DOUGLAS HYND

The Limits of the Market: Christian Reflections on the Economics of Health Care

INTRODUCTION

Health care has been making media headlines in some form or another just about every week over the last few years.

This paper suggests some reasons why this is the case and why the sense of crisis and the headlines are unlikely to disappear. The reasons for this lie in social assumptions and expectations about health care and the religiously rooted narratives that underlie their provision.

This paper uses the analysis of Western societies offered by Fred Hirsch to suggest in general terms why unfettered confidence in the market system may not deliver socially and morally satisfactory outcomes. I then go on to analyse the economic dynamics of health care provision as a case study of the general process.

Issues to do with choice and allocation at both macro and micro levels are then examined in the light of basic Christian affirmations about the world, Christian responsibility and the life of the church.

1. THE POLITICAL ECONOMY OF HEALTH CARE

The perspective I will apply in an evaluation of health care policy and medical practice is that of political economy. I mean by it the consideration of the issues of choice and the allocation of resources as they are shaped by and shape institutions and culture. Let me just note two implications of this perspective:

(i) the process of economic analysis itself is not value-free. It cannot be neatly disentangled from the commitments, intellectual and religious, and the personal experience of the person of community undertaking the analysis. [1]

1. This perspective has been defended at length in a recent important paper by Ross B. Emmett, *Christian Social Thought Embarrassed by God's Presence?* The issue is also dealt with by Paul Heyne in *Moral Judgements on Economic Systems,* a paper presented to the Conference of Anglican Economists, Winnipeg, May 27-28, 1986. See also my paper *'Between the Gospel and the Enlightenment: the Christian Economist as 'Theologian'.*

DOUGLAS HYND is a Research Officer, Senate Committee Office, Parliament House, Canberra.

(ii) the actual process of choice and allocation of resources is an inter-active one in which the process of institutional choice is not value neutral. Cultural consequences follow from economic choices. [2]

This perspective is exemplified in the important analysis by Fred Hirsch *The Social Limits to Growth* (Harvard 1978).

He begins his analysis by asking three critical questions.

1. Why has economic growth in western industrialised countries remained such an attractive goal even though so many of its fruits have proved and continue to prove disappointing and the focus for widespread discontent? He terms this one "the paradox of affluence".
2. Why is there a continuing strong focus on distributional issues — dividing up the economic pie when, according to the received wisdom, living standards can only be raised by baking a larger pie? This he terms "the distributional compulsion".
3. Why is there a continuing trend toward collective provision and state action on economic issues at the same time as individual freedom of action is praised and indeed given a very free reign in non-economic areas of life, e.g., art appreciation and sexual mores, children's rights, etc. This third phenomenon Hirsch describes as "reluctant collectivism".

Hirsch's argument very simply put is that these three symptoms displayed in western industrial countries are not random but are interconnected and the result of a particular structural characteristic of modern economic growth. In outlining the questions in this way, Hirsch has already given recognition to the significant two-way interaction between economic behaviour and religious commitment.

The characteristic that links these phenomena is that, as the average consumption rises above the life-sustaining stage of basic necessities, an increasing proportion of consumption takes on a social dimension. The satisfaction that you derive from the consumption of goods and services increasingly depends not only on the fact of your own consumption, but on the nature and extent of others' consumption of those goods — in economic terms our preferences become increasingly interdependent. A simple example of this is traffic congestion: "... conditions of use begin to deteriorate as use becomes more widespread" (p.3). This applies not only to cars and the traffic congestion consequent upon their increasing availability, but also to dimensions of life such as recreation and less obviously to education. "Social scarcity is a central concept in this analysis ... the good things of this life are restricted not only by physical limitations of producing more of them, but also by absorptive limits on their use" (p.3).

Time is also a critical element in the understanding of the reality of social scarcity. Much consumption theory is developed in the context of a historical world, but this is mistaken. The earliest persons to achieve a certain level of education, for example, enjoy a distinct advantage over those who achieve it, say, ten years later, when many more people will have reached that particular level.

2. An example of this in an area close to the concerns of this paper can be found in the famous study by Richard Titmuss on blood donation — *The Gift Relationship.*

> "Opportunities for economic advance, as they present themselves serially to one person after another, do not constitute equivalent opportunities for economic advance by all. What each of us can achieve, all cannot" (Hirsch, pp4-5).

Above a certain basic level, one's relative place in the economic queue becomes critical. The dynamic process of growth heightens the struggle over distribution. In areas of social scarcity which Hirsch regards as forming an increased proportion of the economy, what you can get depends to an increasing extent on where you are relatively in the economic hierarchy. An increase in the total economic pie would be of little advantage to you if you are low in the pecking order and might even heighten the struggle for socially scarce "consumption" items.

This raises the problem of translating individual economic improvement into overall improvement. To see total economic advance as simply individual advance writ large is to set up expectations that cannot ever be fulfilled (Hirsch, p.9).

The possibility of translating overall economic advance into individual advance in areas of social scarcity requires acceptance of limitations and broad societal co-operation. For without these qualities, the only other way of avoiding competition in frustration is explicit government control and co- ordination and that brings with it other problems that we are all too well aware of. Only a collective approach whether voluntary or mandatory can offer individuals any possibility of achieving an outcome that they themselves would prefer.

By collapsing individual and total opportunities for economic advancement into a single process grounded on individual valuations, the standard view has . . . overstated the promise of economic growth. It has understated the limitations of consumer demand as a guide to an efficient pattern of economic activity. It has obscured the extent of the modern conflict between individualistic action and the satisfaction of individualistic preferences (Hirsch, p.10).

So much by way of background. Within the context of these societal dynamics I want to present for your reflection certain axioms relevant to the economics of health care that were enunciated a number of years ago by Aaron Wildavsky, then Dean of the Graduate School of Public Policy at the University of California at Berkeley, in an article entitled "Doing Better and Feeling Worse: The Political Pathology of Health Policy".

1.1 The Basic Equation

The basic equation with which Wildavsky begins his analysis is the general assumption by the public that medical care equals health or is at least closely correlated with it. As he rightly notes, the equation is quite wrong. 90% of the influence on indices used to measure health — physical and mental well-being — derives from factors over which doctors have little or no control. [3] At a macro level the scope for the improvement of health through addition-

3. For evidence of this see *Health, 'Illith' and Economic Growth: Australia 1931-1975*, a paper presented by Dr. G. Egger to the World Federation for Mental Health Annual Congress on Mental Health and Economic Growth, Copenhagen, Denmark, August, 1975.

al expenditure on drugs, technology, doctors and hospitals in Western industrialised countries is severely limited. There are even situations where it could be downright dangerous, by facilitating unnecessary operations and the excessive prescription of drugs, for example. Table 1 indirectly demonstrates this point. There is a substantial variation between States as to the extent of use of health care facilities, even when the same age groups are compared. Usage at a macro level seems to require sociological explanations rather than being directly attributable to illness. If the latter were the case, either New South Wales residents are 20% more ill than their Victorian Counterparts, or Victorians are a much more stoic lot!

An international comparison by John Cooper reaches a similar set of conclusions. At the end of his study he puts forward four propositions — which I think are worth noting.

(i) The first is that differences in relative levels of health spending are not a response to obvious differences in need for health care between countries.
(ii) The second is that those aspects of health care delivery which are most readily accessible to intervention by national government, have little obvious impact on overall levels of health spending. These aspects include public or private ownership of health service institutions, the coverage of national health schemes and the manipulation of health insurance and other health service funding arrangements. Of course these aspects have a great deal of impact on where the brunt of expenditure falls between the public and the private sector.
(iii) The third is that the basic supply structure of the service delivery system, in terms of both facilities and manpower, does probably have an influence on overall levels of health spending. Governments have great difficulty in changing the supply structure at least in the short term...
(iv) The final proposition is much more speculative. It is that there are probably complex sets of factors, which are deeply enmeshed in different national cultures, and which fundamentally underlie the very substantial variation in relative levels of health spending between countries. Such factors, I believe, are likely to include: social and cultural expectations of health services; the norms and organisation of medical practice and the norms of practice and organisation of other health professions; patterns of geographic and social mobility; and different social and community support structures. (Cooper, p.61).

TABLE 1
Average number of Medicare Services per head, 1985-86

State	Boys 0-4	Men 55-64	Women 25-34	Women 65-74
NSW	10.5	10.2	11.3	14.7
Victoria	8.7	8.0	9.3	12.2
Queensland	9.4	8.1	10.0	14.1
South Australia	10.5	8.7	10.1	12.2
Western Australia	8.0	7.9	9.5	11.8
Tasmania	8.9	7.0	9.5	11.7
ACT	9.0	7.1	9.1	10.3
Australia	9.5	8.8	10.2	13.3

Source: HIC Annual Report

(J. Waterford, 'The unhealthy cost of our health care', Canberra Times, Jan. 25 1987).

(Table 1 shows different rates of use among the same age groups among the States; age structures tend to distort comparisons a bit).

The possibilities for improvement in the provision of health care would seem to be then at the micro level. This implies the re-allocation of resources to allow more efficient and equitable services as between regions, target groups or types of medical practice or service. There is a hidden nemesis lurking in this apparently obvious solution. This manoeuvre does not allow us to escape what Wildavsky calls 'The Paradox of Time':

> . . . past successes lead to future failures. As life expectancy increases and as formerly disabling diseases are conquered medicine is faced with an older population whose disabilities are more difficult to defeat. The cost of care is higher both because the easier ills have already been dealt with and because the people to be treated are older. Each increment of knowledge is harder won: each improvement in health is more expensive. Thus time converts one decade's achievements into the next decade's dilemmas (Wildavsky, p.531).

A quick inspection of Table 2 suggests the order of magnitude of the medical costs that we face due to our success to date.

TABLE 2
Average Hospital and Community Health Expenditure per Head in Australia 1981-82

Age	Spending per head $	$ average for total population
0-15	95	36
16-24	134	50
24-39	173	65
40-49	181	68
50-54	271	102
55-59	392	147
60-64	498	187
65-69	623	234
70-74	726	273
75 plus	1825	686

(J. Waterford, "The unhealthy cost of our health care", *Canberra Times,* Jan. 25, 1987. [4]

4. Note the summaries of two recent U.S discussions on cost containment and the forces underlying expenditure on health in that country:
'Current strategies for controlling hospital costs have focused primarily on eliminating care that is presumed to be of no medical value. These efforts have neglected the central fact that eliminating such care reduces current expenditures, but has little or no influence on three key factors responsible for the upward trend in real costs — population growth, rising input prices ('the hospital market basket'), and technological innovation and diffusion. Ageing of the population and the rising costs of malpractice insurance have received undue attention; together they can account for only three tenths of a percentage point in the upward trend. Gradual elimination of presumably useless care, perhaps as much as 30%

In a satirical way the economics of aging were dealt with in a recent episode of 'YES, PRIME MINISTER'. That popular hero, Prime Minister Jim Hacker, addressing the urbane Sir Humphrey Appleby, remarked that:

> . . . a hundred thousand unnecessary deaths a year — minimum — is a hideous epidemic. He agreed that it was appalling. So I went for the kill. 'It costs the NHS a fortune to deal with the victims. So the Treasury would be delighted if we discouraged it'. This was a tactical error, Sir Humphrey swung confidently on to the offensive, 'Now, I think you're wrong there, Prime Minister'. I couldn't see how I could be wrong. 'Smoking-related diseases', I said, referring to Dr. Thorn's paper which I had in front of me, 'cost the NHS 165 million a year'. But Sir Humphrey had been well briefed too by the Treasury and by their friends in the tobacco lobby. 'We have gone into that', he replied, 'It's been shown that, if these extra 100,000 people a year had lived to a ripe old age, they would have cost us even more in pensions and social security than they did in medical treatment. So, financially, it is unquestionably better that they continue to die at about the present rate (Jay and Lynn, p.195).

1.2 The Principle of Goal Displacement

The next move by medical practice and the accompanying bureaucracy is to invoke the Principle of Goal Displacement. Simply stated, any objective that proves to be impossible or difficult to attain will be replaced in official policy by one whose achievement can be at least approximated. Since improvements in health are increasingly difficult to attain, the goal of improved health becomes equated with equal access to medical care. But it must follow that since medical care does not equate to or prove to correlate closely with health, ac-

---

of inpatient-days, can save many billions of dollars, but can only offset for a few years the forces causing costs to rise in US community hospitals. Indeed, in 1984, the reduction in patient days and resultant slowing in the real rate of rise to 2.1% appear simply to have concealed an underlying real rate of increase that was close to 7%. After all, unnecessary days have been eliminated, the underlying rate of increase will reemerge unless limitations are placed on technological innovation or beneficial services are rationed'. Abstract of 'The Inevitable Failure of Current Cost-Containment Strategies' by William D. Swartz. JAIMA, Jan. 9, 1987, Vol. 257, No. 2, p.220.).

'What about the longer term? Clearly there is an upper limit on the proportion of the GNP that the American people will be willing to spend on health care — possibly 15% perhaps as much as 20%. But before we reach that theoretical upper limit, other forces may come into play. We could face a major crisis in the federal budget which could lead to the transformation of Medicare into a means-tested programme. We could fail to provide essential care to increasing numbers of uninsured persons, thereby creating renewed political momentum for national health insurace. The competitive position of American business could become so endangered that a growing number of large, medium-sized, and small corporations would have no alternative but to cut back on employees' health care benefits. One can think of other pressures and responses, including limiting the introduction of high cost technology and explicit attempts to ration high cost treatments.'

'A society such as ours — which places a high value on pluralism, which is enthralled by technology, which resists domination by the federal government, which accepts the prevailing inequality of income and wealth, and which promotes the sovereignty of consumers — is not likely to opt for serious constraints on biomedical research and developme: or to favour the explicit rationing of proved health care services to the public. Its concerns are more likely to be focused on ensuring access for the entire population to an effective level of care and on finding a way of covering the health care costs of those who cannot pay their own way. Until we approach the upper limit of acceptable health care expenditures — an eventuality that may be far in the future — cost containment is likely to remain the elusive hare that the hounds pursue but never overtake'.

("A Hard Look at Cost Containment" by Eli Ginzberg, *New England Journal of Medicine,* Vol. 316 (18), 30 April, 1987, p.1154.)

cess to medical care (except for marginal cases) is to a large extent irrelevant to health. Caring then comes to replace health as the goal of social policy. Access, however, remains the measure of caring, by at least one of the few publicly 'objective' measures available. As Wildavsky comments:

> For if we don't know what caring is or how much of it there should be, we can always say that at least it should be equally distributed (p.532).

Each step along the path that we have taken opens up further problems. The amount of care demanded within Western Industrial societies is apparently insatiable, for reasons that I think are at root religious and which are manifested in our visions of life and the basic narratives that orient our social structures and political activities. Of that more later. There is an accompanying potential for limitless appeals for funding of various forms of bio-medical research — the need growing exponentially with the increasing sophistication of research techniques and medical technology. At the level of delivery of services, questions of distribution become more and more acute. Mechanisms for rationing apart from a purely market approach include time, distance, lack of publicity, complexity of admission procedures, ethics, committees and/ or any combination of the above. [5]

1.3 Uncertainty

There is a further factor at work in boosting the demand for medical care. This is uncertainty. Paradoxically, the impact of uncertainty in increasing the demand for medical services has grown in direct proportion to improvements in technical knowledge and technological capability. [6] According to Wildavsky:

> If medicine is only partially and imperfectly related to health it follows that doctor and patient both will often be uncertain both as to what is wrong or what to do about it . . . The Medical Uncertainty Principle states that there is always one more thing that might be done — another consultation, a new drug, a different treatment. Uncertainty is resolved by doing more . . . If everyone uses all the care he can, total costs will rise . . . The doctors resolve uncertainty by prescribing up to the level of the patient's insurance (p.533).

The clash between the perception of individual need and the limits of social provision become stark and inescapable at this point. No matter how rationally you or I might discourse about average rates of disease, accessibility of

---

5. See Dr. John Deeble, 'The Boundaries of Health Policy' in M. Tatchell Ed. *Perspectives on Health Policy,* Health Economics Research Unit 1984, pp.13-22.
6. See, for example, the problems posed by developments in heart transplant and replacement technology:

   'Just as the advent of renal dialysis and transplant thrust Medicare into the significant expenses of the End-Stage Renal Disease Programme, so the advent of cardiac replacement will create pressure to finance some portion of the cost of the artificial heart. If this happens, the added burden on publicly financed health care will force certain budgetary re-allocations. These are likely to affect less visible, less 'urgent' expenses such as those for health education, screening, prevention, community clinics, hospital stay, and so forth. Relatively small restrictions in already underfunded programmes may have larger effects on access to care and on the health of the population. In this way, the advent of a new rescue technology can threaten the health of many who depend on public support for their health care. And these are not, it must be noted, only the 'underprivileged', but many made poor by age or by heavy medical expenses due to catastrophic'illness', (Jonsen, p.10-11).

care, success of various treatments — when it comes to the specific case where we are facing illness, we do not recognise ourselves in those statistics. Our chances may be better than average, our needs demand special treatment. [7] Judged from the viewpoint of the individual, this is perfectly rational:

> Most people told that the same funds spent on other purposes may increase social benefits will put their personal needs first. That is why expenditures on medical care are always larger than any estimate of the social benefit received (Wildavsky, p.534).

1.4 The Law of Medical Money

The final axiom that we need to take note of is the Law of Medical Money, which states that medical costs will rise to equal the sums of all private insurance funds and government health expenditure. The only limit on medical costs will come from competition from the demand for resources from other areas of human activity and need.

1.5 In Transition

In a somewhat light hearted way, Wildavsky's axioms bring out clearly why we face a continuing — indeed an ever-increasing problem in allocating resources for medical care. Industrial disputes over the past two years, involving nurses, particularly in Victoria, have highlighted the pressures that face decision-makers, as well as the care givers themselves. A brief outline of some of the questions raised by the disputes will provide a helpful transition from economic to theological/ethical issues.

The dispute brought clearly into focus the issue of limited resources — better salaries for nurses meant fewer resources for other aspects of health care. Within the nursing profession there was a clear tension — they of all people were well aware of the overall limitations of resources.

Several narratives or stories about nursing were clearly displayed and equally clearly are difficult to reconcile in practice. One story had to do with the issue of economic justice and fair reward for nurses. There was at least a partial recognition that this did not sit easily with the historic narrative of care, sacrifice and identification with the needs of the patient that has traditionally provided nurses with a clear identity. Almost submerged but in partial conflict with both was an emerging narrative having to do with the status of nurses as educated, technically-qualified professionals challenging the accepted power relationship of subordination to the medical profession.

Debates about morality in situations of conflict are almost always debates about the exercise of power. But note the assumptions implicit in the narra-

7. The problem is spelled out by Sax in the following terms: 'R.G. Evans, a Canadian economist, drew my attention to two widely held misconceptions about medical care: that the quantity and nature of attention needed by a patient can be precisely specified and generally agreed, and that the appropriate cost of providing what is needed is easily determined by estimates of the cost of 'best-practice technology' associated with the payment of fair fees, wages and profits to the providers. In fact:
   1. Professional opinions about any clinical situation vary widely, and the nature of the response has tended to expand over time.
   2. There is no innate tendency for providers to select the most cost-efficient mode of care.
   3. Providers of health services share a common human feeling that whatever their level of income, it is not enough'' (Sax, p.225).

tive. The patient is by implication powerless. Perhaps it would be more truthful then to speak about patients as victims, at the mercy (however tender) of those who are 'in control', with their knowledge, status and technology.

In reflecting on this dispute I was left with the question — can we maintain an ethic of care and identification with suffering while providing economic justice for nurses and simultaneously struggling for appropriate recognition and status for them alongside medicos?

All these narratives concern substantial goods, yet in the world we live in it may not be possible to realise all three simultaneously. The struggle for one good may quite unintentionally render other goods unachievable.

2. TRAGEDY AND TECHNOLOGY: THE CHRISTIAN NARRATIVE

Anyone wishing to say something distinctively Christian faces some difficulties in a pluralistic society, including being guilty of bad manners by focusing on issues which bring out deeply-rooted differences. Yet to avoid this task is to acquiesce in a practical atheism.

Christian ethics depend upon the power of a narrative about the world, the gospel, and the convictions arising from that narrative to shape a community that is able to face truthfully and compassionately the nature of our world.

This is to relocate the focus of Christian social ethics from the attempt to apply 'principles' to cases, to the formation of a people with the virtues and commitment that enable caring to continue in the face of inescapable tragedy. The connection between the limitations imposed by financial resources and the meaning of tragedy is made clear by Allan Verhey:

> It is 'scarcity' which makes allocation decisions necessary, it is 'sanctity' which makes them tragic. For when the goods or services to be allocated are goods and services on which life or health may depend and when the unbounded love of God for each one requires that we regard each life as of equal value then the necessary allocation decision is necessarily tragic.
>
> The notion of tragedy is not just the 'sad story' but the Sophoclean sort in which goods collide and evils gather. Because goods collide, to choose one good is to choose against another good . . . Because evils gather, they cannot all be avoided, but of course we must never choose the evil. The financial crisis of medicine requires tragic choices of this sort.

And it is here that our real difficulties begin. It is not easy to live daily with tragedy. Ways are found individually and collectively to avoid acknowledging the tragic nature of our activities, in fact to re-describe what is occurring. Christians as a community can make a distinctive contribution to the shaping of society's practices and attitudes to the economics of medical care and research by refusing to take this option. The virtue of truthfulness extends far beyond 'the lie proper'.

The theological rationale for such a stance is found in the biblical narratives which speak of our finitude and created nature, our brokenness and self-deception, and the continuing prophetic criticism of the idols or false gods whom we continue to worship in place of the true and living God:

> Perhaps because medicine reminds us so vividly of tragedy we have used it ironically and self-deceptively to hide and deny tragedy and the limits posed by our mortality and the finitude of our resources. (Verhey, p.11).[8]

2.1 The Issue of Limits

If tragedy is to be acknowledged for what it is, then truthfulness is required as a communal as well as an individual virtue.

Technology still remains as a central self-deceptive way of seeking to avoid tragedy. There is an irony in technological developments in medicine. To the extent that these developments are the expression of a drive to overcome our human limitations and finiteness and so to overcome tragedy, they have had the consequence of making allocational decisions more difficult. Medical administrators, doctors and nursing staff are faced with more and more complex decisions when it comes to issues of life and death. [9] I would not want to be misunderstood on this point. The crisis we face in medical care is not simply the result of scientific medicine. It is the result of our failure to clearly acknowledge the physical and moral limits involved in any attempt to care for one another. Stanley Bauerwas puts the matter provocatively:

> . . . much of the debate about when someone is 'really' dead is not simply the result of our increased technological power to keep blood flowing through our body, but rather witnesses to our culture's lack of consensus as to what constitutes a well lived life. In the absence of such a consensus our only recourse is to report to claims and counterclaims about 'right to life' and 'right to die' . . . . Moreover, the only means it seems to have to create a 'safe' medicine is to expect physicians to treat us as if death is the ultimate enemy to be put off by every means. Then we blame physicians for keeping us alive beyond all reason, but failing to note that if they did not we would not know how to distinguish them from murder ('Salvation and Health', p.213-214), *Theology and Bioethics* 1985, D. Reidel Publishing.)

2.2 Strategies for Allocation

Beyond the appeal to technology or re-describing our activities, we are faced with two possible strategies if we seek to deny the tragic nature of allocational choices. They are (i), to deny 'sanctity' or (ii) to deny 'scarcity'.

A look at the response to the kidney dialysis crisis in the United States in the 1960's provides evidence of both strategies being resorted to. In 1961, the Seattle Artificial Kidney Centre set up a selection committee to allocate scarce medical treatment to the most deserving. The socio-economic background of those judged most deserving bore an uncanny resemblance to the makeup of the selection panel. This was clearly a denial of 'sanctity', of the equal value of the lives of each of the medically acceptable candidates. The strategy of denial of 'scarcity' came at the national level, through the attempt of

8. Jacques Ellul, the outstanding French sociologist and lay theologian, has written some powerful critiques of contemporary society along these lines, e.g. *The New Demons,* Seabury Press, 1975; as has Bob Goodzwaard, *Idols of Our Time,* IVP, 1984; and J.A. Walter, *A Long Way from Home: A Sociological Exploration of Contemporary Idolatry,* Paternoster Press, 1979.
9. See the discussion by Bates and Linder-Pelz in *Health Care Issues,* Chapter 10, 'The Ethics of Rationing Health Care' which sets out a variety of perspectives on this issue.

Congress to provide universal funding for kidney dialysis, thus affirming 'sanctity'.

But the necessity to make allocational decisions cannot be denied for long. A clear separation of responsibility it seems is needed here. The absolute level of resources devoted to medical care must be in fact a social and political, not a medical, decision. We might find it easier to make it if we recognised our limits — financial, moral and spiritual. Within those limits, doctors will need to make choices of life and death. In one sense this is to ask a good deal of doctors: it is asking them to in a particular sense of the term, 'play God'. Paul Ramsey has made an important and helpful distinction here. Medical indications, he says, can be the doctor's only guidelines. Beyond that, when not all can live:

> Men should then 'play God' in the correct way: he makes his sun to rise upon the good and evil and sends rain upon the just and unjust alike . . . the equal right of every human being to live and not relative personal or social worth should be the ruling principle. When not all can be saved and all need not die this ruling principle can be applied only at best by a random choice among equals (Ramsey, p.256).

What other choice do we have if we are to be truthful? Who can perform the utilitarian calculations necessary to weight social worth? Who can predict the future and weigh the complexity of good and evil that a person represents? To acknowledge our limits is to demonstrate humility and leave the final judgement to God, whose mercy and compassion is beyond our understanding.

2.3 The role of the Christian community

One thing more. Those providing medical care to live and speak truthfully will need support. It seems doubtful to this observer at least if such a community, sustained by a narrative that will encourage one when cure is no longer possible, now exists within the practice of medicine.

> Those practicing medicine are called to be present in the mildest of continuing pain and exercising powers of life and death within all the limits of our finitude. How can such a commitment be sustained? Personal example and modelling is the key: people who have themselves learned how to be present amidst suffering and the church claims to such a community . . . a group of people called out by a God who we believe is always present to us both in our sin and our faithfulness. Because of God's faithfulness we are supposed to be people who have learned how to be faithful to one another by our willingness to be present with all our vulnerabilities to one another. For what does our God require of us, other than our unfailing presence in the midst of the world's sin and pain? (Hauerwas, p.221-2, 'Salvation and Health')

Thus the Church is not to be seen as a source of morality and legal codes or principles for ethics committees to apply, but rather as a school for the practices and virtues necessary to sustain the care of those in pain, and to support those carers facing the tragedy of choice and the need for truthfulness and compassion over the long haul. This raises problems in a pluralistic society. It may, therefore, be necessary in the future to find ways of acknowledging that medicine as a moral art is not a single 'value-free' practice, but may be informed by a variety of religious commitments. This will be par-

ticularly necessary at the institutional level of group practice, clinic or hospital. [10]

3. MODELS FOR CARING

The local church can provide a context in which the mismatch between individual expectations and social outcomes can be challenged by practical action, prophetic experiment and a renewal of worship. The Christian church has a narrative which should enable it to act with power and truthfulness: it tells of a God who identifies with the poor, the suffering, the refugee and the stranger. It reminds us in its liturgy of the finiteness of our lives; it is aware of our tendencies to idolatry and our attempts to deny the reality of death. It is irreversibly formed and renewed by a story in which is embodied both sacrificial love and hope, and the power to cast out the demonic.

The institutional life of the early Church gave shape to that story, and it is worthwhile to go back and open ourselves to that story again in the light of our current dilemmas. What can we gain then from a consideration of the early church?

1. When it is being true to its calling, the Church is intended to promote mutual care by its members for one another. This refers to all aspects of our lives: bodily needs, emotional support, social welfare. There may well be situations in which specialist care is necessary. On the other hand, there are many areas in which social assistance is currently required which should not be the case if the church is functioning as it should. As Robert Banks comments, 'The reality of Christian community life should prevent many ordinary social problems arising. It should also support people in such a way that they can cope with more serious difficulties, e.g.: those arising from bereavement, desertion, divorce, unemployment, retardation . . .' (Banks, p.40).
2. The Christian understanding of caring can provide models for action in the wider community. Co-operative and self-help groups are good examples. The means by which they operate rather than their specific objects are the key.
3. The Christian community can assist its members to develop a more critical approach in their role as patients or users of the health care system. This will involve challenging the communal assumptions and expectations as to what health care is and developing a less dependent approach to health care providers. Christians need to be given confidence to articulate their faith as it bears on decisions as to what form of treatment or therapy may be appropriate for them. We need also to be prepared to challenge the professionals on behalf of those who lack the confidence; those who are marginal people in claiming justice with respect to treatment and care.
4. Churches need to find ways institutionally of incarnating their commitment to hospitality and care for the poor and marginal that are appropriate in our time. Hospitals originally expressed this commitment. It may be doubted whether in most cases multi-million dollar investment in nurs-

10. For example, see the discussion by Veatch and Mason on the conflict between the Hippocratic tradition and the Judeo Christian tradition in medicine. They conclude that important differences exist and raise serious problems.

ing homes largely for the affluent adequately embodies a commitment shaped by the way of the incarnation and crucifixion. Drug addicts, alcoholics, the psychiatrically ill, the homeless immediately occur to mind as groups whose healing, empowerment and care are rarely suitably handled by current health care bureaucracies and institutions. Where is the Christian community in pioneering grass roots experience in hospitality?

5. The provisions of alternative modes of caring based on sacrificial giving can provide a powerful demonstration of the gospel as well as providing a vantage point from which to challenge the ethos of the bureaucratic welfare delivery system. I have in mind in this context the Hospice Movement. When faced with death, the efforts to control what cannot be controlled have become more extreme, and the resources needed to maintain care in the face of death, the last enemy, become even greater.

   In the face of death, the architecture, administrative structure and technological capability of hospitals combine to isolate the dying from the networks of care. Alternatives to our current isolation of the dying will not come 'cheaply' in religious terms at least. Alternative forms of care will require medical personnel who can practice a medicine which acknowledges its limits — carers who can bring their wisdom about the working of the body and their technical understanding as to how pain can be alleviated as a form of service. Knowledge in such a medicine becomes directed by the virtues of truthfulness, humility, and compassion.

   For such virtues to be formed and sustained in medical carers, churches will need to re-think the structure of their hospital ministry. They will need to encourage their members who are professional carers to begin reshaping the form of medicine they practice — a medicine which acknowledges that it is not in control, that neither denies tragedy nor acquiesces in it, but seeks the grace of God to continue to care day-by-day, sharing the 'groaning of creation', as we wait in hope for the 'resurrection of the body'.

ACKNOWLEDGEMENTS

This paper is a revised version of one given at the second National Bioethics Conference, April 6, 1987, at the Sydney Adventist Hospital. Thanks are due to Ian Dalziell and Mike Nelson for encouraging and critical comments in preparing that paper and to the House Church Group for listening with enthusiasm. Thanks too, to the Zadok Economists Group in Canberra, particularly Ken Bone and John Goss for their critical discussion of the revised version.

A first sketch of these ideas was published in *St. Mark's Review,* under the title 'Tragedy and Choice: the Limits of the Market and the Economics of Caring'.

REFERENCES AND FURTHER READING

Banks, R. *"The Early Church and Social Work Today"* Interchange, No. 30, 1982, pp.32-46

Bates, E. *"The Ethics of Resource Allocation"* Australian Health Review Vol.10, 1987, pp.9-13

Bates, E. and Linder-Pelz, S.	*Health Care Issues* Particularly Chapter 9 "The Diverse Effects of medical Technology" and Chapter 10, "The Ethics of Rationing Health Care"	Allen and Unwin, 1987. pp.115-130 pp.131-142.
Cassell, E. J.	"Do Justice, Love Mercy: The Inappropriateness of the Concept of Justice applied to Bedside Decisions", in Earl E. Shelp (Ed.), *Justice and Health Care,* D. Reidel Publishing,	1981, pp.75-82.
Cooper, J.	"International Comparisons, and Evaluations of Health Care Delivery Systems", in M. Tatchell (Ed), *Perspectives on Health Policy,* Health Economics Research Unit, ANU,	1984, pp.49-62.
Deeble, J.	"The Boundaries of Health Policy", in M. Tatchell (Ed), *Perspectives on Health Policy,* Health Economics Research Unit, ANU,	1984, pp.13-22.
Egger, G.	*Health, "Illth" and Economic Growth, Australia, 1931-1975.* Paper presented to the World Federation for Mental Health Annual Congress on Mental Health and Economic Growth	Copenhagen, Denmark, August, 1975.
Ellul, J.	*The New Demons,*	Seabury Press, 1975.
Emmett, R.B.	*"Christian Social Thought: Embarrassed by God's Presence?"* A paper presented to the Conference of Anglican Economists	Winnipeg, 27-28 May, 1986.
Ginzberg, E.	"A Hard look at Cost Containment", *The New England Journal of Medicine*	30 April, 1987, Vol. 316 (18) pp.1151-1154.
Goudzwaard, B.	*Idols of our Time*	IVP, 1984
Green, R.	"Altruism in Health Care" in Earl E. Shelp (Ed), *Beneficence and Health Care,* D. Reidel Publishing,	1982, pp.239-254.
Hauerwas, S.	"The Church in a Divided World: The Interpretative Power of the Christian Story", in Stanley Hauerwas, *A Community of Character: Toward a Constructive Christian Social Ethic.* University of Notre Dame Press	1981, pp.89-110.
	"Medicine as a Tragic Profession", in Stanley Hauerwas *Truthfulness and Tragedy: Further Investigations into Christian Ethics,* University of Notre Dame Press	1979, pp.184-202.
	"Salvation and Health: Why Medicine Needs the Church" in Earl E. Shelp (Ed), *Theology and Bioethics,*D. Reidel Publishing	1985, pp.205-224.
Heyne, P.	*Moral Judgements on Economic Systems,* a Paper presented to the Conference of Anglican Economists, Winnipeg	27-28 May, 1986.
Hirsch, F.	*The Social Limits to Growth*	Harvard UP, 1978.
Hynd, D.	*Between the Gospel and the Enlightenment: The Christian Economist as "Theologian",*Zadok Series 1 papers	S34, 1987.
	"Tragedy and Choice: The Limits of the market and the Economics of Caring", *St. Mark's Review*	No. 123/124, Sep/Dec 1985, pp.55-65.
Jonsen, A.R.	"The Artificial Heart's Threat to others", Hastings Center Report	Feb. 1986, pp.9-11
Lynn, J. & Jay A.	*Yes, Prime Minister,* BBC Publications	1986
Ramsey, P.	*The Patient as Person: Explorations in Medical Ethics,* Yale University Press	1970, pp.239-275.

Sax, S.	*A Strife of Interests: Politics and Policies in Australian Health Services,* George Allen & Unwin	1984.
Shwartz, W.B.	"The Inevitable Failure of Current Cost-Containment Strategies", Journal of the American Medical Association	Jan. 9, 1987, Vol. 257, No. 2, pp.220-224.
Titmuss, R.	*The Gift Relationship: From Human Blood to Social Policy,*	Penguin, 1970
Veatch, Robert M & Mason, C.G.	"Hippocratic vs Judeo Christian Medical Ethics: Principles in Conflict", *Journal of Religious Ethics*	Vol. 15, No. 1, Spring, 1987., pp.86-105.
Verhey, A.	"Sanctity and Scarcity — the makings of tragedy: reflections on a crisis in medicine", *Reformed Journal*	Feb. 1985, pp.10-14
Walter, H.A.	*A Long Way from Home: A Sociological Exploration of Contemporary Idolatry,*	Paternoster Press, 1979.
Waterford, J.	"The unhealth cost of our health care", *Canberra Times*	Jan. 25, 1987, p.2.
Wildavsky, A.	"Doing Better and Feeling Worse: The Political Pathology of Health Care", in T. Shannon (Ed), *Bioethics* (Rev. Ed),	Paulist Press, 1981, pp.529-553.