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Improving Spiritual Care to Bridge the Gap Between Demand and Supply of Healthcare Services in South Africa

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ABSTRACT: This article assesses the efficacy and sufficiency of spiritual care and calls for deliberate improvement to bridge the gap between the overwhelming demand and depleting supply of healthcare services in South Africa. Without disregard for other spiritual care groups, this article investigates the activities of healthcare chaplains and a few healthcare organizations in two municipalities in Gauteng which are Johannesburg and Tshwane. As a primary source, a mixed research method was used to collect data from healthcare chaplains, nursing managers, and hospital human resource managers. The outcome agrees with the global statistics that healthcare demand is rising while its supply is depleting. This leads to the question of necessary alternatives to bridge the gap between healthcare demand and supply. Consequently, this article recommends that healthcare chaplaincies, government health departments, healthcare organizations, theological institutions, community leaders, and healthcare professionals should pay more attention to improved spiritual care as an essential alternative support system in healthcare services.

KEYWORDS: Chaplaincy, demand, supply, efficacy, sufficiency, spiritual care

Background

There is a growing concern across the globe regarding the overwhelming demand and the depleting supply of services in the healthcare sector. The sector encompasses healthcare products and services, which includes many industries, sub-industries, and a variation of companies like healthcare services group, pharmaceuticals, biotechnology, equipment, distribution, facilities, and managed care (Ledesma, McCulloh, Wieck, and Yang 2015, 1-9). Among all, there is a growing concern in the healthcare services sector where the gap between the healthcare supply by healthcare professionals and the demand of the populace is increasing. For example, in mental healthcare, the fact sheet of World Health Organisation (WHO) shows that over 300 million people across the globe, regardless of region, culture, age, gender, religion, race, and economic status, had mental illness leading to depression and disability (WHO 2017). In Africa, WHO (2022) submits that above 75% of people suffering from mental healthcare conditions (MHCs) do not receive treatment (cf. Naylor et al. 2012). Further, WHO (2022) indicates that about 5 million annual deaths are caused by MHCs in low and middle-income countries like South Africa (cf. Mayosi et al. 2012, 380). In a similar report, depression has about 100 million victims in Africa, out of which 66 million are women (World Economic Forum [WEC] 2021). In addition, the World Bank opines that MHCs remain "The greatest thief of productive economic life" (WEC 2021). This comes with global economic costs of about 2.5 to 8.5 trillion dollars yearly, likely doubling by 2030. Agreeing further, WHO (2022) maintains that many mental health conditions can be effectively treated at a low cost. Yet, the gap between people needing care and those with access to care remains substantial. Thus, adequate treatment coverage remains extremely low (Caron 2021; Single Care Team 2022). According to Michas (2022), statistics show that in 2020, approximately 4 Nurses, 2 Psychiatrists, 1 Psychologist, 1 Social worker, and 1 other (Spiritual caregiver) are

the available mental healthcare workforce per 100,000 population. This figure supports the gap between the demand and supply of healthcare and the prevalence of healthcare inequality in today's world.

In primary healthcare, the South African private sector serves about 20% of the population via private health insurance, private hospitals, and modern facilities comparable to the best in the world. This leaves 80% of the South African population struggling with public sector services (RBS HCM Module 2016, 27). The shortage of public sector infrastructure is also caused by dilapidating health facilities. Likewise, financial mismanagement in health sector governance caused high medical inflation and a threat to medical insurance schemes. Aikman (2019, 53) reports that the Minister of Finance, Tito Mboweni, announced in South Africa's budget for the 2019/2020 financial year that the health department would receive ZAR222.6 billion, which is a large portion of the budget (cf. PricewaterhouseCoopers 2019). Despite these funds, South Africa's public hospitals are still under-equipped due to corruption, wasteful and fruitless expenditures. These practices are incongruent with government policies but only benefit specific individuals and their families. Furthermore, the 2017/2018 South Africa auditor general's report shows that only 25% of government departments received clean audits (Parliament Monitoring Group 2018). With such a poor accounts report, it can be inferred that financial misappropriation may increase the gap between the demand and supply of healthcare in South Africa (South African National Department of Health 2012).

Correspondingly, reports show long waiting times before patients see Doctors and Nurses, especially in public hospitals. Sadly, the population is consistently growing, but hospitals cannot meet healthcare demands (Trading Economics 2018). Although the flooding of South African hospitals by undocumented immigrants is seen as part of the reasons for the demand and supply crisis, no research supports such a claim. In the counterargument of Zulu (2019), it is more difficult for sick patients to migrate long distances. Meanwhile, the overcrowding of hospitals puts more people at risk of infections, causes a waste of time and extra transport costs on the side of the patients (Aikman 2019, 53). Lastly, there are limited healthcare professionals such as Radiographers, Physiotherapists, Nurses, Spiritual caregivers, and Traditional healers to facilitate primary healthcare. Bezuidenhout Joubert, Hiemstra, Struwig (2009, 211-15), and Medical Brief (2016) report the exodus of healthcare professionals. Reasons for national Doctors' and Nurses' outflow include a lack of finance, a quest for better job opportunities with commensurate remunerations, a high crime rate in the country, and poor training and development of new healthcare workers.

The background challenges discussed above increase the demand and supply gap of healthcare services in South Africa. The question then is – how can spiritual care through healthcare chaplaincy be improved as one of the bridges to reduce the gap in South Africa? Answering this question is the goal of this paper. This article presents evidence of the relevance of healthcare chaplaincy through primary source data obtained via quantitative methods from Pharma Valu Pharmacy and Clinics (PVPC). This is followed by qualitative data reports from Mediclinic and chaplaincy organizations, including Medical and Community Chaplaincy (MCC) and Emergency Services Chaplaincy of Southern Africa (ESCSA). Subsequently, the article presents data results vis-à-vis discussions on healthcare chaplaincy's efficiency, sufficiency, and challenges. Lastly, this article recommends improved spiritual care to bridge the gap between the demand and supply of healthcare in South Africa.

Method

A mixed research method that includes quantitative and qualitative data collection was used to gather information on how spiritual care is supplied to patients, their families, and healthcare workers in Tshwane and Johannesburg municipalities. The quantitative data were collected using seven questions (Q) via a Google survey questionnaire from Pharma Valu Pharmacy and

Clinics (PVPC) in Pretoria. The data was analyzed using Radar and Waterfall chats. On the other hand, the quantitative data via one-on-one interviews were gathered from PVPC, Mediclinic, MCC, and ESCSA.

Quantitative Results

The human resource (HR) and the store managers' reports show that PVPC is an over 20-year-old sub-health organization providing pharmaceutical and mini-clinic healthcare support with about 260 staff in South Africa. Since its inception, the organization has imbibed the culture of providing spiritual wellness to staff members using the services of chaplains in daily morning devotion. Seventy (70) staff members of PVPC participated in this spiritual wellness survey. With 260 staff, the sample population is about 37%. This percentage implies that participation exceeds the minimum sample population (5%) required. It then reflects research accuracy in terms of the efficacy of healthcare chaplains in PVPC. The data was collected from the two biggest PVPC branches, Queenswood and Sunnyside. See the outcome in Table 1 and Figures 1-3 below.

Table 1 – Spiritual care impact of morning devotion led by Chaplains in PVPC

Q	*Impact subject*	*Yes*	*No*	*Maybe*	*Not sure*
Q1	The desire for chaplaincy services by staff members	85.7	7.1	-	7.1
Q2	Impact of devotion on work motivation	90	1.4	8.6	-
Q3	Attraction (Chaplains' message, bible reading, prayers)	100	-	-	-
Q4	Wellbeing impact (Psycho-social)	84.3	4.3	8.6	2.9
Q5	The continuous desire for chaplaincy support in devotion	91.4	1.4	4.3	2.9
Q6	Impact on good customer service and staff interaction	89.9	-	-	10.1
Q7	Spiritual wellness impact on the business success	67.1	2.9	20	10

A. The desire for Spiritual Support (Q1, 3 and 5): Table 1 above shows that Questions (Q) 1, 3 and 5 are tailored towards discovering the staff's desire for spiritual wellness support.

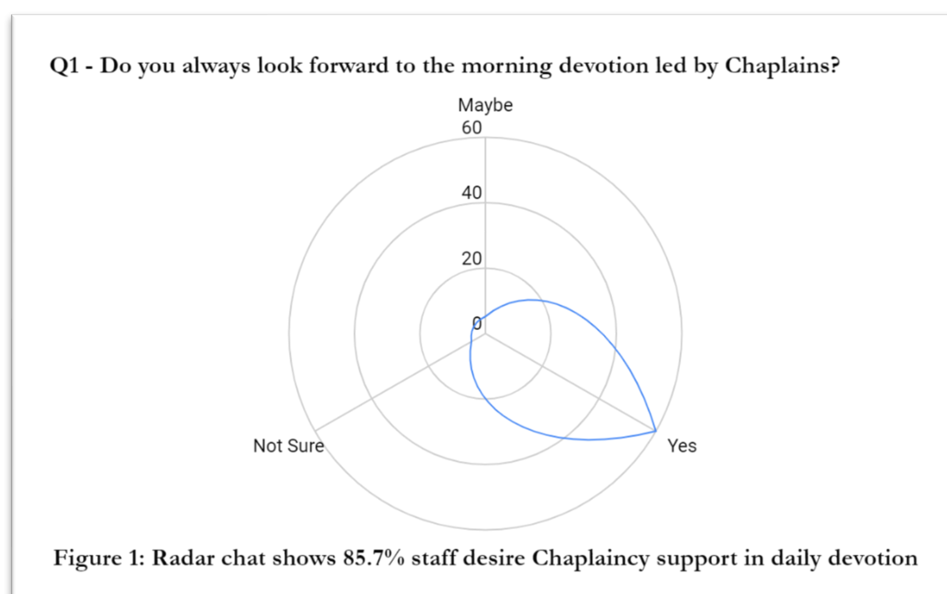

Figure 1: Radar chat shows 85.7% staff desire Chaplaincy support in daily devotion

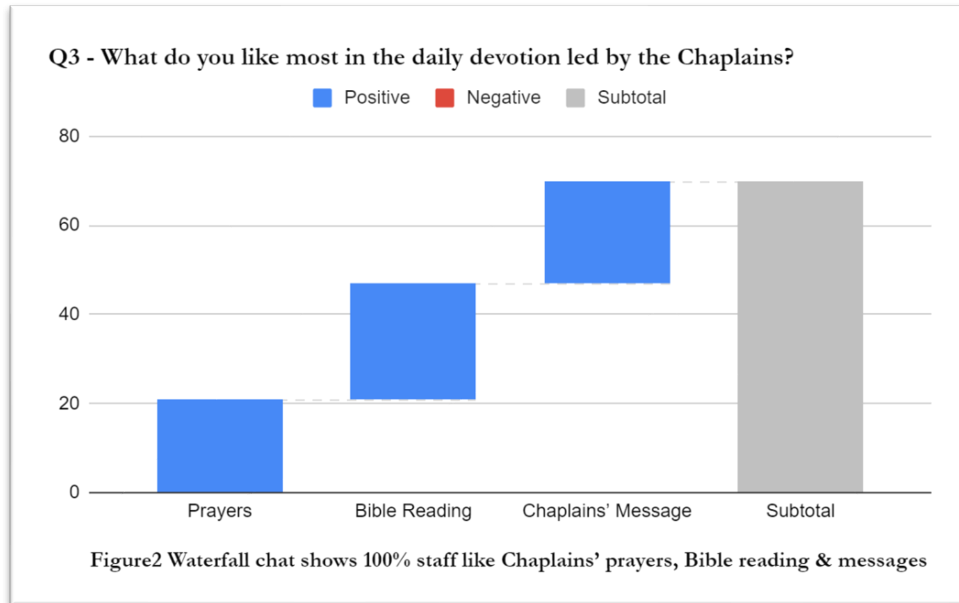

Figure2 Waterfall chat shows 100% staff like Chaplains' prayers, Bible reading & messages

Figures 1 and 2 above reveal that 85.7% appreciate the Chaplain's spiritual wellness support, and more importantly, almost 100% of the staff appreciate the Chaplain's messages (32.9%), bible reading (37.1%), and prayers (30%). This shows that healthcare chaplaincy is indeed relevant.

B. Psychosocial Impact (Q4 and 6): Table 1 above shows that spiritual care in PVPC promotes the psychological and social well-being of over 84% of staff. Figure 3 below reveals that about 89% of staff enjoy psychosocial wellness from spiritual wellness activities. Consequently, the spiritual wellness program engenders good customer service and quality workplace interaction among staff. It also has a business impact because where good customer service and smooth interdepartmental interaction occur, business thrives easily.

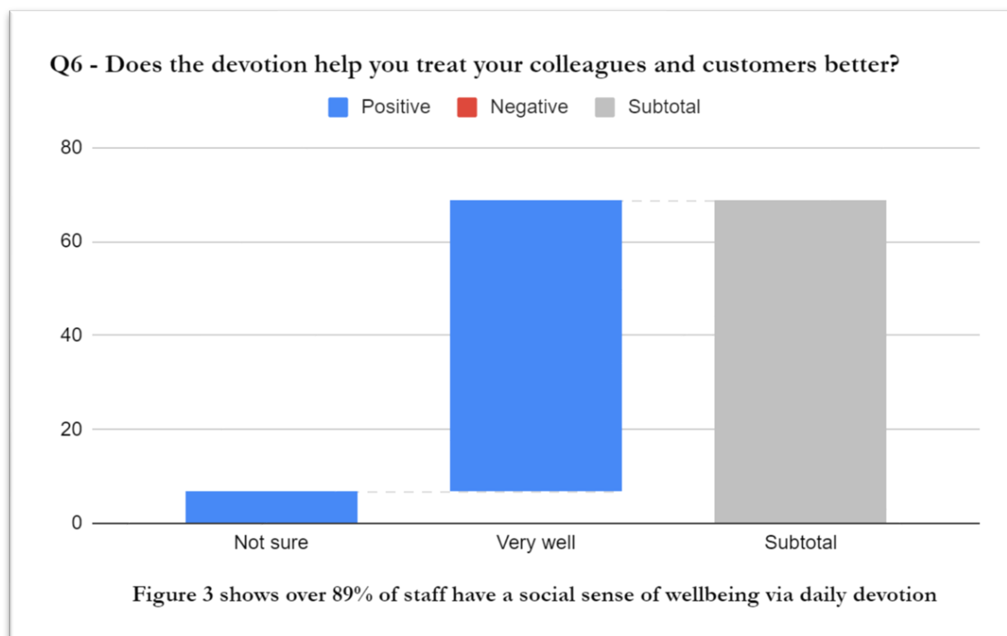

Figure 3 shows over 89% of staff have a social sense of wellbeing via daily devotion

C. Business Success Impact (Q2 and 7): Question 2 in Table 1 above shows that PVPC staff are motivated to work after morning devotion. Likewise, about 67.1% agree that it promotes business success and profit. This data implies that the spiritual wellness of staff can enhance

successful business. Since profit is the hallmark of a successful business, this article infers that spiritual wellness is part of the total package of profit-making.

Additionally, question 5 in Table 1 above shows that 1.7% (1) staff among the 70 respondents does not have a continuous desire for daily devotion, while three (3) are unsure. This shows there may be non-Christian staff members in PVPC. It may also represent the fact that regardless of PVPC's Christian corporate culture, it promotes inclusivity in employment; staff are employed irrespective of their religious affiliation.

Qualitative Result

A. PVPC: The quantitative research outcome above agrees with the HR and store managers' report, suggesting that daily devotion with Chaplains creates spiritual and social wellness. The HR manager stated that "It brings staff together feeling wanted and part of a group as they all share the same devotion working together in God's business." The store manager also asserted that the CEO (Hanes Strydom) insist that as part of corporate culture, all branches must open every day with a daily devotion. Further, in the store manager's words, "Some of our staff leave home very early, like 4 a.m., and return home late in the evening. So, the devotion at work gives them the time to do their prayers regardless of the crazy work hours. It also brings the people together and improves staff's spirits and well-being".

B. Mediclinic: This organisation is the third largest private healthcare provider in Southern Africa, with about 50 hospitals and five sub-acute hospitals (Mediclinic Group, 2023). This research was conducted in 2 branches of Mediclinic in Tshwane. The data obtained is sufficient for accurate research results on the background that Mediclinic, as a brand across South Africa, has a shared corporate culture. Four (4) questions were administered to HR managers with a focus on how chaplains are accommodated, policy guiding Chaplains' interaction with patients and staff, challenges with allowing Chaplains to provide spiritual wellness in the hospitals, and daily devotion for staff wellness. The research outcome shows that, firstly, Mediclinic does not focus on spiritual care; rather, attention is given to the psychological care of the staff. Traumatized staff members in need of debriefing are referred to social workers who operate as external service providers. Secondly, there is no existing policy for healthcare chaplaincy in the organization. Thirdly, there is no provision for daily devotion led by healthcare Chaplains because Mediclinic upholds a corporate culture of diversity and inclusion. Thus, religious diversity among the staff is respected. Staff members cannot be excluded from spiritual care that involves debriefing and related counseling support. Moreover, religious issues are emotional, sensitive, and delicate, so the organization avoids embracing a particular religion or multi-religious chaplaincy services. However, the organization is not rigid as it allows staff members like Nurses to provide voluntary spiritual support for patients of the same faith. Thus, religious Chaplains can be invited on client demand, but not as a corporate culture of Mediclinic.

C. Emergency Services Chaplaincy of Southern Africa (ESCSA): This spiritual care organisation in South Africa is headquartered in Gauteng with over 800 trained chaplains over the last two decades. Although medical healthcare is not the focus of ESCSA, some chaplains provide spiritual healthcare services. Based on a one-on-one interview, the followings are the summary of the research findings. Meanwhile, respondents' anonymity has been maintained as they have been identified as Chaplains 1, 2, 3 and 4.

Chaplain 1 submits that poor training contributes to the rejection of Chaplains' services in hospital settings as some Chaplains conduct themselves in the following manner. 1) Often upsetting hospital patients and staff. 2) Disregarding hospital protocols. 3) Interfering when hospital staff are busy. These attitudes lead to distrust and resistance by both staff and patients. Another issue is the Chaplains' cost of travel to hospitals.

Chaplain 2 served as one of the gifted internists at Sandton Clinic for seven years and testified to have been well received. The initial purpose was to serve a few individuals. But seeing the value, chaplain 2 was told to serve the entire hospital. However, there was a policy made to regulate his spiritual care activities. The Chaplain was instructed not to create an environment of evangelism but to meet patients and hear their emotional and physical concerns if they are comfortable with such support. Chaplain 2 supports patients (including non-Christians) via his faith in Jesus without overwhelming the patients or family members. Chaplain 2 observed that chaplains are rarely employed in South Africa as against the practice in America, where Chaplains are part of the hospital staff.

Chaplain 3 does not work as a hospital staff but was required to serve during covid19 paramedic. The hospital welcomed her services due to the overwhelming situation created by the pandemic, which needed more hands.

Chaplain 4 finds favor with hospitals and equally respects the Doctors and Nurses, addresses them with their titles, and honors them for what they do. She provides spiritual care for Doctors, Staff, and Patients. She is called upon when Doctors and Nurses have difficulties with specific patients, and she assists those with terminal health challenges with the last minutes prayer support.

D. Medical and Community Chaplaincy (MCC): The organization is based in Johannesburg municipality, and its chaplains serve both public and private hospitals, which include Baragwanath Soweto, Charlotte Maxeke, and Helen Joseph hospitals, among others. MCC is 5 years old as of 2023, with about 4000 members serving South African communities. The followings are the outcome of a one-on-one interview with the founder.

The popularity of healthcare chaplaincy in South Africa: MCC founder emphasizes that government does not recognize the role of Chaplains except those serving in law enforcement agencies. But MCC derives support from international bodies like the Bristol Myers Squibb Foundation and continues to function as an activist group, demanding the recognition and support of the government. Currently, some pieces of legislation are being pushed for the recognition of healthcare chaplaincy in South Africa. The government is slowly giving attention to such demand.

How patients, healthcare professionals, and hospital management respond to chaplaincy services: Patients and their families warmly receive MCC Chaplains. Patients look forward to Chaplains' arrival for spiritual support, and in some cases, hospital management invites them at patients' request. Likewise, healthcare professionals and hospital management receive Chaplains as part of their multidisciplinary team and sometimes refer patients to them. MCC Chaplains also support patients who await Doctors' consultation. While waiting, the MCC team provides spiritual counseling, motivation, and sometimes meals for the patients. MCC developed this concept of feeding from Math 25:31. They also support patients in communities where the social workers in hospitals treat the patients poorly. Thus, where social workers operate without conscience, thereby increasing patients' trauma, the MCC team provides spiritual support. But all the Chaplains' activities as multidisciplinary healthcare team members go along with pre-engagement and continuous training in para-medical and nursing fields.

The challenges healthcare Chaplains face with South Africa's health policy: Healthcare policy is unclear about the responsibility of the Chaplains. Yes, the policy concurred that South Africa needs spiritual counselors and caregivers, but the curriculum needs to clarify the healthcare chaplaincy role. Hence, MCC is acting as an activist organization, putting pressure on the government to clarify the role. MCC is also pushing that government should provide bursaries for Chaplains to have some form of nursing and para-medical trainings. Although the government is responding very slowly, corruption may be one of the challenges inhibiting such intervention.

Challenges with healthcare organizations' management and staff: In some cases, HR managers of hospitals resist the services of MCC because of job insecurity; they feel that medical Chaplains may take over Nurses' and social workers' jobs. This is one of the reasons some hospital management support government agencies to probe "Harmful religious practices" in South Africa. Thus, most private hospitals disallow chaplaincy services except on patients' demand. And most hospitals do not employ healthcare Chaplains because the healthcare policy is unclear about it.

Challenges with Christian groups: Some religious leaders and Christian groups in government oppose MCC in the healthcare sector. This is because of rivalry, missional competition, and struggle for relevance in the hospital setting. The capacity of MCC threatens them. This situation causes some discouragements in healthcare chaplaincy.

Challenges with South African communities: Acceptance of healthcare Chaplains is complex because of many communities' affiliation with African traditional spirituality. Thus, allegiance to traditional healing becomes a strong reason to resist healthcare chaplaincy. Worst still, traditional healers are more recognized than Christian healthcare Chaplains by the government. For example, during Covid-19, churches were closed while traditional healers were permitted to provide healing services to their subscribers. Additionally, among all spiritual care organizations, the 2018 Presidential Health Summit had the National Unitary Professional Association for African Traditional Health Practitioners of South Africa (NUPAATHPSA) represented in the steering committee (Presidential Health Summit Compact 2019). This discrimination furthers poor acceptance of healthcare Chaplains' services in South Africa.

Challenges within the chaplaincy: There are challenges with Chaplains who enroll in MCC training. These include doctrinal and positional conflicts. For example, Pastors with titles rarely want to grow in the chaplaincy ranks; they want to carry over their pre-chaplaincy status. With the information gathered so far, a brief discussion will now be presented below.

Discussion

The previous sections have shown gaps in healthcare services evident in the background information, quantitative and qualitative research outcomes. This section focuses on how the research outcome underscores the efficacy, sufficiency, and challenges of healthcare chaplaincy in South Africa vis-a-vis increasing healthcare demand and decreasing healthcare supply. Each of them will now be discussed below.

Efficacy: Cambridge Dictionary (n.d) defines efficacy as the ability or method of achieving something to produce the intended result. In the spiritual chaplaincy context, how efficiently can spiritual care produce the desired result of its intent; to bridge the gap between the supply and demand of healthcare? The quantitative research conducted at PVPC shows the efficacy of healthcare Chaplains in providing spiritual wellness for Pharma Valu staff. The analysis of the research outcome, which shows that spiritual care engenders psychosocial support, business-friendly attitude, and spiritual well-being for the staff, is evidence that spiritual care services are efficient in the health sector. If the reverse is the case, over 85% of the staff will not continue to desire and call for chaplaincy services in daily devotion. Likewise, the qualitative research report from MCC and ESCSA shows that having healthcare Chaplains as members of the multidisciplinary healthcare team of some hospitals stands as evidence of spiritual care efficiency in the healthcare industry. Indeed, spiritual care can be a necessary bridge between the demand and supply of healthcare for health workers, patients, and their families.

Sufficiency: The qualitative data from MCC and ESCSA shows there are between 4000 – 5000 trained chaplains in South Africa, of which the healthcare Chaplains hold the highest percentage. There are about 4000 MCC Chaplains and around 800 ESCSA Chaplains. ESCSA

also estimated that about 50% of the Chaplains are not active, and only 25-30% are employed by law enforcement agencies. According to Khalo (2022), about 160 full-time and 250 reserved Chaplains assist in ministering to an average of 75051 South African National Defence Force (SANDF). Regardless, the current number of healthcare Chaplains in South Africa cannot fill the gap between demand and supply of healthcare. The statistics show that the current number of Chaplains remain insufficient to serve the nation's population.

Challenges: The qualitative report reveals several challenges, which include a lack of recognition and support from the government, especially on the clearance of chaplaincy role in healthcare policy, insufficient training of Chaplains, opposition within the Christian groups, resistance by hospitals management and many African communities influenced by African Traditional Religion (ATR) and lack of Chaplains' employment opportunities. This article suggests that so long as these challenges are not addressed, healthcare chaplaincy cannot be improved to bridge the gap between the demand and supply of healthcare in South Africa. Consequently, the under-listed points have been recommended for improved chaplaincy spiritual care to bridge the gap between the demand and supply of healthcare.

Recommendations

1. Government needs to speedily make an explicit provision for the significant role of chaplaincy in its healthcare policy and provide bursaries for training healthcare chaplains.

2. Communities need to be sensitized by government-relevant agencies, chaplaincy groups, missional organizations, and community leaders to know the importance of accepting the services of chaplains to improve community health. Communities need to know that healthcare chaplaincy service is about their health and welfare and not about their religion.

3. In collaboration with Churches and related missional agencies, chaplaincy organizations need to train more Chaplains to serve the nation. Likewise, the Church community in South Africa needs to support their members and ministers to be part of the community service to provide alternative ways of reducing healthcare gaps and inequality in South Africa.

4. Chaplaincies may also need to pursue unity and collaboration with different religious groups like the South African Council of Churches (SSAC) for specific endorsement to have a stronger voice in the corridors of political power and eventually influence the healthcare policy. Affiliation with theological institutions, healthcare training institutions for some form of theological, para-medical and nursing trainings, and endorsements are also imperative to improve spiritual care.

5. Theological institutions and faculty of theology in South African Universities need to improve their research and training on spiritual care services. A cue can be taken from some institutions' programs, like the Duke University program on Theology, Medicine, and Culture (Duke Divinity School 2015) and the University of Edinburg's chaplaincy project on health academy (The University of Edinburgh Chaplaincy 2023).

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