.

Chaplaincy in the National Health Service is publicly funded, raising questions about the space afforded to religious practice within a public institution in the context of a pluralist society. Chaplaincy models developed during the post-war period and in the light of the growth of the National Health Service are now held to be obsolete, since they do not take into account subsequent religious diversity or changes to healthcare services. In line with NHS best practice, recent models have developed around patient need.

Given that chaplaincy within the National Health Service is funded through Primary Care Trusts, they, like other services, are vulnerable to spending cuts when there are external pressures on budgets. Where the relative value of chaplaincy as against acute healthcare services is perceived to be limited, there is concern that spiritual care, though it rarely consumes more than 0.1% of Trust budgets, is one of the most vulnerable services. Recent media coverage has highlighted particular instances of major reductions to chaplaincy care provision (e.g., Worcestershire Acute NHS Trust’s attempt in 2006 to cut six out of seven chaplains).

Until recently, the evidence base on this point has been limited. The Department of Health, for instance, collects no information on levels of chaplaincy in the NHS. Most surveys focus on the wider issues in chaplaincy and did not seek to measure the amount of chaplaincy available over time. In 2007, Theos conducted research into the extent of chaplaincy provision in NHS Trusts in England and into the level of cuts to the service. The results of this research are summarised below.

1.2 Recent cuts in healthcare chaplaincy
In June 2007 Theos issued questionnaires to NHS Trusts in England under the terms of the Freedom of Information Act (2000) in order to identify if the
volume of chaplaincy had been cut in the NHS, and where these cuts had been made. This research focused on quantitative issues: the number of chaplains in post, the number of units available in individual Trusts, and where there had been cuts to budgets or finance in the previous two years. 198 NHS Trusts initially responded to the Theos questionnaire (an 85.7% response rate). Since Trusts have a legal obligation to respond to freedom of information requests, Theos pursued those which had not completed and returned questionnaires between November 2007 and January of 2008. Theos received responses from an additional 11 NHS Trusts, making the cumulative response rate 90.5%. In this group there were 1,196 paid chaplains, comprising of 352 full-time chaplains and 844 part-time chaplains.

These chaplains provided just over 5270 units of chaplaincy, which is equal to 959,140 hours per annum. Around 1945 of these units were provided by part-time chaplains. One quarter (23.4%/49) of the 220 Trusts responding to the questionnaire reported a reduction in chaplaincy sessions available. Only one Trust reported an increase in the number of sessions available.

In the responding Trusts, 264 sessions of healthcare chaplaincy per week had been lost. This equates to 48,048 hours of spiritual care per annum, (equivalent to around 5% of the chaplaincy now available). The highest recorded loss to an individual was 22 sessions per week (77 hours), equal to over 50% of that Trust’s healthcare chaplaincy. In addition, nine Trusts listed posts as ‘frozen’, with a reasonable expectation of return. In these cases 57.5 sessions were still suspended, amounting to a further 201.25 hours per week or 10,465 hours per annum on top of 48,048 hours of spiritual care per annum already lost to the Trusts in the sample. Collectively, 58,513 hours of healthcare chaplaincy had been put beyond use in the between 2005 and 2007, either by direct cuts or through the freezing of posts. Of the responding Trusts, 23.6% (49) reported a cut in budget, while 22% (46) reported an increase. The authors of the report suspect, however, that even chaplaincy budgets which appeared to remain stable, in terms of proportion a Trust’s spending, were decreasing in real
terms. Indeed, it may be that only those that appeared to be increasing were actually stable in real terms.

It could be argued that, although substantial, these cuts represented less than 6% of the remaining chaplaincy within the data set. However, the cuts were not evenly distributed across all Trusts, but were concentrated in less than a quarter (51) of the Trusts in the data set: so cuts were not widespread but where they did occur they tended to be considerable (at an average of 5.4 sessions/19 hours). In the Trusts reporting cuts, over 17% of chaplaincy provision had been lost. Considering that healthcare chaplaincy depends on the capacity to spend extended periods of time working with or on behalf of a particular patient, cuts to services of this magnitude clearly have the potential to seriously impinge on the core functions of the chaplaincy team.

The research did not seek to investigate the decision making procedure of Primary Care Trusts which made substantial cuts to chaplaincies. However, in public comments regarding Worcestershire Acute Hospital NHS Trust’s substantial cuts to chaplaincy services in 2006, Chief Executive John Rostill said, “the need to maintain the level of clinical roles and medical and nursing expertise is of paramount importance… these are difficult times and we need to do all we can to minimise the impact on front-line services and direct patient care”. In the years running up to chaplaincy cuts, the Trust had indeed been suffering from one of the highest PCT deficits in the country. A cut to the chaplaincy staff by six full time posts, reducing the service drastically, was nonetheless part of a 15% cut in staffing levels (720 jobs) across all services announced in April of 2006. In this instance, at least, cuts to chaplaincy services were probably not driven by a secularist agenda (although this clearly exists), but by these budgetary concerns. It is nevertheless of some interest that Mr Rostill did not consider chaplaincy to be a “frontline service”, nor in the category of “direct patient care”. In light of this, it is worth considering the questions, what do National Health Service administrators think that chaplains do? Have chaplains been able to
articulate the importance of their core tasks? And, what type of evidence could properly support the role of the chaplain in the healthcare setting?

1.3 The purpose and benefits of chaplaincy
The position of the chaplain in the hospital is based on historical precedent and pre-dates the setting up of the NHS in 1948. Typically hospital chaplains have been Christian ministers and have either been employed to work full time for the hospital or take on some part time sessions as part of their parish ministry. Their management was shared between church and hospital and their role as representative of the church in the organisation went largely unquestioned\(^7\).

Recently, however, the imperatives of limited resources have led policy makers to place a requirement that health service treatment, within all disciplines, should move towards being evidence-based. Healthcare chaplains and their professional bodies are therefore directing more and more attention to developing a research base and demonstrating the benefits of chaplaincy. This has raised questions about the role and objectives of chaplains, their professionalization as a discrete discipline within the NHS, and what can be measured in order to demonstrate successful outcomes.

As Harriet Mowatt has observed in her recent comprehensive literature review, healthcare chaplaincy can boast a very limited evidence base for ‘efficacy’ in the healthcare setting. This, along with an ongoing lack of clarity on the objectives and core tasks of the chaplain has meant that chaplains themselves have been unable to ‘market’ and articulate their own role. This adds to a growing sense of vulnerability at an institutional level. Nonetheless, Mowatt argues that an absence of evidence does not necessarily constitute evidence of absence\(^8\). In what follows, we outline how some specialists have defined the role of the chaplain and contributed to the debate on how their efficacy can be gauged.
Historically, key thinkers have sought to locate the chaplain in the context of the broad life of and purpose of the hospital. Michael Wilson, writing in the early 1970s, argued that the three task of the hospital are to cure, care and teach. Building on this, he proposed that the societal function of the hospital is to become a community of health, enabling patients, their families and staff to learn from experiences of illness and death how to build a healthy society. This places the work of the hospital chaplain in the centre of the organization and the hospital community, and conceives of him or her as a theological educator.

Those now in dialogue with Wilson’s ideas argue that his approach to defining the core tasks of chaplaincy reflect his more his more religiously homogeneous context. For example, Anne Aldridge, Deputy Lead Chaplain at Addenbrook’s Hospital Cambridge and currently President of the College of Healthcare Chaplains, has observed a change from chaplains being responsible primarily for cultic ‘religious’ functions towards a role conceptually more focused on ‘spiritual need’ and pastoral practice in light of religious pluralism. Thus, the chaplain is conceived as a broadly ‘spiritual’ rather than religious expert. This might include offering therapy and psychological counselling to patients and staff. He or she may also function as a teacher on bereavement, ethical and faith issues to the wider staff. Further, many chaplains find themselves acting as interpreters “for patients who do not understand the medical jargon, for staff who do not understand patients’ pain language, for families confused by hearing too many voices giving conflicting information”. Other roles may include what Aldridge calls the Prophetic voice – standing out in the face of injustice or unethical issues, developing their own skills in particular areas, participating in research and audit, and functioning as something of a clinical ethicist. Nevertheless, the role remains a mixed one: it still incorporates a view of the chaplain as a religious expert, able to articulate the Christian story, guide in sacrament and ritual, provide a locus of spiritual authority and offering prayer. It is worth noting that many of these tasks will be staff, rather than patient, oriented. Chaplains can spend as much as 40% of their time with staff.
The role of the healthcare chaplain as an industrial chaplain, therefore, should not be underestimated.

In an attempt to define the core task of chaplaincy, other studies have focused on chaplain’s time use. Mowatt and Swinton, for example, conducted qualitative research with 44 chaplains in Scottish hospitals\textsuperscript{12}. The interviews revealed, again, a lack of widely shared definition of core tasks and an emphasis on chaplaincy as a process: “Chaplaincy is a complex process of developing particular forms of caring relationships which takes place within the intimate spaces of people’s lives… The content of these ‘intimate spaces’ often remains unnoticed and unarticulated within a healthcare system which tends to focus on the universal, technical aspects of illness rather than on what illness means to unique individuals at particular moments in time”\textsuperscript{13}. The overriding theme of this and other research is, therefore, one of plurality – and therefore the nebulous nature of what constitutes a ‘good’ outcome in chaplaincy work.

This inevitably leads to the question of what criterion is appropriate for chaplaincy and, more broadly, how a case can continue to be made for its ongoing inclusion in the suite of services provided in the healthcare context. The Rev Peter Speck takes up this point in \textit{A Standard for Research in Health Care Chaplaincy}, part of the Caring for the Spirit project: “…the question arises as to what is the best quality of care? Is the care we offer today any different from that which we offered ten or twenty years ago? How do we know that our current practice is the most effective way of meeting the needs of the particular patient in front of us today?”\textsuperscript{14}. Similarly, Helen Orchard argues that, “serious effort [should be] expended on demonstrating to other healthcare professionals what chaplains are bringing to the bedside that is therapeutically effective rather than simply edifying”\textsuperscript{15}.

There is disagreement in the literature over what could count for evidence of healthcare chaplaincy’s usefulness. This has been addressed by some commentators through exploring different sources of knowledge on the broad canvas – tradition, education and training, personal experience, trial
and error and so on. Hundley argues for a simple, but broad classification of evidence incorporating randomised controlled trials, other robust experimental or observational studies, and more qualitative evidence such as data based on expert opinions and endorsements of respected authorities\(^\text{16}\). While it is clear that evidence in the first category cannot in the main part be brought to bear on chaplaincy, other robust experimental or observational studies might. Overly narrow definitions of science rely on knowledge only being correct if it is tangible, scientifically verifiable, generalisable and reproducible\(^\text{17}\), but this is a standard of evidence that is not always suitable even in the sciences. McManus, among others, has therefore argued for a broadening of the notion of evidence in policy making\(^\text{18}\).

Professor John Swinton has argued that chaplains should seek to build a narrative research base for their work. This takes into account the lived experience of illness “not simply as illustration to confirm or disconfirm diagnostic assumptions, but as a unique media which reveal new or “forgotten” dimensions of health and illness”\(^\text{19}\). This involves grasping the uniqueness of their own discipline and rather than becoming scientific in a narrow, positivistic way, they should pursue methods that help individuals and groups understand and transform illness. The use of a narrative approach, such as that which is advocated by Speck, is now relatively common in chaplaincy policy documents.

---


5 ‘Hospitals set to sack chaplains’, BBC News Online, 8 August 2006.


8 Ibid, p.11.

9 Cited in Mowatt, p.15.


12 Mowat H and Swinton J What do Chaplains do? The role of the Chaplain in meeting the spiritual needs of Patients, Mowat Research Ltd. 2006


17 Mowat, p.46.


2 Religion and patient experience/outcomes

Summary
This chapter begins by considering the pertinence of trust for patient experience, inline with the growing acknowledgement of its importance amongst the academic and policy communities. From this basis it is set out that the role of trust or faith, in a religious sense, may be beneficial to patient wellbeing as well as that which is focused on healthcare professionals. The second section provides an overview of the expanding empirical evidence for this role of faith, as a means of coping with illness and in developing the sense of meaning and ‘coherence’ important for good health, in physical and mental health outcomes. The implications of these findings for the training and conduct of healthcare professionals are then considered in a third section - alongside some of the practical and ethical concerns which arise from suggestions that practitioners need to recognise and engage with the importance of religion and spirituality for health and illness.

2.1 Background: Faith as a coping mechanism and lens for ‘understanding’ illness
Recent policies in the NHS have rightly acknowledged the importance and salience of patients’ trust in their healthcare professionals (and the wider NHS) in playing a key part in the quality of their healthcare experience. Trust is fundamental for healthcare due to its role in enabling patients to accept a certain level of vulnerability in the face of uncertainty. Vulnerability is an intrinsic aspect of almost all healthcare experiences due to both the potential for negative outcomes (as a consequence of the intervention/treatment) and the sensitivities (stigma, discomfort and pain) that may be associated with the experience of the condition itself. Uncertainty similarly exists due to the range of potential outcomes (either positive or negative) which could result from their treatment and difficulties in defining the nature and gravity of the illness. Furthermore the competence and motives of the professionals who are charged with treating the patient can never be absolutely guaranteed, and recent incidents in the NHS of
incompetent doctors, or the Harold Shipman affair, may make the existence of such doubts in patients’ minds more likely.

There are many who have argued that features of late-modern societies act to heighten awareness and perceptions of risk, vulnerability and uncertainty – particularly in relation to healthcare. A paradox exists by which an increasingly refined encyclopaedia of medical knowledge and capability for treating illness through technological advances is accompanied by accentuated sensitivity to the fallibility of medical knowledge and the potential for flawed decisions by the experts applying this knowledge. This environment is therefore one where people are increasingly required to place their trust in abstract systems and expert-strangers (those individuals whose expertise we must depend upon in spite of a complete lack of familiarity) whilst being more aware than ever before of the risks involved in doing so.

Such features of increased uncertainty and vulnerability make apparent the possibilities for high levels of anxiety in a society where risk is so evident. Yet the value of trust is in its ability to ‘bracket against anxiety’ which awareness of risks might otherwise bring about (in allowing the truster to ‘assume away’ and more or less ignore that which might otherwise be a source of worry). Trust is thus a coping mechanism by which the uncertainties (those things which are unable to be known) inseparable from healthcare are able to be explained away through a complex inferential process based on that which can be known. A number of studies, in their assessments of trust in a range of healthcare settings, thus underline the ‘leap of faith’ intrinsic to trust – in that trust involves positive expectations in spite of limited knowledge.

The ‘leaps of faith’ these studies typically describe is to do with trust in specific healthcare institutions or professionals. However a more general religious faith – a trust in a higher power – may have similar effects in the attenuation of anxiety in the face of risk, uncertainty and vulnerability. For in the same way that trust in healthcare professionals centres around beliefs
that the practitioner is able and willing to put the patient’s best interests first\textsuperscript{13}, many forms of religious faith involve the belief that there is a powerful deity who is watching over and looking after the world and individuals within it. That is not necessarily to say that such beliefs are invested in notions that ‘nothing will ever go wrong’ – but rather that such world views are a useful tool in ‘making sense’ of illness in the face of adversity and of offering a different perspective and focus for the patient’s attention.

For as Kierkegaard illuminates, anxiety is ultimately a factor of that which we choose to focus upon:

\begin{quote}
“one may liken dread [or anxiety] to dizziness. He whose eye chances to look down into the yawning abyss below becomes dizzy. But the reason for it is just as much as his eye as the precipice. For example if he had not looked down”\textsuperscript{14}.
\end{quote}

Religious faith may therefore be of great utility to patients in shifting their gaze and attention from the abyss. Where this is the case and anxiety is accordingly attenuated, significant gains in healthcare outcomes may result – not only in the sense of peace of mind and therefore quality of life, but in more directly physical results such as post-surgical recovery\textsuperscript{15}.

Thus in the same way that trust in professionals must be taken seriously due to its effect on enhanced patient outcomes, there is a parallel case for acknowledging and tending to the religious faith that patients hold (for example through the work of chaplains – see section 1). Under-girding the main arguments outlined thus far is a growing body of empirical work researching the links between faith and health (mental and physical), as well as the utility of the former in coping with illness. A large-scale review of this literature found that: “a large proportion of published empirical data suggest that religious commitment may play a beneficial role in preventing mental and physical illness, improving how people cope with mental and physical illness, and facilitating recovery from illness”\textsuperscript{16}. The links between religious beliefs and ‘good health’ is investigated in the following section but in terms of coping with illness – a study looking at how older women from a range of
religious backgrounds coped with the experience of breast cancer noted the positive impact of spiritual and religious beliefs in three key modes: “beliefs provided various forms of emotional support; social support stemming from the patient’s religious ‘institution’ – church, synagogue, etc; and “the ability to make meaning in their everyday life, particularly during their cancer experience”\(^\text{17}\).

Whilst the myriad different ways in which religious or spiritual beliefs may help patients ‘make meaning’ of their illness is beyond the scope of this study, the concreteness of such beliefs would appear to provide an anchor of certitude amidst a wider sea of uncertainty, and therefore a focus of their attention away from the ‘abyss’ as referred to by Kierkegaard. This more cognitive form of coping, combined with the emotional reassurance of faith and the assistance through the social networks which exist around religious and spiritual groups/institutions thus offer a multi-layered and potent means of coming to terms, and coping, with the illness experience. Though the discussion thus far has concentrated almost entirely on physical illness, these factors stemming from religious belief may be seen as equally salient, or even more so, for those experiencing or recovering from mental illness\(^\text{18}\).

### 2.2 The influence of religion on good health: mental and physical

Notions of preventative medicine, or public health, are increasingly prominent on the policy agenda alongside more traditional concerns over curative medicine. Promoting healthy living and enabling people to live well are seen as both creating potential financial savings\(^\text{19}\) and promoting social justice\(^\text{20}\), as opposed to a merely reactive means of combating morbidity and mortality. Within this expanding awareness of how lifestyle factors affect health is an array of evidence suggesting the interdependence of mental and physical health and the causal linkages between the two. The ways in which mental health and associated processes affect physical health are crucial in understanding the influence of religion on the latter. This is returned to later within this sub-section. First though, it is important to discuss the effects of religion specific to mental health.
It is vital to underline that whilst there is much research attesting to the positive influence of ‘religious observance’ on mental health\textsuperscript{21}, there is also evidence which points in the other direction - towards a negative or mixed relationship\textsuperscript{22}. Studies which refer to ‘belief in God’ or similar blanket terms would therefore seem to be too crude in investigating the complex causality at work here – especially as certain studies suggest that even within religions (for example comparing different Christian denominations) there are significant variations across conceptions of the nature of God (benevolent versus judgemental) and corresponding impacts on mental health\textsuperscript{23}, for example in relation to self-esteem\textsuperscript{24}. The subtleties and complexities hinted at here underline the value of having mental health professionals who have sufficient knowledge and understandings of religious beliefs across their patient groups and the impact it has on their lives. Even in a society where institutional religious observance is relatively low (such as is the case in the UK), broader notions of spirituality and existential outlooks are likely to be crucial when considering psycho-social wellbeing.

In terms of the more positive impacts of religious observance and social involvement within religious institutions, there are a number of factors which may be effectual. One study looking at this impact on adolescents suggests nine different factors which may lead to positive healthy outcomes\textsuperscript{25}: “moral directives, spiritual experiences, role models, community and leadership skills, coping skills, cultural capital, social capital, network closure, and extra–community links”. Ultimately the author argues that these factors manifest themselves around three central tenets: “moral order, learned competencies, and social and organizational ties”\textsuperscript{26}. The latter two suggest relatively unproblematic, positive effects on mental health in the way they offer individual and socialised means of coping with potential problems. Though this would of course assume that the learned competencies and means of interacting are congruent with the social norms of the wider environment within which the person moves.
The notion of a ‘moral order’ however, as discussed above, could have both positive and negative effects. For example Francis and colleagues’ research conducted with a large sample of adolescents in Scotland demonstrates “a positive relationship between self-worth and images of God as loving and forgiving, and a negative relationship between self-worth and images of God as cruel and punishing”\(^27\). Thus on the one hand a ‘moral order’ within which the individual feels coerced, judged and living outside the auspices of a less than benevolent deity may induce negative effects. On the other hand however a particular understanding of a ‘moral order’ may offer a definite sense of coherence within day-to-day living which Antonovsky suggests is fundamental to health and wellbeing\(^28\). Religious belief in this sense can offer much assistance in the way of manageability, meaningfulness and comprehensibility which are vital, according to Antonovsky, to abilities to mentally cope with life, thus attenuating stress and therefore ill-health.

It is Antonovsky’s concept of salutogenesis – supporting health and wellbeing as opposed to fighting illness – that points us towards the crucial links between mental health – in particular stress or a lack thereof – and physical health\(^29\). Antonovsky’s research, as corroborated by many other more recent studies, noted that those living under less stress typically had better health and greater resistance to illness\(^30\). Building on this salutogenic-based research, and with a more particular focus on religion, has been the social-epidemiology as carried out by the likes of Levin\(^31\). Meta-analyses of hundreds of studies carried out since the late nineteenth century point to the seemingly strong relationship between religion and the maintenance of ‘good health’:

“in light of possible methodological limitations, there was currently insufficient evidence to claim that these studies definitively "proved" a protective effect of religious attendance. The consistency of findings, however, was highly suggestive that frequent religious attendance was conducive to better health and that this topic thus warranted further investigation”\(^32\).

Greater insights into the particular workings of this causal chain have been provided through more recent research into psychoneuroimmunology – “the
study of how social and psychological factors affect the neuroendocrine and immune functioning\textsuperscript{33}. Through this framework Koenig and other colleagues point out links between the effects of stress on immunology, wound-healing, cancer and other physical health issues\textsuperscript{34}.

Factors associated with stress aside, there may be other reasons for associating particular religious beliefs with health, or indeed ill health. Adherence to certain religious beliefs may mean that particular lifestyles are followed – for example in the non-consumption of particular substances such as alcohol or illicit drugs – which may have positive benefits on health once aggregated over a wider population sample. Moreover for those recovering from substance abuse: “among recovering individuals, higher levels of religious faith and spirituality were associated with a more optimistic life orientation, greater perceived social support, higher resilience to stress, and lower levels of anxiety”\textsuperscript{35}.

The adherence to certain diets linked to religious or spiritual beliefs may have more or less positive effects on wellbeing\textsuperscript{36}. Indeed many of the studies referred to by Levin (as mentioned above) originally set out to explain links between religious affiliation and health in terms of the diet and general consumption/lifestyle habits\textsuperscript{37}. However, as set out in this sub-section, there is increasing evidence to suggest that it is not merely the diet and ‘physical’ lifestyle effects of affiliation which is effectual on health, but moreover the very religiosity and belief itself which is crucial through its effect on the psycho-social lives of ‘religious’ individuals\textsuperscript{38}.

\textbf{2.3 Trust in professionals: the importance and concerns of recognising religious norms and values}

Thus far this chapter has recognised the importance of faith in dealing with the complexities, uncertainties and vulnerability associated with ill health (and its treatment), as well as the potential beneficial effects of religious faith or spirituality on health. These two considerations combine to make a case for ensuring the awareness and recognition of religious norms within the patient-professional interaction. On the one hand an understanding of the
patient’s worldview is crucial to appropriate treatment and adequate reassurance, on the other hand acknowledging and harnessing faith and spirituality might be seen as effectual in the promotion of recovery, healing and health/wellbeing\textsuperscript{39}. Whilst the ramifications for the latter are discussed in more detail in the next chapter, this section will consider the importance and predicaments of considering religious faith within the professional-patient interaction.

As was recognised in the first section of this chapter, trust is of fundamental importance to patients’ experience of treatment and illness, their quality of life and clinical outcomes. The first section went on to focus on trust or faith in a religious sense, though the vast majority of research carried out into trust in the domain of healthcare has been related to patient-professional trust\textsuperscript{40}. Recent policy-making within the UK assumes this trust as an extension of a wider confidence in the system\textsuperscript{41}, yet there is increasing academic research to suggest that it is rather the communicative interactions between healthcare professionals and patients on which the latter’s trust in the former is based\textsuperscript{42 43}.

A phenomenological approach to understanding the importance of communication between professionals and patients underlines the role of the patient in building knowledge about the professional – particularly regarding the latter’s competence (to do a good job) and care (to put the patient’s interests first)\textsuperscript{44}. These beliefs are based on ideal-types of how a ‘good’ doctor, nurse or occupational therapist should present themselves. Such suppositions can then be further tested by the patient through asking questions and garnering assurance that the professional is aware of the best interests and concerns of the patient and willing and able to prioritise these above other factors\textsuperscript{45}. Where patients’ concerns and best interests are related to their religious or spiritual beliefs, the ability of the professional to understand and reassure these is fundamental to patient trust. For example, research into the experiences of patients towards medical decisions regarding their cancer treatment concludes that: “If faith plays an important
role in how some patients decide treatment, and physicians do not account for it, the decision-making process may be unsatisfactory to all involved\textsuperscript{46}.

The potential for ‘unsatisfactory decision making’ and correspondingly diminished trust/increased anxiety is heightened when patients have minority, non-mainstream religious/spiritual beliefs. Firstly there is greater possibility that these views might challenge typical healthcare practice protocols. Secondly it is less likely that the professional will be familiar with these beliefs and able to convince the patient that these perspectives are fully understood and therefore respected. Thirdly, and related to this previous point, it is more likely that the patient may have had prior experience with healthcare or other welfare state institutions where their beliefs and worldview have not been respected and therefore their ideal-type perception of professionals or agents of the state may tend more towards mistrust than might otherwise be the case, \textit{ceteris paribus}.

This section thus far has set out reasons why understandings of religious and spiritual worldviews as they apply to various patient contexts need to be taken seriously and why professional training, as it increasingly recognises the holistic and communicative aspects intrinsic to good healthcare, needs to include training which prepares healthcare professionals to be able to offer care which addresses the spiritual, as well as physical and emotional, needs of patients\textsuperscript{47}. That professionals recognise that lay-knowledge sources and meanings which may be compelling for patients go far beyond positivist bio-medicine is crucial. Illness, and therefore satisfactory outcomes and trust\textsuperscript{48}, is as much to do with socialised understandings and lived experience as it is about measurable symptoms. This therefore requires the communicative competencies and sensitivities of the practitioner are capable of offering a ‘mutuality of accounts’ between a bio-medical/scientific approach and a lay, common-sense paradigm\textsuperscript{49}; that is, to explain their scientific evaluation and intervention of the illness in a way that is accessible and meaningful to their patient.

Yet although such an approach would appear keenly desirable, its application is far from straightforward, both in terms of practicalities and
ethical problems. Clearly not all people desire, or find helpful, discussion of more spiritual aspects of patient need and care. This varies across age, ‘religiosity’, clinical situation and seriousness of illness. Hence the ability of the professional to ‘evaluate’ the needs of the patient and ‘pitch’ their communication accordingly is critical. Many studies emphasising patient preferences for spiritual aspects to be considered more effectively have been carried out in the US, and whilst the UK would apparently present a quite different (arguably more pluralist) religious demographic, there are nonetheless likely to be pockets, especially amongst certain ethnic minorities, where high levels of religious interest and spirituality are more important.

In the large number of cases where patients who are interested in discussing spiritual aspects of their condition or treatment are happy to be referred to a specialist (i.e., chaplain), notions of boundaries between medicine and metaphysics are less problematic. Post and his colleagues note that although that the traditional specialisation and differentiation between professions (physician and clerical) is crucial for their effective functioning and credibility, pressure may well come from patients that puts pressure on physicians to bend these boundaries. They recommend that healthcare professionals respect these boundaries nonetheless and when placed in such situations “might assert, for example, that professional boundaries ensure higher degrees of competency through specialised training and that there may be issues a patient will want to tell chaplains but not physicians, and vice-versa.

This final section, in building on the earlier parts of the chapter has sought to raise a number of issues around the importance of professionals being skilled in assessing the potential spiritual needs of the patient and being suitably prepared and informed to respond to these in the most appropriate way. This has been seen as especially salient due to the influence such an approach can have on the patient’s trust and satisfaction with decision-making and care-giving. The next chapter will delve further into the importance of spiritual and religious awareness for effective healthcare,
though will relate this more particularly to the context of public health and health promotion.


6 Furedi F. *Culture of Fear: risk taking and the morality of low expectation*. London: Cassell; 1997


10 Elliott A. *Subject to ourselves: social theory, psychoanalysis and postmodernity. 2nd edition*. Boulder: Paradigm; 2004


14 Kierkegaard, S. *Concept of Dread*. p. 55


Though the cost-effectiveness of many public health initiatives has been called into question – for a discussion of some of these issues see Wanless D. Securing our future health: taking a long term view. London: HM Treasury; 2002

Since the Black Report (1980) there has been an increasing recognition of inequalities in health resulting from class-based health determinants.


Francis L, Gibson H, Robbins M. God images and self-worth among adolescents in Scotland. p. 103


32 ibid p. 850


38 ibid


42 ibid


45 ibid


ibid


Ibid p. 581
3 Religion and public health

Summary
This chapter discusses the potential for religious or spiritual institutions to promote health in vulnerable communities, particularly due to the correlation between cleavages experiencing profound health inequalities (such as certain ethnic minorities and older people) and membership/attendance of faith-based communities. It is noted that, by their very nature, religious institutions may already be attenuating the negative effects of health determinants through their provision of social support networks, coping mechanisms and a more general ‘sense of coherence’. The latter parts of section 3.2 and section 3.3 then go on to look at the possibilities (both theoretical and via more concrete empirical examples) of health promotion activities to work through, and in co-operation with, faith-based communities. It is suggested that these religious institutions have a number of unique resources (organisational, human capital, social capital/trust, knowledge of local community sensibilities, access to vulnerable groups) which may make them especially effective in the work of health promotion – especially where these resources are combined with adequate health promotion experience and expertise.

3.1 Background: Correlations between determinants of health and religious affiliation
As briefly referred to in the previous chapter, public health is a proactive, preventative approach to healthcare as opposed to the more traditional reactive, curative practice of medicine. The UK Government has increasingly sought, particular since the 1990s, to improve the general health of the nation\(^1\)\(^2\) as much as simply providing healthcare for the sick. Central to understandings and approaches of public health are notions of health inequalities, the existence of which was made glaringly apparent by The Black Report, published in 1980\(^3\). In contrast to the neo-liberal underpinnings of certain conceptualisations of public health which emphasise the responsibility of each individual for living ‘well’, increasing
evidence points towards the stark contrasts in opportunities for healthy living based around a number of determinants – not least class.

Socio-economic status and income are defining variables which explain a great deal of inequalities in morbidity and mortality – often functioning through associated variables such as education and ‘health literacy’, employment conditions, housing, social support networks, cultural capital and social status. Gender is another factor associated with certain differences in health and morbidity, going beyond the biological and related to social norms and constructs and again interacting with, and working through, socio-economic and occupational life-history\(^4\). Hence why life expectancy in ‘Glasgow City’ (one of the poorest areas in the UK) for men is 69.3 years, whereas men living in Chelsea and Kensington (one of the wealthiest) live on average for 80.8 years - whilst for women the figure is even higher in the latter location, at 85.8 years\(^5\).

Although the previous chapter referred to a significant portion of research pointing towards the health benefits attached to religious and spiritual beliefs, the inequalities outlined thus far in this section help explain why many people suffering from the greatest inequalities in health may also have strong religious affiliations. The key linking factor between these variables is ethnicity – where “Pakistanis, Bangladeshis and Caribbeans have the poorest health of anyone in Britain, because so many are living in poverty”\(^6\). Within these cleavages further inequalities become apparent: “Pakistanis and Bangladeshis are 50 per cent more likely to suffer ill-health than whites and Caribbeans are 30 per cent more likely to be in poor health. Pakistanis, Bangladeshis and Caribbeans are the three poorest ethnic groups in Britain. Indians, African Asians and Chinese, who are closest to whites in income, are as healthy as whites”\(^7\).

That significant portions of these poorer ethnic minorities have religious affiliations explains the correlations between religion and poor health amongst these minorities, and why Muslims have the poorest overall health in the UK\(^8\). It is important not to synonymise ethnic background and religious
beliefs/affiliations\textsuperscript{9}, nor to assume that those who state religious affiliations are regular attendees at churches, mosques or other such institutions, yet it would seem that the ethnic groups with the poorest health are also those most likely to be religious – where “fewer than 1 in 200 Pakistanis and Bangladeshis reported having no religion”\textsuperscript{10}. In spite of these strong correlations with ill health, there is a lack of initiatives and research into the health needs of specific religious minorities within the UK, not least those of Muslims\textsuperscript{11}. Potential for such approaches will be set out in later sections of this chapter.

Ethnicity, though important, is not the only connecting factor between religious affiliation and (poor) health. Age is also an important correlated variable. Church attendance, for example, remains relatively high across the older UK population compared with younger generations\textsuperscript{12} and this group, for a range of reasons, are more likely to suffer poor health. Traditionally old age has been seen as synonymous with poor health. Yet this apparent inevitability is increasingly coming to be seen as a fallacy, with corresponding increased efforts towards health promotion amongst older adults\textsuperscript{13}. Poor health and old age are again correlated with socio-economic factors as well as those associated with lifestyle, nutrition, social isolation, home safety, dignity and cognitive training. Most of these are amenable to modification through health promotion initiatives\textsuperscript{14}. The combination of poor health and increased religious affiliation amongst older people highlights the possibility of using the latter as a means to combating the former, as will be set out later in this chapter.

The health determinants discussed thus far linking poor health to both ethnicity and older age suggests that it may be ‘ethnic elders’ who face the greatest inequalities in terms of their health. The combination of age and race-related socio-economic inequalities can render parts of these populations most vulnerable\textsuperscript{15} and yet most isolated. The other research discussed thus far linking both older age and ethnicity to increased religious affiliation suggests therefore the likelihood of ethnic elders experiencing
poor health, but yet being more likely to attend church, mosque, synagogue or other religious institutions.

A brief, simplistic assessment of this evidence would seem to suggest that it contradicts the findings described in the previous chapter which pointed towards positive correlations between religious or spiritual belief/affiliation and health. However, as set out earlier in this chapter, there is no direct causal linkage between religious interests and poor health, but rather that both are linked to the common independent variable of socio-economic deprivation. Therefore it would seem tenable to suggest that were it not for religious beliefs, the health inequalities resulting from ethnic- or age-correlated poverty would be even more pronounced, and that it is likely that religious or spiritual beliefs are an attenuating factor in this causal relationship between the independent socio-economic variables and the dependent variable - poor health\textsuperscript{16}. The following two sections will look at ways in which this mediating factor of religious affiliation may already be at work. They will also seek to address at least some of the array of possibilities for health promotion and other related policy initiatives to harness the influence of religious institutions on the lifestyle, social lives, mental health, and attitudes towards healthcare institutions of their attendees.

3.2 Religion, lifestyle and the facilitating of healthy living

Before setting out in a more thorough way how religious institutions may play a role in maintaining and promoting the health of vulnerable groups, it would be useful to briefly sketch some of complexities surrounding the vulnerabilities related to older age and ethnic minorities as a result of socio-economic inequalities. The socio-economic inequalities faced by certain ethnic minorities are not merely related to income, but rather are caused by, and result in, wider issues of access to education, health information, cultural capital and social networks. Not only are these self-perpetuating from one generation to the next but moreover a lack of access to one often also precludes the others. Problems with accessing these socio-cultural resources which can affect health are typical of those of lower socio-
economic status but may be especially pronounced amongst certain ethnic minorities (especially those whose composition is linked to more recent migration) due to issues of language competencies and a lack of familiarity with prevailing cultural norms.

Limited opportunities to access the labour market may result in a less active lifestyle and poorer mental health, with these two outcomes potentially reinforcing one another. Similarly complex and mutually effectual co-morbidities are prevalent amongst poorer older people. Where limited physical capacity may precipitate social isolation, this can result in negative effects on mental health which in turn leads to a less active lifestyle, further limiting physical capacity. Such vicious circles are the modes through which socio-economic status can have such a profound impact on health – the effects of which (as already discussed) are likely to be disproportionately experienced by certain groups which are more likely than most to participate in corporate religious activity. Hence places of prayer, worship or other spiritual involvement are potentially able to limit the negative effects of these health determinants such as social exclusion.

The social support, networks and organisational structure provided by religious institutions\textsuperscript{17} may go some way to redressing the deficiency of more mainstream social networks and corresponding opportunities for social support and accessing the labour market. Attending meetings, being visited by members of the institution or the development of further social ties may therefore ward against the isolation which might ordinarily be experienced by some older people. Equally certain religious communities may provide the means for finding employment, friendship and wider forms of social support which might not be accessible for certain members of minority ethnic groups within the wider, mainstream social community. As will be explored in more detail, religious centres may also form the basis of wider voluntary and community sector initiatives which may be able to assist members of vulnerable communities beyond those who regularly attend the religious meetings. Such fostering of social capital and in some cases social
entrepreneurship\textsuperscript{18} may therefore have broader impacts on mental health and wellbeing across the local community\textsuperscript{19}.

On a more individual level, and as was referred to in the previous chapter, by encouraging and educating attendees in the spiritual beliefs and moral order of the faith system, religious institutions are therefore equipping these people with the coping skills and competencies to develop a ‘sense of coherence’ (a means of making sense of the world as ordered rather than chaotic)\textsuperscript{20} even amongst the daily experiences of social exclusion and economic disfranchisement. These benefits of religious or spiritual belief and affiliation, though beneficial, must remain outside the direct involvement of health policy due to the need (as set in section 2.3) to maintain differentiation between the central concerns of the clerical and medical professions. However the educative role provided by these institutions and their credibility amongst those attending them points towards the possibility of harnessing these institutions as the basis for specific health -education and -promotion projects. Certain religious groups, by the nature of their general teaching on lifestyle and morality, may already have health promoting affects on their members, for example research into the behavioural factors associated with adolescent morbidity and mortality in the US noted that “religious youth are less likely to engage in behaviours that compromise their health (e.g., carrying weapons, getting into fights, drinking and driving) and are more likely to behave in ways that enhance their health (e.g., proper nutrition, exercise, and rest)”\textsuperscript{21}.

There exists further potential for religious groups in areas with elevated health inequalities to carry out health education programmes to improve the health awareness and ‘literacy’ of their members and the wider community (see next section). The development of Faith Community Nursing programmes in Australia\textsuperscript{22} similarly illustrates the potential for healthcare work to function amongst, and in co-operation with, specific faith communities. The Australian model is one of co-operation between healthcare chaplains, church pastors and nursing staff, though it is recognised that the viability of such a system depends very much on the
organisational culture and perspectives of the professionals involved. Yet in providing and combining “physical and spiritual care by creatively linking healthcare chaplains, parish clergy and the nursing profession with those in the community needing support,” the model represents one form of solution to the problems of the inequalities and specific needs deriving from certain minority groups. For example, Sheikh underlines the health inequalities and specific needs amongst British Muslims. These include preferences for seeing doctors of the same sex and the prescribing of pharmacological interventions where alternatives to alcohol and porcine based drugs are made available. Having specifically trained health professionals attached to certain religious institutions, or working amongst these communities, would provide one proactive means of meeting these needs and tackling the specific health determinants they face.

This approach may also help overcome the reluctance of certain isolated or excluded minorities in seeking help from healthcare agencies. In the field of mental health, ethnic minorities may be less likely to seek interventions due to narrow stereotypes about the role of mental health services whilst religious minorities may tend towards seeking pastoral help at the religious institution for emotional problems rather than specialist mental health support. Issues linked to an individual’s familiarity with institutions, and correspondingly of trust, may be important to overcoming these, and partnerships between healthcare professionals and religious institutions may be one effectual means of achieving this. This co-working also would facilitate the sharing of expertise between clerical and medical professionals – improving the assistance that both are able to offer.

3.3 Religious organisations as effective vehicles for health promotion
The previous two sections have set out a range of rationales as to why certain groups who are vulnerable as a result of overarching health inequalities, and who are more likely to attend religious groups or institutions, could benefit from enhanced health education and promotion schemes working through these same organisations. This final section of
the chapter will discuss the experiences of a handful of projects that have already begun to work within such an approach.

Whilst central government and local primary care organisations may take the leading role in driving and organising health promotion – there is an increased recognition that local, organically developed initiatives may be the most appropriate and effective means of working to promote health amongst vulnerable groups (see also chapter 4 for a consideration of this). Partly this is due to the trust that these groups are able to build over a prolonged period and which is unable to simply be recreated by new state-initiated interventions, but also this is due to the way that these local schemes are able to tailor themselves to the particular needs and sensitivities of that community. Furthermore, whereas state-backed public health programmes may be perceived as coercive ‘big brothers’ who seeks to regulate people’s habits, local initiatives stemming from civil society may suffer from lower levels of such mistrust and correspondingly be more successful. These reasons, combined with the increasing preference amongst central and local government for seeking to invigorate the voluntary and community sector (and thus generate social capital) and longer-term trends towards contracting out the provision of services, present significant reasons and opportunities for health promotion linked to faith-organisations (see chapter 4 for a wider discussion of faith-based NGOs and their potential for working in the health and social services sector).

The Bromley-by-Bow centre, set in Tower Hamlets (the most deprived local authority area in the country) represents one interesting example of such a health promotion initiative. Dating back to the mid-1980s, it was originally started in a church hall and has now developed its own, architecturally innovative, buildings though is still influenced by its faith-based background. The local population is highly ethnically diverse, with the largest portion being of Bengali ethnicity. They are reached by a range of arts and community work which are at the heart of the centre’s work. The centre also
hosts a range of different or mixed faith religious services as a means of bringing together and reaching a range of local citizens:

“There has been a long tradition at the Centre of providing common services for different ethnic groups, reflected in the interfaith ceremonies within the United Reformed Church (URC) on site. Although many health and welfare services are targeted at specific needs and different social groups, it is of over-riding importance at the Centre that such services be integrated within the umbrella of one organisation”32.

Hence this combination of arts and community work amongst and across the various ethnic minorities, combined with religious activities, helps breed familiarity and cohesive community which forms of the basis of more explicit health promotion work - such as ‘diabetes fairs’ for example, or advisory and leisure activities for older Bangladeshi men. A GP practice and other community care facilities are integrated into the same site, again as a means of encouraging and facilitating access to healthcare services. This holistic and organic approach, working through community engagement of which religious/spiritual activities and organisations are intrinsic components, has garnered significant recognition and commendation from central government and other sources as a ‘flagship’ model33 for working amongst deprived, ethnically diverse communities.

In stark contrast to urban East London, LIMA (Quality of Life in Older Age) is a health promotion project working amongst older people in Austria, with a specific focus on those in remote rural areas, small villages and the very old34. Whilst the project does not incorporate religious services or faith-based activities, it uses the network of Catholic (and other) churches across the country as an organisational means of accessing more isolated older people, as a source of logistical support and as a provider of venues where the ‘memory training’ and other activities can take place. Within such rural and older populations the church may play a crucial function in maintaining contact with, and knowledge about, vulnerable people who may be at risk of poor health.
Several examples of faith-based health promotion activities also exist in the United States. In one locality, partnership working between community outreach programmes, a nursing school and local hospitals have produced health promotion projects run within a number of different (though generally Christian) faith-settings\(^35\). Another intervention, ‘Project Joy’ was run as a cardiovascular health promotion activity amongst African-American women. These nutrition and physical activity programmes were based in churches and were successful in making significant reductions to risk factors associated with cardiovascular health\(^36\). The findings and experiences reported in all of the above projects suggests that where possibilities of co-operation between health promotion experts and faith-based communities exist, potentially effective interventions can result due to the latter’s detailed knowledge of the target groups and their influential position and access within these. The sharing of health knowledge and healthy living practices within these communities also has the potential to spread beyond the immediate congregations to have positive effects on the wider local populations.

---

7. ibid
8. Sheikh A. Should Muslims have faith-based health services. *BMJ* 2007; 334:74
9. ibid
11 Sheikh A. Should Muslims have faith-based health services.  
12 Coleman P, Ivani-Chalian C, Robinson M. Religious attitudes among British older people: 
p. 167  
13 Department of Health. National Service Framework for Older People. London: 
Department of Health; 2001  
14 Billings J, Brown P. Overview on health promotion for older people in the United Kingdom. 
August 2008  
15 Silveira E, Ebrahim S. Social determinants of psychiatric morbidity and wellbeing in 
812  
16 The importance of religion as a basis of coping with adversity - as employed by ethnic 
minorities - is pointed towards by: Tarakeshwar N, Hansen N, Kochman A, Sikkema K. 
Gender, ethnicity and spiritual coping among bereaved HIV-positive individuals. Mental 
17 Smith C. Theorizing religious effects amongst American adolescents. Journal for the 
18 Froggett L, Chamberlayne P, Wengraf T, Buckner S. Bromley by Bow Centre research 
and evaluation project: integrated practice - focus on older people. London: Bromley-by-
Bow Centre  
19 Hawe P, Shiell A. Social capital and health promotion: a review. Social Science and 
Medicine 2000; 51(6):871-855  
20 Antonovsky A. The sense of coherence as a determinant of health. Advances 1984; 1:37- 
50  
21 Wallace J, Foreman T. Religion's role in promoting health and reducing risk among 
22 van Loon A. The Development of Faith Community Nursing Programs as a Response to 
23 van Loon A, Carey L. Faith Community Nursing and Healthcare Chaplaincy in Australia: a 
new collaboration. in: Vandecreek L, Mooney S (eds.) Parish Nurses, healthcare chaplains 
and Community Clergy: navigating the maze of professional relationships. Binghampton: 
Haworth Press. pp: 143-160  
24 Ibid. p. 143  
25 Sheikh A. Should Muslims have faith-based health services.  
26 ibid  
27 Marwaha S, Livingston G. Stigma, racism or choice? Why do depressed ethnic elders 

29 Luhmann N. *Trust and Power*. London: Wiley; 1979

30 Neighbors H, Musick M, Williams D. The African American Minister as a Source of Help for Serious Personal Crises: Bridge or Barrier to Mental Health Care?


32 Froggett L, Chamberlayne P, Wengraf T, Buckner S. *Bromley by Bow Centre research and evaluation project: integrated practice - focus on older people*. p. 3

33 Ibid.


35 Kotecki C. Developing a Health Promotion Program for Faith-Based Communities. *Holistic Nursing Practice* 2002; 16(3):61-69

4 The ‘faith-sector’ and healthcare services

Summary
New Labour has been committed to the introduction of a mix of welfare state service providers, including the third and ‘faith’ sectors. This article explores the opportunities for commissioning of faith based providers as the third sector agenda develops in provision of public healthcare. It explores the potential advantages and disadvantages before considering examples of how faith and faith institutions can sustain and innovative within successful public service partnerships. In view of difficulties which may ensue, the chapter suggests that there should be no fixed logic to partnerships between faith groups and the state; commissioning should be explored in the context of public good, particularly where there is to be no threat to the motivational ethos of voluntary sector groups.

4.1 Background: the third-way and the involvement of the ‘third sector’
The centrepiece of New Labour’s domestic agenda has been the reform of public services. This has been driven by a critique of public administration focusing on low levels of productivity, inefficiency, poor quality of service and professional rigidity to change – in the face of a growing gap between increasingly high popular expectations versus an ever diminishing willingness of taxpayers to meet the escalating costs of welfare expenditure\(^1\). One controversial solution for this Gordian knot of problems has been the opening up of provision to non-public providers such as private enterprise or third sector organisations\(^2\). In terms of the latter, the argument in favour is that voluntary groups offer added value to the taxpayer in the form of specialist knowledge and skills, social capital and cohesion, freedom for public sector organisational sclerosis and greater choice for the service user.

In ideological terms, the dominant narrative is a move away from unqualified allegiance to either private or public providers towards a pragmatic commitment to ‘what works’ for public service delivery. Close relationship with the Third Sector also chime with the strong Labour tradition of
voluntarism and an attachment to communitarian political philosophy. And while the precise shape of public service reform is obviously one of heated political debate, there is some evidence to suggest that the future of public services increasingly lay outside the remit of direct public administration: in 2005/06 £11 billion of public expenditure flowed towards the charitable sector (of which £6.882 billion came against Government contracts), the first Government Minister for the Third Sector was appointed in May 2006 and a recent Cabinet Office review paper included recommendations that the Government should continue to take steps to “empower citizens to shape services around them; open up the supply side, where appropriate… and help the hardest to reach”\(^3\).

One of the most prominent examples of a public service that has been opened up on the supply side is that of 11-16 years education in the form of City Academies, of which there are now over 80, a significant proportion of which are operated by faith-based providers. Contrary to Government rhetoric on opening the supply side, only 2% of public spending in the United Kingdom goes through the voluntary and community sector. However, according to Campbell Robb, the Director General of The Office for the Third Sector, government has ‘never ruled anything in or ruled anything out’ in terms of areas where it would be inappropriate for the Third Sector to take on roles currently delivered by the State\(^4\). Partnership in Public Services: An Action Plan for Third Sector was published by the Cabinet Office in December 2006 and lists specific opportunities: audiology services, low vision services, community equipment and wheelchair services. It seems likely, therefore, that public sector markets will grow\(^5\).

For both New Labour and potential future Conservative administrations, faith based organisations are already seen as potential partners in the provision of public services. The Government is supporting the development of the ‘faith sector’ as service providers through initiatives like FaithAction, one among a number of government bodies set up to assist sector professionalization, and a recent Communities and Local Government White Paper Communities in Control: Real People, Real Power\(^6\) committed to
remove the barriers to commissioning faith groups for public services. However, this is not always an easy relationship: in her accompanying House of Commons statement the Communities Secretary Hazel Blears outlined that faith-based providers would have to manage contracts under certain limitations:

I am concerned to ensure that if faith groups become involved, they do so on a proper footing—not by evangelising or proselytising, but by providing services in a non-discriminatory way to the whole community. I intend to work on a charter. Faithworks has a similar one, which is very simple and straightforward, but which makes those points very clearly.

This points to a series of potential difficulties with the notion of faith-based organisations providing public services in general and health care services in particular. Seeking Government contracts necessarily involves compromises in procedure and bureaucracy if not of core values. Some of these compromises will be explored in more depth later.

4.2 Rationales for the engagement of faith-based organisations

We have seen in previous chapters how for many, religious belief lays at the heart of patient experience, and that having regard for more holistic approaches to health care could improve outcomes. Beyond this, however, it should also be noted that religious belief can be a marker for health inequalities. Muslim communities, for instance, are predominantly congregated in the inner-city, have the lowest household income, poorest educational attainment, and highest unemployment and experience more poverty than any other faith community. Before even addressing faith specific healthcare needs (circumcisions for Muslim and Jewish patients, a desire amongst some religious groups to avoid porcine derived or alcohol based drugs or self adjustment of treatment regimes during Ramadan), these inequalities have been seen by many as reason enough in itself to deliver culturally competent and faith specific healthcare in minority faith contexts (see also sections 3.1 and 3.2).

Moreover, there are considerable positive advantages of partnership with
faith-based organisations; these are fairly well rehearsed in existing 
literature, but it is worth reviewing them here before we consider how they 
apply to the possibility of contracting as health care providers. In research 
carried out for the Home Office, Professor Vivienne Lowndes of De Montfort 
University has identified three core rationales – normative, resource and 
governance – which motivate policy makers to engage faith based agencies 
in civic and social activity⁹.

**Normative:** As noted in our introduction, religion is an increasingly 
important factor in the shaping of modern identities. The so called 
‘secularisation thesis’ failed to take account both of the retention of a latent 
sense of Christian identity by Britain’s ‘indigenous’ population and the fact 
that migrant and refugee communities often carry strong religious beliefs 
with them as they relocate to the United Kingdom. This is true not only of 
Muslims, Sikhs and Hindus from the Indian sub-continent but also of Roman 
Catholics from Central Eastern Europe and large numbers of evangelical 
Pentecostals from Africa. These ‘imported’ forms of Christianity have a 
dynamism that has proved attractive to politicians in the main political 
parties. Particularly in marginalised urban settings, these groups are seen 
as providing civic infrastructure grounded in ethical and cultural 
commitments which it is not possible for the state to replicate. These values 
include “peace and harmony, humanity, equality, justice, solidarity, trust and 
understanding, forgiveness, and a positive vision for the future.”

**Resources:** Lowndes argues that the resources of faith based 
organisations can be separated into three distinct categories: human capital 
(staff, members and volunteers), social capital (networks of trust and 
reciprocity) and physical capital (buildings).

It has often been noted that individuals active in a religious community are, 
in general, more likely to volunteer. Successive governments have been 
interested to extant human resources in faith groups:

> Faith community organisations are gateways to access the tremendous reserves of 
energy and commitment of their members, which can be of great importance to the 
development of civil society¹⁰.
Churches and other religious communities are already responsible for a range of activities which contribute to social welfare and wellbeing in communities without recourse to public finance. Of course, faith-based social and welfare initiatives vary in formality. Some come in the form of service delivery contracts, such as daycare for the elderly or childcare provision, whereas others are established on an *ad hoc* basis. At least some of these, however, might be ‘scaled up’ or extended in their scope and reach in order to deliver on a ‘diversification of providers’ agenda\textsuperscript{11}.

Furthermore, faith-based community groups have a greater proximity to service users, be they members of the faith community or the wider local community, than publically administered bodies. They are therefore more responsive to particular local needs: “local faith bodies (whether places of worship or representative organisations) can offer valuable local experience and expertise in delivering services…”\textsuperscript{12}. Religious congregations also tend to have buildings available for community use. Uses range from general civic and community events like election hustings, to many health and wellbeing related uses such as weight loss groups, exercise classes or blood donation sessions.

**Governance:** Beyond the voluntary resources, faith communities often offer the possibility of a professional local leadership presence in communities that would otherwise lack this voice. The roles played by local clergy – the parish priest or their equivalent – can vary greatly and the degree of emphasis placed on the priestly or the pastoral responsibilities may be different according to religious tradition and the personal vocation of the incumbent. Nonetheless, they can act as catalysts of action to meet the needs of their congregations and other members of the community and can provide some support, stability and continuity\textsuperscript{13}. In a sense, this local leadership plugs a ‘government deficit’ in deprived areas.

**Some problems:** Before considering whether these alleged advantages would result in improvement to healthcare services, it is worth considering some of the objections levelled against engaging third and faith sector providers in public service provision.
Firstly, Lowndes argues that a series of caveats need to be set against her three core rationales. Tensions between policy makers and faith groups can arise precisely because of the normative identity of faith groups. Concepts such as grace and religious practices like prayer are not optional add-ons, but instead undergird the added value that faith groups bring. At the same time, it is these concepts and practices which can seem to connote evangelism or proselytism which, in turn, can alienate faith-based organisations:

Indeed, we found some cynicism among faith groups about attempts by policymakers or practitioners to hijack the normative agenda – for instance, claiming ‘grass roots legitimacy’ on the basis of people’s involvement, without actually engaging with their values and practices. A yet more hostile reaction argued that: ‘The Government doesn’t want to hear about what makes us faithful people. They’ll fund us if we don’t do anything religious with the money’.

Similarly, faith groups can feel their resources are taken for granted: the recruiting, training and management of volunteers is not as easy as the added value rhetoric assumes, physical spaces like church buildings can be hard to maintain and indeed often constitute a drain on human and financial resources, and local congregations in disadvantaged communities often simply reflect the resource- and skills- poor characteristics of their locality.

Secondly, a recent report by the Public Administration Select Committee, *Public Services and the Third Sector: Rhetoric and Reality*, raised a series of questions over the perceived advantages of the voluntary over the public sector. The Committee drew a strong distinction between tradition of independent, voluntary and altruistic ‘good works’ and the modern welfare state:

Providing “services to the public”, however, is not the same thing as providing “public services”. Public services, crucially, are funded by the taxpayer, and the responsibility for ensuring that they are delivered to every citizen who needs them lies with the State.

Since 1945, a great many “services to the public”, including healthcare, have become public services. In the words of one witness to the Committee,
it is the public sector that arrived late to the feast. As we have already noted, the Labour administration have been seeking to give services back to voluntary and community groups while at the same time seeking to maintain the status of the action as ‘public service’, so much so that in 2002/03 the income of the voluntary sector generated by government contracts overtook the income received by grants. The Committee raised concerns about the effect that this would have on the independence of the charitable sector. As “shopping” relationships overtake “giving” relationships, the fundamental character of the sector might change. Furthermore, the Committee felt that the perceived advantages of the third sector over others – focus on service user, specialist knowledge of expertise, flexibility and ability to provide joined up services, innovation of service, ability to attract higher levels of trust from service users and the added value elements of social capital and voluntarism – had not been duly evidenced, considering the weight these are given in government policy. The considerable diversity of the sector suggests that some of these elements will be present some of the time, but not all of them in all cases. Where advantages are relevant, they could be buried by inflexible procurement processes or accountabilities.

Finally, and specifically in regard to the faith sector, commentators have raised the issue of the potential for discrimination:

TS organizations have worked to cast off their previously held paternalistic values but echoes remain of the legacy of the ‘cold-hand of charity’ when judgments were made of those who were classed worthy or unworthy of assistance. These difficulties are currently highlighted by faith-based organizations and whether they should provide services, especially if conditional on religious convictions. Undoubtedly these organizations play a vital service to members of their community who have specialised needs. Nevertheless, it is quite different to suggest that these providers could become mainstream suppliers of a universal service, available to all. In other words, public services, which are provided according to principles of equity, can be supplemented by organizations providing benefits and creating public value through their use of resources, procedures and organizations. When this is restricted to specific communities, it suggests that a different rationale is being used to provide public services, other than a principle of universalism.
Others argue that this reflects a misunderstanding of the principles behind religiously motivated social action, which in the Christian tradition is certainly to be directed outside of the boundaries of the faith community. The Von Hügel Institute report, *Moral, But No Compass* suggested that the key themes behind Christian welfare activity were not membership of the faith community but sacrifice, gift, covenant, consistency, prophetic concern for the oppressed, subsidiarity and empowerment\textsuperscript{18}. Nevertheless the quote above illustrates an ongoing perception of a risk associated with commissioning faith groups for public services which churches and other religious organizations would have to overcome if they aim to compete with other third sector agencies for commissions.

4.3 Evidence of good practice and future possibilities

We have noted that under Lowndes’ model, the first rationale for public partnership with faith based agencies was their normative advantages. They tend to have proximity and commitment to local communities, which leads them to take a holistic interest in an individual’s wellbeing; in the language of the public sector, they are *responsive* to users. They do this because they are bringing theological and spiritual impulses to bear on the needs of the local community and reflect the World Health Organisation’s broad definition of health as a dynamic state of physical, mental, spiritual and social wellbeing.

A notable example of an initiative operating to this broader understanding is the Bromley by Bow Centre in Tower Hamlets, we have already explored this at some length as an example of good practice, but it is important to observe that there is a strong tension between Centre’s experimental, holistic and relational approach and the target driven regulatory culture of local and central government:

> While the religious origins of the Centre are highly specific, thought needs to be given to how this ethos can be protected at the Centre (and reproduced elsewhere) in the face of technical-rational systems of quality assurance and regulation\textsuperscript{19}. 

However, the religious life of the Centre also undermines some of the myths that have grown around faith based provisions of services, specifically that there ought to be a separation between the religious and community functions of a faith based organization, and that a religious ethos can result in the exclusion of those of different, or no, faith:

The spirit of openness that is re-affirmed in cross-faith services and festivals has meant that the existence of a church on site has been no impediment to the full participation of a devout Muslim population. This is an achievement in the present climate and confounds assumptions about the desirability of separate cultural provision for different faith communities. In line with the Centre’s understanding that integration involves more than colocation, the current minister, Helen Matthews, argues that there is a difference between faiths tolerating each other, and the experience of spiritual enrichment that comes from a deeper level of inter-faith experience. Although some projects in the Centre cater for specific religious or cultural groupings, they do so under the shelter of a ‘canopy’ (symbolised by the physical canopy that demarcates the flexible and moveable space devoted to worship)20.

The Centre’s story also highlights some of the difficulties of service delivery through the third sector. This underlines the “vicious economic conflicts and precariousness underlying ‘welfare pluralism’, a degree of uncertainty that – beyond a certain point – undermines pretensions to ‘partnership working’”21. Indeed, the London Borough of Tower Hamlets withdrew a Community Care Contract form the Centre in 2004, only to reinstate it in 2005. Thus, the ideological flexibility which allows a mix of providers also means that faith based providers can come under considerable financial strain. Faith based organizations would therefore do well not to become reliant on vicissitudinous Government contracts if they are seeking to deliver holistic health and social services to the community.

Our second example of a healthcare service grounded in religious and theological conviction is that of the modern hospice movement. St Christopher’s Hospice, established in 1967 and the first hospice of the modern palliative care movement, was established on principles that would sound peculiar to current healthcare practitioners. Quoting Dr Olive Wyon,
one of the members of the founding committee of the hospice, Cicely Saunders wrote:

St. Christopher’s Hospice is a religious foundation, based on the full Christian faith in God, through Christ. It’s aim is to express the love of God to all who come, in every possible way; in skilled nursing and medical care, in the use of every scientific means of relieving suffering and distress, in understanding and personal sympathy, with respect for the dignity of each patient as a human being, precious to God and man…

St Christopher’s Hospice is still committed, like the Bromley by Bow Centre, to the care of the physical, psychological and spiritual needs on the individual. It is now, and has always been, open to all patients regardless of their faith. Again, this calls into question the assumption that spiritual and theological conviction results in exclusivity and discrimination.

The NHS is committed to providing its patients with palliative care, indicating that it is a public service rather than a service to the public. However, adult hospices in England and Wales receive, on average, only 31% of their costs from the Government in spite of the fact that they provide 80% of inpatient beds as well as day care and at home services. Funding is negotiated with Primary Care Trusts on an annual basis. In this area at least, the goal of full cost recovery for Third Sector public service providers is a long way from realization.

A third example of potential partnership is the ‘Parish Nursing’ movement. This is a comparatively new healthcare delivery model, developed in the United States in the 1980s and 1990s. It is founded on an a distinctively theological aspiration to offer community based “nursing guided by the Holy Spirit which is provided to both the congregation and the wider community, alongside existing pastoral care.” They are registered and accredited nurses, working under the remit of the Primary Care Trust, and offering holistic care to members of church congregations and the wider community, which practically leaves them with a broad medical, social, psychological and theological role. One practitioner’s experience is worth quoting at length:
I work around 30 hours a week and since starting have obtained 54 clients, all with health needs of some kind – spiritual, physical, psychological or social. I can and do respond quickly to an official referral or just an informal request. These have come from the Citizens Advice Bureau, GPs, other health professionals, police Community Support Officers, and church members. Out of my 54 clients 25 attend church, 29 do not.

I give ongoing support to a mother with adopted children who has no parental skills; support a bereaved widow and encourage confidence in going out; attend hospital appointments with clients and interpret medical information; act as an advocate between client and officials; support clients and their relatives with mental health issues; act as a co-ordinator between multidisciplinary healthcare teams; visit hospital and home on behalf of the church; pray with the dying and their relatives; help a family find a Christian home for their relative and assess the outcome; raise the profile of the elderly in the church; and generally have a presence, praying and giving advice as and when needed.

Although the movement here is in its infancy, with only around 40 voluntary practitioners in the United Kingdom, and no research conducted on its efficacy to date, there are 10,000 Parish Nurses in the United States. Research conducted in the United States suggests that “clients perceived having a parish nurse as positive and beneficial for individuals, the congregation, the church, and community” and that “parish nursing was viewed as a useful, meaningful, and effective health intervention and setting, and parish nurses were viewed as effective and meaningful health providers.”

4.4 Harnessing strengths but acknowledging limitations
In evidence to the Public Administration Select Committee inquiry into the role of the third sector in public services, Will Werry of the Commissioning Joint Committee asked, “If the sector is so good, why aren’t they winning now?” His rhetorical point is that the Third Sector does not show significant competitive advantages over public or private providers.

We have rehearsed Lowndes’ research on the perceptions of the advantages of commissioning faith groups, and see that there are examples of this working in practice. Secondly, we have observed that religious providers tend not to suffer from the disadvantages of popular perception:
they open themselves to those off all faith and none, demonstrating that they deliver against universality and equity while maintaining a rich motivational ethos. There are potential problems with commissioning faith groups, but these tend to be those that would afflict the rest of the third sector, such as the potential for full cost recovery and the fact that the determination to be innovative, community focused and experimental leaves it ill at ease with a target driven culture.

From the perspective of both government and the faith-based organizations, the key may be to identify cases where a partnership might be appropriate. In evidence to the Public Administration Select Committee, Campbell Robb said that the mass transfer of services to the third sector was “absolutely not” the Government’s intention. Instead,

It is about finding those kinds of examples where they really make a difference and, wherever possible, creating the right environment where commissioners and others can have the tools and the organisations to get that to scale if we want it to happen28.

Ed Miliband echoed this distinction, telling the Committee that government would not “automatically transfer services into a particular sector because we simply assume in advance that it will always be superior…this is not the basis on which these judgements should be made”29. Just because faith based organizations have delivered healthcare services in the past does not mean that they retain this capability and can do so again, nor that they would significantly improve those services were they to deliver them. 60 years of the National Health Service is both a cause of for celebration and mourning; the all pervasive welfare state has removed from civil society the responsibility and the capacity to deliver many kinds of service:

[Steve] Chalke argues that all he is doing is picking up and renewing the tradition of Christian social activism that the welfare state commandeered in the 1945 government. "In 1921, my church had nine medical staff and ran a clinic, but the state took off churches their welfare role. The welfare state was set up slightly wrongly; it set up a division between government and citizenship that has led to the decline of the public realm…”30.
Should faith based organisation seek further commissioning for the provision of health services? There is no simple answer. According to Nick Spencer, it is always the task of the church to engage in public action on behalf of those in need. In other words it will always, if being true to itself, be in the business of ‘services to the public’. When and where these become public services is a matter of judgement, will it result in public good? Certainly there are examples where this has been the case, and a closer and more sympathetic partnership will improve matters still further. It would be to the disadvantage of the public, however, if faith based groups were forced, for instance, to compromise the high (theologically grounded) view of the individual in order to deliver services. If the regulatory environment makes this demand, or if public sector procurement practices squeeze out distinctiveness, innovation, and flexibility, then ‘added value’ will never be significant.

In closing, it is worth noting that even within the “command and control” healthcare system, there are a small number of non-profit hospitals associated with religious bodies. This includes several hospitals run by the Hospital Management Trust (HMT), a registered charity with objectives of promoting and developing the services of charitable and religious hospitals and care homes. The field of healthcare is already open for a confident, well organised and entrepreneurial faith-sector – particularly in delivering holistic care which acknowledges the physical and spiritual needs of service users – but it will be on the basis of an ongoing negotiation with the public bodies and a refusal to enter into a fixed logic of partnership with the state.

------------------

1 Kelly, Josie. ‘Reforming the Public Services in the United Kingdom: Bringing in the Third Sector’. Public Administration, Volume 85, Number 4, December 2007 , p. 1003
2 Finding comprehensive definition of the Third Sector has been notoriously difficult, since it includes a variety of different types of organisations ranging in size from local neighbourhood watch groups to £multi-billion charities employing thousands of people. For ease, we intend a broad definition here: the ‘third sector’ is that part of society which is neither part of the public nor private sectors, and include charitable initiatives, social enterprises to mutual interests groups.


7 House of Commons Hansard, 9 July 2008: Column 1422


11 *Faith Based Voluntary Action: Mapping the Public Policy Landscape*

12 Home Office Faith Steering Group, February 2004: p.61

13 *Faith Based Voluntary Action: Mapping the Public Policy Landscape*

14 *Faith Based Voluntary Action: Mapping the Public Policy Landscape*


17 Kelly, Josie Public Administration, Volume 85, Number 4, December 2007 , p. 1018


20 ibid, p. 108.

21 ibid, p. 128.


23 See [http://www.stchristophers.org.uk/page.cfm/Link=2/t=m/goSection=2](http://www.stchristophers.org.uk/page.cfm/Link=2/t=m/goSection=2)


25 Ibid.


29 Ibid, p. 20.
31 Spencer, Nick, Neither Private nor Privileged, Theos, 2008, p. 35
Conclusion

Religious belief and practice have significant implications not only for individuals but also for healthcare service. The aim of this report has been to demonstrate that healthcare professions and institutions can and should engage with faith and religious institutions in order to improve patient outcomes. A variety of opportunities are open for partnership between healthcare practitioners and religious institutions which could enhance the work of the National Health Service.

The underlying logic of this report is that faith is becoming a more, not less, significant part of life in Britain. Currents of migration which flow from South Asia, Africa and Eastern Europe have brought diverse religious beliefs and practices to many communities: Roman Catholicism is projected to become the largest church in the United Kingdom in the near future and so called Black Majority churches have provided a significant fillip to urban Protestant Christianity. Muslim communities are also growing, by recent reports at a rate of nearly half a million in the last six years. For healthcare practitioners and institutions, the presence of these faith communities can provide both challenges – because of ethnically associated healthcare issues and cultic practices which impinge on the health of the individual – but also opportunities: successive governments have and will continue to harness faith communities’ energy for social and collective action, and mine the theological resources of religious belief for the values that underpin and sustain public institutions like the National Health Service.

The role of Chaplains within healthcare institutions, briefly reviewed in Chapter 1, is perhaps the most visible influence of ‘faith’ related work within the NHS, yet a neat, measurable and compelling justification of their role and contribution to health has thus far been lacking ‘hard’ data (p.14). Nonetheless there is much to suggest their utility and continuing relevance, both for staff and patients, as councillors, mediators, translators, teachers, watchdogs as well as their more traditional role.
Whilst it is important to recognise that “the government desire for measurement is such an unsatisfactory way of improving public services because what matters is never measurable and what is measurable rarely matters”\(^1\), a better evidence-base for the role of chaplaincy may nonetheless be important for making visible the valuable role they play and, in blunt terms, to serve as a continuing defence of their presence as a publicly funded NHS service when financial resources are scarce. It may be that the work of Koenig and Atonovsky cited in Chapter 2, respectively regarding the psychoneuroimmunological effects of spiritual care and the importance of a ‘sense of coherence’, may be the basis of such a research programme. The sense of spiritual, moral and ethical perspective chaplains bring, along with a wider social ‘sense of coherence’ would seem to point towards highly positive benefits for patients and staff alike. Given the arguments presented in Chapter 2 around the importance that healthcare professionals are aware of, and sensitive to, religious/spiritual sensibilities and concerns of patients, a further role of chaplains, as trainers and advisors, becomes plain. Whilst Chapter 2 recommends the continuing division and specialisation of labour between clerics and medics, the greater understanding of spiritual needs and bases of a ‘sense of coherence’ by professionals, the more effective and holistic care they are able to offer.

Chapter 2 also considered the significance of the concept of trust within faith traditions and healthcare institutions. In the healthcare setting, the patient is required to place their trust in abstract systems and expert-strangers\(^2\) (those individuals whose expertise we must depend upon in spite of a complete lack of familiarity). In such a context, the ability of patients to trust is vital, not least as a “bracket against anxiety”. Religious faith may attenuate a sense of risk and vulnerability, and have a strong utility in assist patients to cope with illness or the stress of a healthcare environment.

Chapter 3 noted the importance of faith for health, and the correlation between poor health and religious observance represents a means by which health inequalities, as faced by older people and certain ethnic minorities for example, may be usefully targeted. This – alongside the norms, cohesion,
resources and governance which faith-institutions can contribute to the public sphere and healthcare environment in particular – makes clear the potential role for the contracting out of services to faith based organisations. There are, we have noted, some risks associated with embarking on these partnerships: one is that faith based organisations will introduce exclusivity into public services, another that public bodies will be so instrumental in their approach to faith based organisations that the values, norms and corresponding motivations will be “squeezed”. This report argues that the former is overplayed – the theological themes behind faith based engagement in welfare services tend to be universalist rather than exclusive – and the latter underplayed – state actors can treat faith based providers perversely, ironical demanding that they abandon their strong theological attitudes that underpin their social capital. In policy terms, the line between ensuring that contacted-out services remain genuinely open to all and undermining the very rationale for engaging religious groups in welfare provision is a thin one. With this in mind, this report argues that neither public bodies nor faith based agencies should become fixed in their approach, but remain flexible and open to opportunities when are where partnership is feasible. Meanwhile, faith based agencies should exercise caution and avoid being drawn in by political hyperbole on supply side reform (when only 2% of public spending goes to the voluntary and community sector).

Globally, there are a series of attractive case studies which could be developed and deployed in a variety of contexts. The development of Faith Community Nursing in Australia, along with the Parish Nurses movement in the United Kingdom, suggest that there may be a case for dedicated nursing teams across the faith traditions, trained specifically to meet the unique healthcare needs of particular communities, simultaneously taking advantage of the point of access that the faith community may provide in tackling public health inequalities. The Bromley-by-Bow centre is an example of a more positive approach to health promotion and illness prevention, grounded in the metaphysical and physical space of a faith tradition, and precisely because of this remaining open to the community as
a whole. The Austrian LIMA projects provide a further example of faith communities can be a site of engagement with groups of vulnerable people, in this case, the elderly. All three utilise the social capital and connections of the institutions, as well as the health-enhancing aspects of the beliefs and spiritual wellness.

**Recommendations**

In conclusion, how should healthcare providers respond to the arguments put forward in this report? Theos would like to offer the following recommendations

1. Primary Care Trusts should continue in enthusiastic support and development of chaplaincy services, while at the same time engaging chaplaincy teams in programmes of research aimed at developing an evidence base for their work. In short, chaplaincy need to be better understood by administrators and practitioners.

2. Primary Care Trusts should seek to develop training programmes for staff on the spiritual needs of patients as an integral part of their approach to equality and diversity. This is another area of work where chaplaincy teams should be usefully engaged.

3. Healthcare institutions, particularly those carrying public health functions, should consider whether faith communities can provide points of access to socially disadvantaged groups, such as the elderly or particular ethnic minorities. Where this is the case, specific projects can be launched to make connections, through faith communities, with those vulnerable groups.

4. Primary Care Trusts should begin to purposively explore appropriate partnerships with local faith based organisations, following existing models of good practice.

Selected Bibliography


Donovan N, Halpern D. *Life Satisfaction: The state of knowledge and implications for government*. Prime Minister’s Strategy Unit, 2002


Froggett L, Chamberlayne P, Wengraf T, Buckner S. *Bromley by Bow Centre research and evaluation project*. London: Bromley-by-Bow Centre

Furedi F. *Culture of Fear: risk taking and the morality of low expectation*. London: Cassell; 1997


Kelly J. ‘Reforming the Public Services in the United Kingdom: Bringing in the Third Sector’. Public Administration 2007; 85:4


Kierkegaard, S. Concept of Dread. Princeton: Princeton University Press; 1957


Kotecki C. ‘Developing a Health Promotion Program for Faith-Based Communities’. Holistic Nursing Practice 2002; 16(3):61-69


Luhmann N. Trust and Power. London: Wiley; 1979


Poortinga and Pidgeon N. ‘Exploring the dimensionality of trust in risk regulation’ Risk Analysis 2003;23:961–73


Sheikh A. Should Muslims have faith-based health services? British Medical Journal 2007; 334:74


Spencer N, Neither Private nor Privileged, Theos, 2008.

Swinton J. ‘Rediscovering Mystery and Wonder: Toward a Narrative-Based Perspective on Chaplaincy’ Journal of Health Care Chaplaincy, 13:1, 2002


