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The Economy and Health

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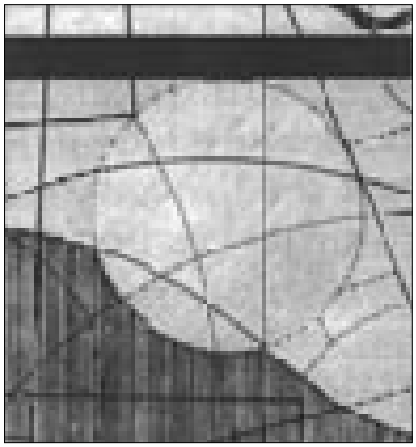

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ADDRESS OF HOMAGE TO THE HOLY FATHER BY H.E.MONS. LOZANO BARRAGÁN

Most Holy Father,

I would like to express to you a sincere greeting from the Pontifical Council for Pastoral Assistance to Health Care Workers and from all the participants of the Fourteenth International Conference on "Health and the Economy".

Holy Father, you entrusted to the Pontifical Council for Pastoral Assistance to Health Care Workers the task, amongst others, of guiding the health-care ministry in line with the doctrine of the Church. This task has been embraced by us at a heartfelt level and we have sought to carry it out with special reference to the illustrious teachings of Your Holiness.

A very urgent subject and one of great contemporary relevance is that of the economy at the service of health. For this reason we chose it as the subject of our fourteenth international conference, and the question we pose is: what are the guidelines that we must follow in this field in order to respond with the Word of God to the difficult questions which present themselves? We organised this international conference in the following way. Eminent theologians and scientists from different parts of the world helped us to reflect upon this subject. We began with a general vision of what the Word of God tells about the question. We considered it in the light of the health-care economic reality of today's globalised world – a reality which we illuminated with theological reflections. This was done, however, without forgetting about the ecumenical side of things as a path towards unity. And we have outlined operational guidelines which can guide us in this field of health in general and especially in hospitals, in clinics, in mobile clinics, and other entities which wish to follow the guidelines of the Catholic Church.

Today we have come to you, Holy Father. Above all else in order to thank you at a heartfelt level for having received us. We also beseech you to condescend to illuminate our reflections with the guidelines to be followed and which spring from your authoritative words. With these we will thus complete our endeavours of the last year of the millennium and they will be the certain way to be followed at the beginning of the third millennium.

Thank you, Holy Father, for having received us, and thank you for your most valuable guidance which will be the key to our health-care ministry.

His Excellency Mons. JAVIER LOZANO BARRAGÁN,
President of the Pontifical Council
for Pastoral Assistance to Health Care workers,
the Holy See

ADDRESS BY THE HOLY FATHER

Venerable brother in the Episcopate and the Priesthood,

Distinguished ladies and gentlemen,

1. I am pleased to welcome you on the occasion of your participation in the International Conference which the Pontifical Council for Pastoral Assistance to Health Care Workers wished to dedicate this year to reflection on the relationship between the economy and health: a theme that is so timely and problematic, for it involves both the formulation of national policies and the Church's task of evangelization.

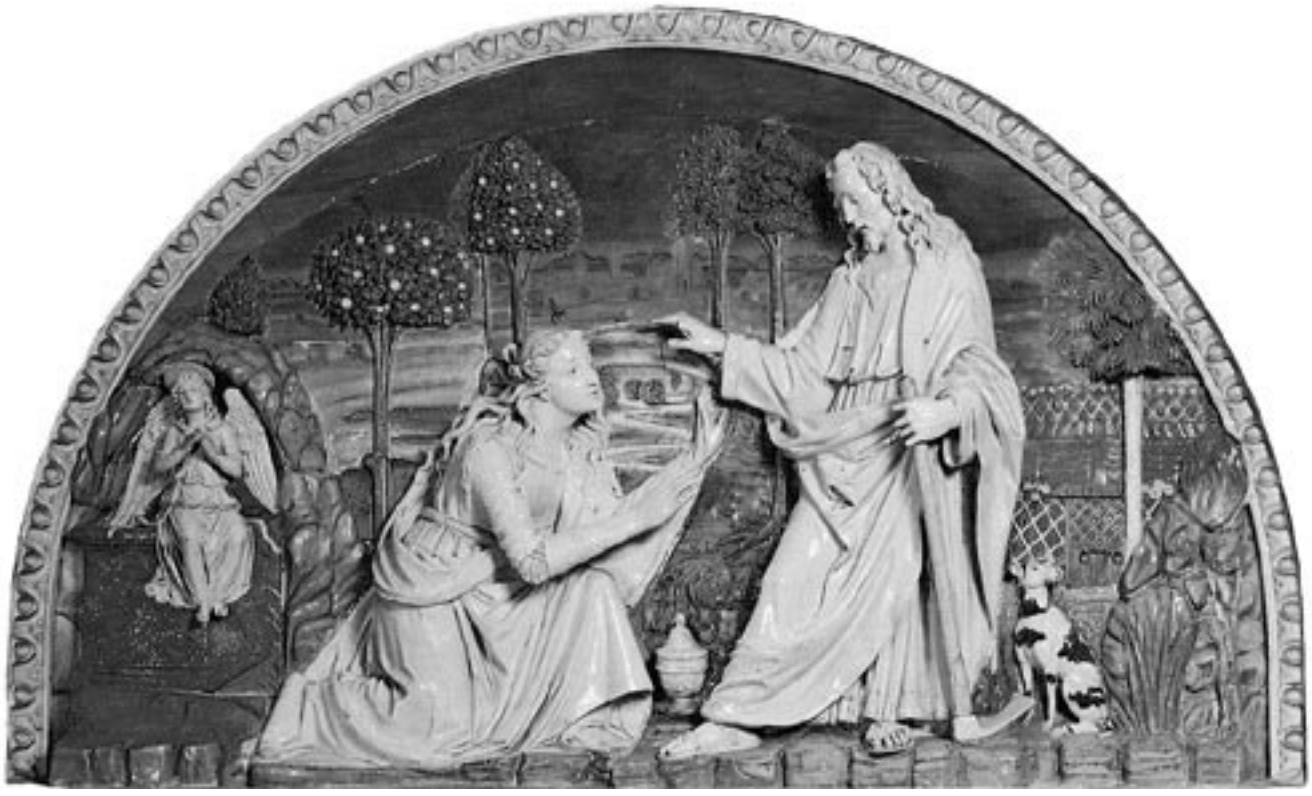
I greet Archbishop Javier Lozano Barragán and I thank him for the kind words he addressed to me a short while ago on behalf of you all. I extend a cordial welcome to the staff of the Pontifical Council for Pastoral Assistance to Health Care Workers, as well as to the distinguished scholars, researchers and representatives of the States and Governments which have wished to honour this important symposium with their presence and their scholarly contribution.

In order to identify concrete lines of action, you have addressed the question not from a merely technical standpoint, but in a scientifically organized and structured way. Your reflection starts from the horizon of faith. It is in fact by beginning with the word of God, bearer of integral salvation for all mankind, that the economy-health relationship is best considered, both globally and in its various scientific aspects.

A better understanding of this situation, which in itself is so complex and of global importance, is certainly fostered by the serious interdisciplinary approach that you have so opportunely chosen. You wished to consider the relationship of the economy and health in the light both of its historical development and of the Church's social doctrine, theology and morality. And all this in the spirit of a constructive ecumenical and interreligious dialogue.

Every person has the right to sit at the common table

2. Moreover, your reflection does not lack a subsequent practical goal: you have proposed lines of action capable of improving the existing relationship between the economy and health at all levels: economic, social, political, cultural and religious. You have thus tried to respond to the question of what action to take, at the global level and in every



country, to implement in the most human and Christian way the relationship between the economy and health.

This is a disturbing question which this conference must raise with all people of good will, particularly those who at the world level and in every individual country have the greatest responsibility in this area.

In fact, it is intolerable that limited economic resources, so often experienced at the present time, should in fact have repercussions mainly on the weaker sectors of the population and on the less well-off areas of the world, depriving them of necessary health care. In the same way these limitations cannot be allowed to deny health care to some age groups or situation of particular frailty and weakness, such as newborn life, old age, serious disability, terminal illnesses.

Every human person, created in the image and likeness of God and called to share in his divine life, has the right to be able to sit at the table of the common feast and enjoy the benefits of progress, science, technology and medicine.

3. In the same way, it is important to acquire a more adequate vision of health based on an anthropology which respects the person in his entirety. Far from being identified with the simple absence of illness, such a concept of health must aim at full harmony and a healthy equilibrium at the physical, psychic, spiritual and social levels (cf. *Message for the Eighth World Day of the Sick*, n. 13).

On the basis of this new vision of the economy and health, a more positive mutual relationship between them can be achieved. It is not the Church's task to define which economic models and which health systems can work out the best economy-health relationship, but it is her mission to do everything possible so that, in the context of so-called "globalization", this issue is addressed and resolved in the light of those ethical values that promote respect for and the defence of the dignity of every human person, beginning with the weakest and poorest.

4. It is with deep sorrow that we must note that the gap between situations of wealth that is even excessive and poverty even to the point of destitution, rather than decreasing, tends to be ever wider (cf. *Sollicitudo rei socialis*, n. 14). This is a factor that has very heavy and sometimes tragic repercussions precisely on the economy-health relationship.

Fortunately in this situation there is a growing awareness of the dignity of every human person and of radical human interdependence: as a result there is a greater sense of the need for solidarity. It is only with this perspective that one can overcome a vision that puts too much stress on economic concerns and too little on health issues, and move beyond the many unjust disparities that exist in the economy-health relationship.

Fortunately in this situation there is a growing awareness of the dignity of every human person and of radical human interdependence; as a result there is a greater sense of the need for solidarity. It is only with this perspective that one can overcome a vision that puts too much stress on economic concerns and too little on health issues, and move beyond the many unjust disparities that exist in the economy-health relationship.

For Christians, in particular, solidarity becomes a virtue that leads to love and is constantly nourished by it, resulting in attitudes of friendship and support, including the care of the sick. The supreme reference-point remains Trinitarian communion, from which the Christian knows he must draw inspiration for his own life in order to achieve a relationship of genuine love, particularly for his weaker brethren, which include the sick.

Issues must be resolved solely by concern for the common good

5. To them I now wish to address a special word of affection, which I extend to their families who are concerned about their health and to all who serve them with generosity and solidarity. To each of them I wish to express again the Church's loving closeness and to assure them of her tireless commitment to building a more just and fraternal society.

I especially call upon political leaders and international bodies that, when addressing the relationship of the economy and health, they may be guided solely by the search for the common good.

I ask the pharmaceutical industry never to let financial gain prevail over the consideration of human values, but to be sensitive to the needs of those who do not enjoy social security, carrying out effective programmes to help the poorest and most marginalized. We must work to reduce and, if possible, eliminate the differences between the various continents, urging the more advanced countries to make available to the less developed their experience, technology and some of their economic wealth.

May the dawn of the third millennium see our planet, with all its resources, more conformed to God's plan, so that no one will feel excluded from the care owed to his person and his health, with respect for the equal dignity of all.

To the Virgin Mary, model of the Church and of reconciled mankind, I entrust the fruit of your work, so that by her maternal intercession the longing for justice and peace in the heart of every person may be fulfilled.

My blessing to you all!

The Economy and Health

JAVIER LOZANO BARRAGÁN

Introduction to the Fourteenth International Conference on the Economy and Health

1. The Subject and the Issues

From the beginning of the 1980s the governments of the Western countries have worked very hard to contain expenditure on the provision of health care. Such expenditure has everywhere risen more each year than the corresponding wealth produced by each country. For this reason, they have applied restrictive policies and new health care policies in an attempt to extend the presence of health care and medicine within the framework of the free market system. It is argued that the welfare system of health care has generated inefficiency, given rise to immense expenditure which is no longer sustainable, and produced corruption and the plague of bureaucracy.[1]

2. In Support of the Welfare System

Opinions against these decisions did not take long to arrive. It has been argued that to approach the world of illness and health in a commercial spirit is absurd because in such a way health is seen as a product which a firm should offer at a competitive price by putting the resources available to the best possible use and concurrently reducing costs. In such an approach the patient, it is asserted, becomes a mere customer. Those who oppose the general trend argue that a health care centre does not work to increase its output and to increase the services it offers. It works, rather, to reduce people's needs. Furthermore, they argue, in the health care field a saturation of the market, where an increase in the supply can be matched by an increase in demand, does not exist. At the same time, the description of health as a commodity offends the overall concept of health because health embraces the mental and spiritual dimensions of man as well as the physical dimension. In addition, to define the sick person as a "customer" is equally unsuitable. This involves an exclusively economic perspective where every illness is wrongly held to have its own fixed unfolding, time and process. The relationship between the medical doctor and the patient, in this approach, would be abandoned and once the product is handed over the customer is left to himself. Many sick people, for whom the law of supply and demand does not work, would be abandoned: for example the terminally ill or those afflicted by incurable illnesses such as AIDS, or the elderly and the infirm for whom psychological and spiritual care is essential. At the same time, the links with the family relatives of the sick person would be weakened – links which are essential to their care and treatment; the concept of voluntary work would be emptied of its contents; attention would be paid to commercial considerations and not to the health of the sick person; and health centres would have as their goal economic gain rather than the recovery of the sick person.[2]

3. Against the Welfare System

Despite this attitude of rejection of the general trend, most contemporary government policies in the health care field, at least in the West, accept the free market system as applied to health and advance a number of arguments to show that in their opinion the alternative system – the welfare system – is obsolete and can no longer be maintained in a way which is congruous with the present-day development of their various countries. They propose the model of the free market in health as a model for the first world, and in a certain way, with due changes, for the third world as well.

The improvements suggested for the welfare system by the proponents of the free market must never undermine the basic nucleus of fairness and solidarity. An attempt is made to find conditions which would favour the promotion of the benefits produced by greater decentralisation, ways of applying the techniques of private commercial management, and the extension of responsibilities and effective instruments to outlying managers. This approach requires a structure which allows a clear distinction to be made between the principal actors of the health care system and a recognition of their respective responsibilities. The central administration would become the chief sources of funds; the health areas, the recipients of services, the hospitals, the various health care centres, and the medical doctors and pharmacists would be the suppliers; and the users would be the customers. The fundamental obligation of the buyer would be to obtain a higher quality of service given the resources available. This domestic health care market would produce a competitive stimulus for the various entities which are responsible for the provision of services.

In this way skill and expertise

would be created which should produce improvements in the quality and the cost of the services and provide the user with a greater choice in relation to suppliers. The fundamental basis of the relationship between suppliers and users would be a contract accepted after a detailed analysis of its effectiveness. Both the public and the private sectors would form a part of this process.

An awareness of this personal obligation and of the fact of having to be aware of results are thought to be incentives and factors which improve the administrative forms of welfare. These forms are held to be inadequate to the task of understanding and managing the complexity and the volume of present-day health care services. The normative rigidity of welfare would become transformed into versatile services and the perverse supremacy of the bureaucracy would be avoided in a way that would give more space to the consumer. Two factors would come into play: economic self-interest and freedom of choice. The first could act upon the quality of the product whilst the second would do the same in relation to the quality of the service. Both can degenerate, it is true, but they can also be factors to be taken into account in relation to the fairness and the distribution of resources in the health care field. Modern techniques of private commercial management lead to a speeding up of procedures, a definition of responsibilities, and a delegation of authority. The management of health care should also bear in mind the quality of the product, the need to respect budgets, the reduction of costs, productivity, the motivation and the remuneration of staff and personnel, research and development, and thus, in a few words, the correct functioning of the hospital firm. People should be made aware of expenditure, and this is true of both users and suppliers. Health, it is said, certainly has a cost, but it is also priceless. It is argued that what really characterises the bureaucratic system in the world of welfare is an erroneous allocation of resources, a waste at the level of consumption.

Competition requires permanent training on the part of the suppliers of services. Constantly advancing technology should be incorporated into a health service, and this is something which is indispensable. The speeding up of procedures, the definition of responsibilities, the delegation of authority, the quality of products, conformity to budgets, the reduction of costs, productivity, the motivation and remuneration of staff and personnel, research and development, awareness of the expenditure on, and costs of, health, technology and on-going training – these are all said to be some of the advantages of this kind of management which should be applied to health care provision in the contemporary world.

Within this free market system, the elderly, the chronically ill, the convalescent, and those who require pain-reducing treatment, would all be looked after. The market of products and services would see to this but the recipients of these forms of care and treatment would not actually be seen as being agents in the market.

4. The Fourteenth International Conference on "the Economy and Health"

Are we in favour of, or against, the free market in the world of health? Do we want to continue with the welfare system? How can we deal with the costs of health, especially in the poorer countries, given that health care needs are on the increase? Who should pay the bill? Does the globalisation of the market economy prevent a human approach to the world of health? Is the welfare system ruined by bureaucracy or corruption? To achieve better health what is the best economy? What have the rich countries, and especially the poor countries, to say on the matter? What does God tell us on the subject? What does the Catholic Church think? What do the great religions think about this impelling set of issues? And lastly, in order to avoid remaining at a purely economic level, what should we do to reconcile the economy and health in the most human and Christian way?

These and other areas of the field of the economy and health ask for our response with ever greater force. In order to provide a reply the Pontifical Council for Pastoral Assistance to Health Care Workers has organised this fourteenth international conference on "the economy and health". The subjects to be considered cluster around the following questions: what does the Word of God tell us about the economy and health? What at a practical level is the international reality of the world of the economy and health? How can we illuminate that reality with the Word of God? What should we do in practical terms? Twenty experts of worldwide importance marked by the highest professional profile wanted to come to this encounter in order to give us their answers. And these answers will be co-ordinated by five chairmen who are also very highly qualified.

I would like to welcome and thank them all in heartfelt fashion for their active participation at this conference.

I would like, lastly, to extend a welcome and a warmly-felt greeting to all those taking part. May the light of the Holy Spirit accompany us in our studies and exchanges of experience so that we can offer those who so wish for it a valid answer! And an answer which strengthens the healing ministry of Christ in the sphere of the economy and health in this world at the end of the century and the beginning of a new millennium which is subject to so many changes. Once again thank you very much for your presence!

H.E.Mons.
JAVIER LOZANO BARRAGÁN
Archbishop-Bishop Emeritus of Zacatecas,
President of the Pontifical Council
for Pastoral Assistance
to Health Care Workers,
the Holy See

Notes

[1] TONELLI-GIANIN, 'L'Evoluzione Naturale dei Sistemi Sanitari', in *Panorama della Sanità*, 49/97.

[2] CARDINAL F. ANGELINI, 'Problematiche Ethiche e Deontologiche', Policlinico Gemelli, 2-3 June 1995.

FIORENZO ANGELINI

The World of the Economy and the World of Health

The terms and concepts of "economy" and "health", within the cultural and socio-politico-health care context that we live in today, are not the same as was the case in the past. If the "economy", as is affirmed by etymology, is the art of administering the home and the interests of the family (and not without a background which refers to parsimony and saving), today the fan of specific references is very broad: it goes from the macroeconomy to the microeconomy, not to mention the "economies" in the plural which are involved in the boundless field of finance.

The term "health", which should be understood as physical and mental wellbeing – although I would also add the adjective "spiritual" – should also be kept well distinct from the term and the concept of "health care", something which refers to the set of structures and instruments which are placed at the service of health.

Health is what the human being seeks to safeguard or to recover; health care is what society places at his or her disposal in order to achieve this end.

Given the meaning of these terms addressed by this international conference, it seems therefore more appropriate to speak about the "world of the economy" and the "world of health". In this way we can include in these two phrases everything that bears on the resources which should be allocated to the promotion and defence of health seen as a fundamental human right.

The path of health care and the means which it can draw upon is thus a path which has gradually responded to the needs of a very complex process or development.

At one time a hospital was called "House of God" ("Ville de Dieu") and was not a health-care company. The sick person was neither a product nor an abstract illness with so many days or hours allocated to his or her diagnosis and treatment. He or she was an individual afflicted by a pathology which was never seen as being identical to another at the level of personal experience.

Unfortunately, in the past not everybody had the possibility of being taken care of. This was because of a lack of structures and because of the scarsity of available resources allocated to health care. This limitation, even though this is not the case in all countries, has now been overcome, although difficulties remain which should not be ignored.

If, therefore, notwithstanding the steps forward which have been taken, I express certain worries, I do this without any critical intention, but solely because the continuing presence of some shadows, which diminish the great deal of light of the achievements which have been achieved, is something which is painful.

There can be no doubt that the socialisation of medicine – set in motion and enacted by the Church as an expression of great love towards one's neighbour – made major advances following the adoption of the principled stance and awareness that the right to health is a duty of justice for which the social community must shoulder the responsibility seen as a primary concern. Indeed, amongst all the fundamental human rights, the right to health is the right which is most closely bound up with the right to life, which in turn is the principal right, the first right in absolute terms.

There are determined and clearly-defined times to satisfy the right to education, to a home, and to a job. The right to health, instead, accompanies man throughout the whole of his existence, from his conception until its natural eclipse. Indeed, its recognition, and respect for it, can be decisive in defining the actual length of his period of existence.

Today reference is made to the globalisation of all essential human problems, but it is certainly significant – even though this is something which was largely predictable – that the first form of globalisation (with all its limits and its risks) is now taking place within the economy.

The prospect of a "great market", capable of involving all the economic flows, will either meet certain inescapable ethical criteria or will be a pseudo-globalisation. And advance in the promotion and the defence of the right to health of all human beings is without doubt a very effective parameter by which to judge, especially from an ethical point of view, the significance and validity of globalisation. At the present moment we have before us perhaps the globalisation of awareness of the health-care problems of the world. We are, however, very far from their globalisation, or rather from a desire and ability to work together to achieve a remedy for them.

In the middle of the 1970s the World Health Organisation launched the programme, which subsequently turned out to be

utopian in character, of "health for all by the year 2000". The year two thousand is just around the corner and the goal hoped for is still very far off. And this is also because of the fact that the achievement of this goal involves the implementation of certain requirements which are an essential pre-condition to its realisation.

I believe that the first observation which is required when we address ourselves to the question of the relationship between the economy and health is that of the very deep imbalance which exists between rich and poor countries, and this at a time in international evolution when the rich countries seem to move towards greater wealth while the poverty of developing countries is becoming endemic.

I said that the socialisation – which today we could call globalisation – of medicine and health care took place in the name of the evangelical commandment of love. Because today the criterion of justice seems to be a prisoner of the iron laws of the economy, we should urgently engage in a recovery of the meaning of the solemn duty to provide loving service to one's neighbour so that this can once again be transformed into support for justice. All of this can be readily seen in the very large number of parts of the world where bloody conflicts are still underway: more than any other action, that action involving the defence and promotion of health is only possible when a renewed sense of solidarity which can be pushed to the point of heroism reawakens the sense of justice.

Furthermore, a cause for reflection can also be found in the fact that the overwhelming majority of countries which are weighed down by foreign debts have as their creditors – if one excludes Japan – countries of a consolidated Christian tradition, and even a formal label to that effect. If we transfer or apply this undeniable fact to the imbalance between the health-care systems of the First World on the one hand, and the health-care systems of the Third or Fourth Worlds on the other, we can perceive the extent to which Christians, or those who profess themselves such, are distant from the actual application of the parable of the Good Samaritan.

If, however, from the general analysis of the relationship between the economy and health we pass to the more specific analysis of this relationship as it exists in developing countries, we immediately perceive the inadequacy of this tandem of two terms.

The promotion and the defence of health are not only an economic question. Indeed, this enormous limitation is still more evident where the resources allocated to the world of health are very great. I say this although I have personally always greeted with great satisfaction the advances achieved in our country to make the health service accessible indistinctly to everybody. Indeed, I remain convinced that good, indeed excellent, health care greatly exceeds the sporadic and isolated phenomena of bad health care. All this, however, confirms the given fact that the correct working of health care is not only a question of the allocation of resources. The institutions involved should recover what the Holy Father in his Apostolic Letter "Salvifici Doloris" calls the human *heart*, something which is indispensable to their support.

Places of treatment and nursing homes became – for example in Italy – at the outset a local health-care unit with the aim of involving the whole of the local territory in the provision of health care, and then became a business. The sick person from being a patient has become transformed into a product, and instruments of care have become transformed into elements of consumption. Nobody can deny that this process of transformation has its positive aspects, but it would be a serious error to conceal the risks, indeed very serious risks, that this process involves. These are risks which run from the politicisation of health care to its bureaucratisation.

The health-care staff and personnel, through trade unionisation, can be induced to forget that just as suffering knows no truce so service to it cannot seek pauses – pauses which can have even lethal consequences for those who are cared for and treated. At this point I would like to observe that, whenever this has come within my range of possibilities, I have always fought for the administrators of health-care structures, too, to be seen as "health-care workers". This battle has been won if we consider that the Holy Father John Paul II himself, in his encyclical "Evangelium Vitae", included the administrators of places of treatment and care within his definition of "health-care workers".

Furthermore, the emphasis – because of the needs of economic budgets – on the illness rather than the sick person leads to a neglect, in relation to the latter, of the interaction of moral and spiritual care which, in the judgement of real medical science and the Church, can even be a determing factor in treatment.

Personally, I have always worked energetically to ensure that every sick person, whatever his or her religious faith, is guaranteed suitable and freely asked for spiritual assistance. The excessive bureaucratisation of health care, however, makes the sick person increasingly isolated, and his face has become a medical case history which is circulated amongst people he does not know. Bureaucratisation for its own sake, like a letter without true spirit, is not life but death. In such an instance we are at the very opposite of the promotion of the defence of life.

The *trait-d'union* between the economy and health cannot but be justice sustained and nourished by solidarity-inspired love for one's neighbour. This is something which is not only required by our Christian vocation, it is also something called for by the by now recognised limitations to reforms which, side by side with the economic and strictly health-care aspects, do not take into consideration the contribution to be made by an ethical vision of life and of the dignity and sacredness of the human person.

H. Em. Cardinal
FIORENZO ANGELINI,
President Emeritus of the
Pontifical Council for Pastoral Assistance
to Health Care Workers,
the Holy See

DIONIGI TETTAMANZI

The Economy and Health in the Light of the Word of God

It is well known that the miracles performed by Jesus for the sick include *the healing of the woman suffering from an issue of blood*, who surprised the Lord from behind and touched his cloak in the belief that if she could only touch his cloak she would be healed.

In the account of the episode provided by St.Mark the Evangelist there is a very brief reference which deserves to be taken as a rich and suggestive introduction to the subject we are addressing here today. St.Mark writes: "And now a woman who for twelve years had had an issue of blood, and had undergone much from many physicians, spending all she had on them, and no better for it, but rather grown worse, came up behind Jesus in the crowd (for she had been told of him)..." (Mk 5:25-27).

I do not in the least think that this sacred text seeks to express a negative judgement on medical doctors and their art, even though in this instance the medical part played is seen as the cause of a great deal of suffering on the part of the woman, who, indeed receives no improvement from the treatment she is given but finds her condition worsened. As support for this interpretation we may return to the Book of Sirach, for example, which offers us a very beautiful and evocative picture of the medical doctor. Indeed, it invites us to honour the physician as "should be done according to the circumstance"; recognises that the marvels of science are used by the medical doctor to "treat and eliminate pain" and that "from him comes the wellbeing of the earth"; calls on the praying man to pay special attention – after God – to the physician: "make the physician come to you – the Lord has created him as well – and not be distant from you, because you need him. There are cases where success lies in their hands" (Sir 38:1ss).

These last words, namely "there are cases where success lies in their hands", in their reference to the success of the physician, concretely and openly recognise a success which has not taken place. This is something which is also referred to by the Gospel text in which emphasis is placed in a refined ironic fashion on the disappointment of this woman, if not indeed on her embittered dismay at having spent "all she had on them, and no better for it, but rather grown worse for it". However, all this is destined to illuminate to the full the power to work miracles possessed by Jesus on the one hand and the faith of the woman of the other – the two elements which constitute the heart of this story narrated by the Gospels.

At the same time, even though this takes place within the above-mentioned kind of specific context, we encounter the fact that the episode described by St.Mark also has a reference to the relationship between the economy and health, between money and medicine. There can be no doubt that this evangelical passage has no bearing whatsoever on the questions and issues of "the economy and health", the subject of our international conference. We have here merely a very brief reference. And this lack of relevance is especially the case if we consider that we are within a social and cultural context which is very different from ours. But this reference to money is nonetheless interesting because it can act as an introduction to the title of this paper: "the economy and health in the light of the Word of God".

1. Which Reference of the Word of God?

The first question which we should seek to answer is the following: *is it right to turn to the Word of God* in order to gain light by which to approach and solve the question of the relationship between "the economy and health"? It would appear that the answer is in the negative, and for a variety of reasons, notably the two I will now discuss.

The first reason, and the most immediate, is that the Word of God to be found in Holy Scripture is too distant from us and is at the same time extremely simple or elementary. It is distant from is us both in the sense of time and also, and especially, in cultural and social terms. This is because the present-day conditions of the question of the relationship between "the economy and health" make that question very complex and sensitive: it does not bear so much upon the relationships between certain people (for example the medical doctor and the sick person) but upon the relationships between large numbers of structures and entire systems within the framework of both national and international society. In today's world, the economic-financial system and the health care system are those which most bear upon each other.

The second reason is of a more profound nature and is to be found in the pre-eminently "theological" meaning of the Word of God. This latter, indeed, is the revelation of the face of God and His mystery. It tells us who God is and what He does for us in the *historia salutis*. Such is the case, but in addition to revealing the face of God this word also reveals the face of man and his mystery, given that man is created in the image and likeness of God. In this way

can we understand the "anthropological" meaning of the Word, something which is closely bound up with its theological meaning – the Word of God also tells us who man is, and what his dignity, his vocation and his destiny are. This is what takes place, in its central significance, in Jesus Christ, real God and real man. Hence the enlightening statement offered by Vatican Council II: "in reality only in the mystery of the Word made flesh can we find the real light of the mystery of man... Christ, who is the new Adam, in revealing the mystery of the Father and his love also fully reveals man to man and points out to him his very high vocation" *(Gaudium et Spes*, 22).

In this way human life, too, in all its different aspects and contexts, comes to be illuminated by the Word of God: those to do with the economy and health, those to do with economic goods and their use, and not only from the point of view of their being two distinct realities but also in terms of their actual relationship. Here another question poses itself to which we should give an answer. If it is right to turn to the Word of God in matters connected with the economy and health, we should then ask what *original contribution* can be made, and is made, by the light of the divine word to the question we have before us. It seems to me that I can affirm that this contribution concerns man in line with the profound and admirable definition given by St. Ireneus of Lyon: "*Gloria Dei vivens homo; vita autem hominis visio Dei*" (*Control le Eresie*, IV, 20, 7). Man is defined in terms of two essential aspects:

– the first sheds light on the origins or bases of man – his personal dignity lies in his being a living image of God (*imago Dei*: the glory of God is living man!);

– the second aspect refers to the goal or the supreme destination of man: the vision of God. Not only does man *come from* God but he is also precisely for this reason *for* God and his glory (the life of man is the sight of God).

It is necessary to complete and perhaps further specify the definition of man provided by St. Ireneus by referring to another essential aspect of man which links together the two aspects which have been discussed so far: responsible freedom. Man is a being who comes from God and is for God, but in line with his specific nature, that is to say his being a rational and free being. Differently from the other beings created by God and ordered to God, man is entrusted to his own freedom. This is his ethical dimension. Following these three aspects which define man, almost in a kind of itinerary made up of stages which are bound up with each other, we can find in the Word of God that light which illuminates the question of the relationship between the economy and health, something, indeed, which is suggested to us by the psalmist: "your word is the lamp for my steps, light on my path" (Psalm 119, 105).

2. The Inviolable Personal Dignity of Every Man

As the Bible teaches in the first two chapters of the Book of Genesis, man is *dust*. It is true that the creation of man is the crowning event and fulfilment of the creative work of God: it pre-supposes the production of all the other inert and living beings, earth and water, air and fire, minerals, plants and animals. And in this sense man is different and superior; he transcends the infra-human world. But it also true that man is closely related to the infra-human world because he too has been brought out of the earth: "Thus the Lord God made man out of the dust of the earth and blew into his nostrils the breath of life and man became a living being" (Gen 2:7).

Yes: man is dust. But he is shining dust, dust which shines a great deal, because he reflects the splendor of the face of God. Man, indeed, is certainly related to the earth, but he is also related to God. This is because he is created in the likeness and image of God and is therefore called to take part in a mysterious and uniquely special way in the grandeur and goodness of the Creator. As the Bible writes: "And God said: "Let us make man in our image, in our likeness, and have lordship over the fish of the sea and the birds of the air...God created man in his image, in the image of God he created him, male and female he created him" (Gen 1:26-27).

But what is the *meaning* of the idea that man is the image of God? Taking the Bible as our point of reference once again, it must be answered that this meaning is to be found in the relationship of dialogue, in the relationship of the "you" which is typical of man as a rational and free being. It is a relationship that concerns God, others and the world of things; a relationship which is based upon, and at the same time is fulfilled in, reference to God: God can speak to man and man can not only listen to the voice of God but can also answer Him. In this sense Vatican Council II, in *Gaudium et Spes*, explains the being of man created "in the image of God" with the words "able to know and to love his own Creator" (n.12). Here we encounter the specific nature of man: he is a rational and free being, with awareness and freedom which find their chief roots and their supreme realisation in God. Herein lies the personal dignity of man.

It is precisely this dignity which constitutes the *fundamental ethical principle* (and also the fundamental architectonic principle) by which we can judge and solve all human questions and issues, even those concerning the relationship between the economy and health. This can perhaps seem a principle which is too abstract and anyway distant from the practical and complex questions which are at the centre of our present-day debate. But such is not the case because they reveal themselves to be able to reach the heart of the questions and issues involved, and they do this with a special innovative force or strength, if not even revolutionary power, when we compare them to the cultural parameters which dominate today's world.

Personal dignity is identified with man; it is the constituent reality of man himself. It is not simply to be found in the trajectory of having, but in that of being! It defines man as man.

It is precisely for this reason that *personal dignity belongs to all men and to each and every man*, without exceptions or any kind of distinction. The human being is marked by this dignity at every "stage" of development and in every "condition" of his life – from the beginnings of conception to natural death, in a state of health and in illness. Indeed, in a certain sense, it is precisely in situations of greatest fragility and suffering that such dignity – which

is objectively present – asks to be subjectively perceived, and thus recognised, respected, defended and promoted by everybody. The appeal of the Book of Sirach is in this sense emblematic: "O son help your father in his old age, and do not grieve him as long as he lives; even if he is lacking in understanding, show forbearance; in all your strength do not despise him" (Sir 3:12-13). Thus it is that the splendor of the face of God reflected on the face of man does not become attenuated, not does it disappear, when man experiences situations of weakness or illness. On the contrary, rational and free man is called to receive the indelible divine splendor which is present in these situations as an ever greater call to respect and veneration.

From what has been said hitherto, flows the condemnation and the rejection of all those *forms of discrimination* which take place under the pretext of the presence of an excessive health-care expenditure or an expenditure which is deemed to be too high for society to bear, especially in relation to the weakest categories such as unborn children or the elderly. These forms of discrimination can even lead to the destruction of malformed foetuses or to euthanasia. In his message to the next World Day of the Sick, the Holy Father observes that it is "necessary to recognise that unfortunately in by no means few instances economic, scientific and technical progress has not been accompanied by authentic progress centred upon the person and on the inviolability of every human being. The very conquests in the field of genetics, which are fundamental in the defence of health and above all else in the protection of unborn life, become an opportunity for unaccaptable selections, of senseless manipulations, of interests which are antithetical to authentic development, with often deeply disturbing results. On the one hand there are major efforts made to prolong life and even to create it in an artificial way. But on the other those who have already been conceived are not allow to be born and the death of those who are no longer considered as being useful is accelerated" (n.5).

These paradoxical forms of discrimination and types of situations are contrary not only to evangelical principles but also to human and rational principles. They trample, first and foremost, on the fundamental right to life, and at the same time contradict true and authentic democracy, something which means equality between all men and which to be achieved must certainly "begin from the least of our brethren". In this sense the so-called "preferential option in favour of the poor" certainly has, in common language, a pastoral meaning. But its contents also have a meaning which is merely human and social – it is an unescapable requirement of the process of modern and mature democracy.

3. How is a Man Better for it if he Gains the Whole World...?

Personal dignity is the most valuable element that man possesses, thanks to which he transcends in terms of value the whole of the material world. Man is to be valued not according to what he "has" – he is to be valued for what he "is", as indeed emerges clearly from the words spoken by Jesus: "How is a man better for it if he gains the whole world but loses his own soul" (Mk 8:36). It is not so much the goods and possessions of this world that count as the good of a person, the good that is the person.

At the same time God also gives to man the goods of this world, and entrusts him with the task of using them for himself and for others.

God makes him the "lord" of things: "And God said: let us make man in our image after our likeness, and let them have dominion over the fish of the sea and over the birds of the air, and over the cattle, and over all the earth, and over every creeping thing that creeps upon the earth" (Gen 1:26). But the "lordship" of man, precisely because he is the living image of God, must be carried out in an intelligent and loving way, thereby reflecting the infinite wisdom and the infinite love of the Creator. And this takes place when the goods of the world are not absolutised by being transformed into real and authentic idols, but when they conserve and promote their essential destination for man, the real good of man, indeed of all men, through work and the economy. Hence the fundamental anthropological meaning of economic activity, expressed in the precise words of Vatican Council II: "In economic-social life, too, the dignity and the overall vocation of the human person should be honoured and promoted, and the same may be said of the good of the whole of society. Indeed, man is the author, the centre and the end of the whole of economic-social life" (*Gaudium et Spes*, 63).

It is precisely this anthropological meaning of economic activity which is the ethical criterion by which to assess and decide in matters connected with the numerous and complex economic questions and issues which concern in particular the health-care world. If we wanted to list certain key aspects of this criterion the following both theoretical and practical guidelines could be proposed:

– from what has been said above it should be stressed, first and foremost, that the *economy is not an end in itself* and does not contain within it the fundamental and decisive criteria for its human realisation. It is connected by an unbreakable law with man, with the personal dignity of man. And just as it comes from man so it is ordered to man.

In this sense so-called economic questions – including those, or rather above all else those, which bear upon health care – are not only *sic et simpliciter* economic. They are always – at least from certain points of view – also anthropological and thus also ethical questions. The ethical dimension, as at this point should be evident, is neither

simply superimposed nor automatically imposed from outside the economy. It is intrinsic to an economy which seeks to be human and humanising. Even though the ethics of economic questions need to be connected to other sciences and disciplines, the tackling of the questions and issues of the relationship between the economy and health care in an indifferent or secondary way which has or does not have some recognition or other of the intrinsic and inescapable role of an ethical approach is not acceptable.

– The most specific and habitual point of reference of the economy is *profit*. The position of the social doctrine of the Church is well known on this point, in particular the teaching reproposed and specified in the encyclical *Centesimus Annus*. In this publication we read, among other things, that "the modern *business economy* has positive aspects. Its basis is human freedom exercised in the economic field, just as it is exercised in all other fields" (n.32) Further on we read: "The Church acknowledges the legitimate *role of profit* as an indication that a business is functioning well... But profitability is not the only indicator of a firm's condition. It is possible for the financial accounts to be in order, and yet for the people – who make up the firm's most valuable asset – to be humiliated and their dignity offended. Besides being morally inadmissable, this will eventually have negative economic repercussions on the firm's economic efficiency. In fact, the purpose of a business firm is not simply to make a profit, but is to be found in its very existence as a *community of persons* who in various ways are endeavouring to satisfy their basic needs, and who form a particular group at the service of the whole of society. Profit is a regulator of the life of a business, but it is not the only one; *other human and moral factors* must also be considered which, in the long term, are at least equally important for the life of a business" (n. 35; cf also n. 39).

– We can use the language of the Gospels and affirm that *man is not made for the economy but the economy is made for man*. And here we can immediately make a specific observation: for "the whole" man, for "every" man, for "all" men. Here three perspectives which are especially interesting, committing and stimulating in relation to the world of health, and thus for the economic contribution that this world requires, present themselves. Once again it is necssary to proceed in the argument by a process of references.

The idea that economy is for *"the whole" man*, or rather for the wholeness and unity of his values and his needs, especially when man is compromised in his health, raises the question of what a correct concept of *health* really is, and what a correct concept of "*quality of life*" really is. It is evident, in fact, that there is a close connection between these concepts of health and the quality of life and corresponding expenditure on health care. The Pope has observed in relation to this point: "While there is a sound appreciation of health expressed in an increase in the number of initiatives to promote it, something which reaches at times a sort of cult of the body and a hedonistic search for physical efficiency, at the same time life is reduced to being seen as a mere commodity of consumption, and this brings about new forms of marginalisation for the disabled, the elderly, and the terminally ill" (Message for the VIII World Day of the Sick, n. 5).

Furthermore, the relationship between the economy and health, in terms once again of "the whole" of man, leads to very different outcomes according to whether medicine chooses to place itself at the service of "rights" or of the "wishes" of the individual.

Once again we encounter the inescapable need to invoke a suitable anthropological approach if we want to deal in a truly human way with the large number of questions and issues connected with the relationship between the economy and health, with special reference to the prevention, diagnosis and treatment of the illness of man, who should not be seen and treated in terms of mere different compartments.

– Furthermore, the economy is for "every" man. By this very elementary phrase I want to stress two factors. The first concerns in a specific way those people who are in situations of especial psychological or physical fragility or who suffer from a serious illness. The sick person, the elderly person, the handicapped person, and the person who is not self-reliant etc., have the right to be helped economically so that they can obtain, where possible, a better condition of health and life situation, even when such help does not lead to a profit but to a loss. Yes indeed: a loss. But what kind of a loss are we dealing with here? In what terms is something being lost? As can be seen, we return once again, and in a strong way, to the fundamental question of the relationship between economic considerations and human requirements, or if it is preferred the question of an economy for its own sake or an economy:made for man. The second observation about the need for an economy made for "every" man involves the principle of due consideration for the individual in his uniqueness and unrepeatable nature. This means, also and above all else in the health-care field, that equality is not egalitarianism but an ability to give to each person according to his own particular situation. Here, too, the democratic principle referred to above of "beginning again from the least of our brethren" holds true.

– Lastly, the idea that the economy is for *"all" men*. This universal destination raises a series of questions and issues in the field of illness and health which lead back after a certain fashion to the question of the *allocation of health-care resources*, or rather of how to distribute economic goods and services amongst people who can benefit

from them. This can take place through *macro-allocation* in health-care policy, both in relation to the investments in health-care as opposed to other social sectors (education, the fight against poverty, defence, the family etc.), and in the form of a policy favouring certain areas of health-care as opposed to others and thus their various programmes. It can also take place through *micro-allocation* at the level of the social-health care organisation of specific institutions, something which involves the questions of the selection of patients to whom resources should be destined and the selection of priorities in treatment.

Once again the response to these questions and issues depends upon the anthropological perspectives which are chosen: on whether they take the form of individualistic liberalism, social utilitarianism, egalitarianism, or ontological personalism. From what has been outlined above, it will be evident that this paper follows this last anthropological approach, which is based upon a recognition of the absolute value of every human person and upon the search for common good through the good of individual persons (cf E.Sgreccia and A.G.Spagnolo, *Etica e Allocazione delle Risorse nella Sanintà* (Milan, Vita e Pensiero, 1996; and in particular cf L.Palazzini, 'Teorie della Giustizia a Allocazione delle Risorse Sanitorie' in *Medicina e Morale* 1996/7, pp. 901-921; and by the same author 'Per una Giusta Distribzione delle Risorse Scondo la Medicina Personalistica' in *Medicina e Morale* 1992/3, pp. 485-496).

In particular, the idea of the economy for "all" men immediately directs our attention to the *increasingly global horizon"* in which the issues and questions connected with "the economy and health" are situated. Here we should logically encounter the question of present-day *globalisation* with all its negative and positive features and aspects, not least in relation to the costs of health. We need only outline, in an extremely abstract form, the policy followed by the Magisterium of the Church, which repeatedly and forcefully calls for respect for, and the promotion of, the ethical dimension and thus approaches the reality and issue of globalisation under the banner of global solidarity.

In this sense we cannot neglect the very serious social inequalities in relation to access to health-care resources which are still today to be found in vast areas of the world, especially in the countries located in the south of the globe. As the Pope writes in his message for the Seventh World Day of the Sick of 11 February 2000: "this unjust inequality affects in an increasingly dramatic way the area of the fundamental rights of the person: entire populations do not have the possibility of taking advantage of even primary medicines, whilst elsewhere there is a high level of abuse and waste of even expensive medicines. And what should be said about the terribly high number of brothers and sisters who do not have enough to eat and are thereby the victims of every kind of illness? And this not to speak of so many wars which cover mankind with blood and sow, in addition to death, physical and psychological traumas of every kind" (n.4).

4. God wants to leave Man "in the Hands of his Advice"

The "lordship" of man, to which reference has already been made, is not primarily of an exterior character, that is to say in relation to the world of things. It is, rather, interior in nature, It concerns man in himself, in his self-possession, as St. Thomas Aquinas loved to say: a free man is a man who has control over himself and decides on his own the meaning of life, or rather in line with truth and good. As Vatican Council II writes: "But man can turn to good only in freedom, that freedom which our contemporaries value so highly and search for so strongly, and with good reason. Often, however, they cultivate it in a wrong way, almost as though everything which is pleasing is right, including evil. True freedom, however, is the very high sign within man of the divine image. Indeed, God wanted to leave man "in the hands of his advice" (cf Eccl. 25,24), so that he could spontaneously search for his Creator, and freely reach, through adherence to Him, full and blessed perfection" (*Gaudium et Spes*, 17).

Freedom is inextricably bound up with truth – in the words of of Jesus "the truth will make you free" (Jn 8:32) – and is intimately connected with the conscience which is the "most secret nucleus and the sacrarium of man, where he finds himself alone with God whose voice is to be heard in his own inner self" (*Gaudium et Spes*, 16) and which is a certain sense is the "heart" of morality. It is precisely this morality (which as we have sensed possesses a deeply religious or theological basis and destination) which can connect the economy and health in a human and humanising way.

For this reason, what has been said above can be seen in a more organic and deeper way and further developed and expounded in terms of morality or responsible freedom. We only need engage here in a few rapid observations to demonstrate that morality is able to:

– provide the economy – esepcially the economy in the field of health – with its essential ethical dimensions and requirements;

– act upon the health-care economy by reducing costs in a large number of ways; for example by educating people to follow a sound and healthy "quality of life"; by favouring prevention as a means to prevent people falling into certain situations of illness and infirmity; by excluding illnesses which are more or less the direct outcome of a real and authentic abuse of freedom, etc.;

– obtain a more equitable distribution of the available economic resources by avoiding the use of useless medicines and admissions to places of treatment and care, by favouring day hospitals, etc.;

– improve the professional and human quality of health-care workers, both through permanent training and through growth in their spiritual and religious lives.

5. The Word of God and Human Words

Here this paper must draw to its conclusion. Two observations on the Word of God which have been the basis for this paper on the subject of the relationship between the economy and health can be especially useful.

The first concerns the connection between the Word of God and *human words*. As was pointed out at the beginning of this paper, we cannot hope that the Word of God will provide us with a complete and definitive answer to every human question, especially at the level of great detail and in new and unprecedented historical situations. The Lord who gives us the light of his revealed Word is the same Lord who also gives us the light of human *reason*. We are thus directed not only to listening to the Word of God but also to rational thought and reflection, at an ordinary level, in critical terms, at the level of scientific elaboration, as a theoretical reflection and as existential experience – and this is a search which is not only personal but also collective. It is precisely with reference to questions where Revelation does not provide explicit and detailed teachings that Vatican Council II writes: "temporal undertakings and activity are specifically, if not exclusively, the responsibility of the lay faithful... Their consciences, already well formed, are called to write divine law into the life of their earthly city. Spiritual light and force are to be expected from priests by the lay faithful. They should not, however, think that their pastors are always so expert that in response to every new question – even the most serious – which arises, they have ready a concrete solution or that priests are called to this by their mission: they should, rather, face up to their own responsibilities, in the light of Christian wisdom and with respectful regard for the teaching of the Magisterium" (*Gaudium et Spes*, 43).

The second observation stresses the absolute *originality of the Word of God*. It is "revelation" and this always offers a great and new light on man in his personal dignity as the "image of God" – this is a light which inevitably shines, albeit in different ways and at different levels of intensity, on all the questions which concern man. But it is not only revelation, it is also a "commandment" and "grace".

As a "*commandment*" the Word of God is a challenge to our freedom and a constraint on our conscience. Our freedom must be "responsible", or rather be obedient to the design and will of God in relation to man, and our conscience must enter into the dialogue of man *solus cum Deo* and "listen" to his voice. But, as the Pope writes in the encyclical *Evangelium Vitae*: "the commandment of God is never separate from his love: it is always a gift for the growth and joy of man. As such, it constitutes an essential aspect and an inalienable element of the Gospel, indeed it is itself is a "gospel" or good and happy news" (n.52). If it is a "gospel", if it is a "grace", the commandment of God is certainly entrusted to the freedom and conscience of man, but it is even more made possible in its achievement and after a certain fashion made easy and gentle by the freely-given love of God. This kind of conviction of faith can also generate lucidity of vision, hope and courage in facing up to the complex questions and issues connected with the economy and health.

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Models of Health in Contemporary Society

The phrase "the right to health" has by now become a phrase in current use. Over the last fifty years the meaning of this phrase has become clearer in a process which has linked it to the right to development and growth. The first politicians to launch the doctrine of the rights of man sought to so direct social organisation as to ensure that everybody could meet their own essential needs.

The right to health is a part of the fundamental rights of man, and this is something which can be verified at an empirical level by looking at the innumerable charters of rights which make reference to it.

What is the basis of this right? This question should not be considered ingenuous, nor should it be avoided by a mere invocation of common sense which places "feeling well" at the summit of every possible and imaginable heirarchy of "values". This is an essential question, primarily because it is of the essence in any anaylsis of this right from both a juridical or sociological point of view (that is to say in what way the defence and/or the promotion of this right has an effective character which impinges on the present-day historical context and geographical environments). In the same way, it should be observed that the scientific formulation of the category "right to health" by legal and jurisprudence experts often fails to have full conviction when it comes to its epistemological origins and validity.

Feeling well or feeling bad are absolutely personal subjective states or conditions whose interpersonal capacity for communication is very difficult from an objective point of view. In other words, there is no shared yardstick by which to define or assess the wellbeing produced by "health" or the ill-feeling generated by "illness".

Rather than speaking about the right to health we should refer to the right to the protection of health. This is because it is possible to assert that there is not only the right to subsist but the right to authentic quality of life. This is something which means access to health care and to those means and instruments which are needed to ward off the dangers to health – dangers which the individual or a group feel powerless to defend themselves against.

In a certain sense all of us fall ill at a certain moment of our lives, and after a certain fashion illness is bound up with health. For this reason, the definition of health as such, according to the definition laid down by the World Health Organisation, could appear to be utopian. Health is not only the absence of illness – it is also a state of complete wellbeing, which is economically productive, socially acceptable, and universal in character. Is such a universal character really possible? Are societies really ready to transform this description into reality? Although this aspiration can certainly appear to be a dream, it nonetheless constitutes a fundamental orientation or horizon of the humanistic vision, and as such it also matches the Christian vision of what the destiny of man should be.

In discussing the subject of illness and health, an eminent Spanish medical doctor who is a specialist in endocrinoloy, Prof. Martin Ibanez, arges that although in studying medicine doctors are taught to recognise the symptoms and manifestations of illness, they are not at the same time taught to recognise the symptoms and manifestations of health. And this despite the fact that were they to do so, we could probably alter our lifestyles accordingly.

The right to the protection of health is recognised by the majority of the fundamental texts concerning this area to be found in industrialised countries. However, the process of globalisation which is today bringing with it so many advantages and opportunities, is also at the same time presenting us with enormous challenges to health.

In the contemporary globalised world, where it seems that everything is reduced to a discussion of social questions and issues in merely economic and financial terms, a serious problem is raised when reference is made to health and to the related question of economics and financing. For this reason, this right is not possible if the state does not guarantee access to health care to all of its citizens, irrespective of their economic status and condition, their educational level, their geographical location, and so forth.

The advances achieved in the field of medicine in recent decades may indeed appear "to work miracles". But this is something which has been achieved at a high cost. Not so long ago our knowledge allowed us only small room for action, although it is also the case that what was done could be done for everybody. Nowadays, however, in the changed situation which presents itself, certain governments apply restrictive policies in this area.

Those countries which are economically advanced have for some time been undergoing a major increase in their outlays on health-care expenditure. Within the context of a decrease in overall growth this has brought about a worrying increase in the relationship between health-care expenditure and national domestic product, something which has been accom-

panied by growing tensions within the general framework of financial compatibilities.

This set of circumstances has given rise to the birth of a conflict which has so far not been resolved, namely the conflict between the specific goals of the health-care system as expressed by the current policies pursued by governments – that is to say the increase in the length, and the improvement, of the physical quality of life of citizens – and a dependence upon an increasingly restrictive budget in relation to public sector expenditure.

Personal expenditure on health has increased at levels beyond any reasonable forecast. Contemporary diagnostic instruments and methods have in the same way been encouraged in their development and use by insurance companies operating in the health-care field. In other words, it is possible to demonstrate the existence of a connection between incentives behind scientific research – which tend to encourage and develop particular forms and directions of technology – and the role of insurance systems on the one hand, and the effects of now types of technology on the other.

The functioning costs of present-day welfare provisions, which are far-reaching and solidarity-inspired, are very high. This endangers the financial equilibrium of government budgets with regard to public health-care services and the respective balance of personal contributions to public and private systems based upon insurance.

These systems are experiencing a growing financial and organisational imbalance as they try to deal with the expansion and intensity of request for health, based as they are upon their original forms of providing equality in provision to everybody more or less without direct charges.

However, the solution to the economic and financial problems involved cannot be found in the mere reduction of health-care expenditure by public authorities.

The factors which determine the levels of health in a community are many in number: those which are directly concerned with health (technical and human means and instruments) and those which help to create the conditions which enable the inhabitants of a country to enjoy the best possible levels of health (education, growth and development, and social and economic integration).

However, if these resources are not distributed equitably access to health necessarily comes to be denied. For this reason, a health-care system is equitable only when it guarantees equal access to care and treatment and offers the same services to people in similar states or conditions. In order to be equitable this system must also provide different forms of treatment to individuals who find themselves in different life situations: that is to say, what is really required is a policy of equal treatment for equal people and different treatment for different people.

Health must be maintained in line with the commandment “thou shalt not kill”. This is a commandment which in a positive sense requires care for health. It is based upon four principles which explain its nature: the life of man comes from God, who created man in his own image; man must be free to direct his life constantly towards God; God alone initiates life and ends it; and God has transformed this life into the life of the children of God.

In his message to the Seventh World Day of the Sick, which will take place on 11 February 2000, the Holy Father observes that two duties require special attention on the part of the Christian – the defence of life and the promotion of a health which is worthy of man.

Health has biological, psyhcological and social connotations. During the early history of man health, and in particular illness, were seen as things which came from the transcendental world and depended on the good will or ill will of superior beings. Their social dimension received much emphasis through the provision of treatment in the form of public ceremonies and rites.

But with the advent of the modern secular age everything in the realm of health and illness which previously had a religious connotation was put to one side, and health and illness received a purely biological connotation. Such was the case during the last century and the early decades of this century, although, to tell the truth, today people are beginning once again to lay emphasis upon the psychological and social dimensions to health and illness.

In the present-day world significant advances have been achieved in relation to health-care services. However, there still exist major failings which have to be corrected, and this is because democratic regimes do not exist throughout the world. One thousand three hundred million people live below the poverty line; the gap between the rich and the poor grows ever greater; demographic growth also has an effect; the high levels of rapid urbanisation; emigration; the ageing of certain populations; climatic change; the thinning of the ozone layer; air and water pollution; changes in the distribution of public and private health care; low levels of infant mortality; the decrease in contagious diseases; higher levels of life expectancy; the increase in non-transmittable diseases; AIDS and smoking – these are the major causes of death. And this within a context where effective and economic forms of technology provide us with the opportunity of helping the least protected sections of the population.

The right to health is coming to acquire a new character which perhaps, and probably in definitive fashion, has entered into the collective conscience, albeit not always in an explicit fashion. This new character is that of the identity itself of the human person.

In claiming health as a right, in the final analysis the individual claims the right to be recognised in relation to his or her own identity, as a right which is rooted in the sphere of relations. In recognising health as a fundamental right, the legal system recognises, and also takes seriously, the shared and equitable subjectivity of all human beings.

The way in which attention is paid to the needs of collective rights to health centres around three principal systems. For the pure liberal the person who has money pays and the person who does not have money has to resort to public charity. For the humanitarian liberal the person who can do so pays for health-care provisions, and the health of the person who cannot engage in such a course of action is the responsibility of government. Thirdly, there is the liberal-socialist position. According to this approach, the state is responsible for everybody but the individ-

ual who so desires can have access to private medical care.

Medical care, therefore, is organised in today's world in a whole variety of ways, beginning with independence and freedom and ending with a situation where medical services are exclusively and totally provided by the state. It would be impossible to give a detailed description of all the systems which presently exist, but it can be said that whereas in some countries help is given only in extreme cases of need in others a system of health insurance prevails, and in yet others a policy is adopted whereby a complete system of health care is organised where personal initiative exists side by side at various levels with government action and policy. This is something which further varies the ways in which medical care and treatment are provided to members of a population.

The model of health for today's world should introduce a way of doing things which means that the peoples of the globe can achieve a state of health which enables them to live a life which is economically and socially productive in a way which respects the global environment, and the values of the past, with adaptations to changes and present-day needs and the proposing of solutions for the future which should always be rooted in the equality of the rights of man.

This model should have as its object the raising of life expectancy and of levels of quality of life, an increase in the health prospects for contemporary and future generations, and a reduction in death rates linked to ageing. The practical principles by which to achieve these goals are the following: action at a world-wide level to protect health at a national and local level; the drawing up of a policy which brings science near to actual facts and is completed by the participation of the population in the taking of decisions; a commitment to health-care strategies which are compatible with sustainable growth and development; the application of a global concern with the life of the individual in health-care development; a commitment to respect the specific character and needs of each of the sexes; a commitment to promote the quality of life; and the application of flexible strategies which can be adapated and applied to permanent change.

We need to promote macroeconomic and social policies based upon fairness which involve direct investment in health-care provisions and services based upon a demonstrable cost/effectiveness relationship. Such policies should concentrate on unprotected groups and should introduce insurance factors which can protect vulnerable populations. We should not forget that in the face of a generalised reform of how we are governed the welfare state which was with us for so many decades is now beating a retreat.

For this reason, it would be a good idea to remember that all the economic models which in the final analysis go to make up a society must be rooted in man, and must find their support and points of strength in man – the epicentre of the divine creation. Although the new ways of looking at the social and economic spheres mean that governments nowadays are no longer the benefactors which they were for decades, this does not imply that they are no longer responsible for their citizens and that such a responsibility has shifted to the private sector and in particular to private companies. Were this to happen we would run the risk of having an unfair society lacking in solidarity which would favour individualism in a context where the human being would come second to the economy in terms of importance and value.

With regard to the whole world of health-care systems and services, a policy of decentralisation should be engaged in and an approach of solidarity between the rich and the poor, the healthy and the sick, and the young and the old, should be developed and consolidated.

When it comes to the management and utilisation of human resources in the health-care world, these latter should be up-dated through courses which should also be held for professional workers. We should transform principles and values of action into a struggle against economic inequality which will then bring about less provision of health care because the need for it is much reduced. We need to give priority to those countries which are most afflicted by poverty and illness.

Today health services are on the increase and from an economic point of view they are becoming, like many other services, a commercial commodity. This is happening to such an extent that we all know that there are chains of multinational hospitals, just as there are chains of hotels, where service is assessed from the point of view of what is provided in terms of the comfort of the patient without any reference necessarily being made to the quality of medical and technological services which are on offer.

It is probably the case that the technology in these hospitals is the most up-to-date available, but we should ask ourselves whether the most modern forms of technology are really the best that there are. It seems as though such is the case because, as fashion is to be found everywhere, if these institutions do not use the latest technology the patient could fail to be satisfied.

Governments cannot deny their responsibility in relation to health. Although they are not the direct providers of health they are, however, the responsible legislative body according to the constitutions of each individual country. For this reason, I would like to make an appeal to the authorities who wield responsibility to ensure that at the present time when the role of the state is being redefined we do not end up by being a state only on paper. Such

authorities must not be passive spectators of a situation which is presented to them. They must shoulder their political responsibilities towards the state and society, and in so doing they should avoid the lack of faith of the former and the lack of interest of the latter.

Although over the last twenty years the world has produced the highest level of wealth ever in its history, it has also produced the highest number of poor people. There is an imbalance here, a disjunction. We all know, and this is especially true of the most industrialised countries, that life expectancy has increased markedly. In opposite fashion, developing countries have problems of health, chronic illnesses which previously did not exist – or at least at present-day levels – and contagious diseases. Non-contagious diseases are also present in these countries, but their origins are different. This is because previously people did not live long enough to have chronic illnesses in these areas as a result of the fact that mortality rates were very high during childhood.

At the present time a suitable and appropriate health-care policy must be based essentially on three fundamental elements. Firstly, the right to health. Secondly, fairness, solidarity and an ethical approach. Thirdly, an equitable treatment of men and women. These values are those of the message of the Holy Father to the Seventh World Day of the Sick and of the Christian principles of the Catholic Church.

Ethics as applied to health must be effective from the beginning of life until its end. For this reason, both from a curative point of view and in terms of prevention, health must be supported by an ethical approach and by respect for the human condition in its highest form.

When it comes to health-care services and life expectancy, this subject should be discussed not only in terms of care and treatment but also with reference to the quality of life, to the human condition where such quality of life must be provided according to the means and instruments which are available within each community.

Equity in health-care services must be achieved in relation to needs and should not be a matter of the ability to pay of each individual or each community.

Present-day policy must place health at the centre of development. In this way, on the threshold of the third millennium, man and the dignity which springs from his nature should become ever more dominant as the primary values of global society.

In the field of health and health care the meaning of the dignity of man has a very special relevance, given that political, social and economic factors and realities must be subordinated to it.

Together with the right to life, health is one of the human rights which most bears on the full development and implementation of the other human rights. If his health is compromised an individual cannot work regularly, family groups become weaker, and many other negative consequences follow which could also be listed. What is needed, therefore, is a new allocation of budget resources so that, in conjunction with education and schooling, the effective validity of the right to health is upheld and promoted.

Health is a good to which we should be able gain access. But the distribution of resources between countries and within a nation are not equal. For this reason we must ensure that health-care services do not favour only a minority of the population or the world's nations. Health must be the subject of a voluntary policy promoted by governments. The goal of a health-care policy must not be reduced to the mere defence of the members of a community against illness but should be the outcome of an approach designed to mobilise economic and other resources by the state, thereby ensuring fairnes in the access to health-care services for those who are in a condition of poverty or material need. Mechanisms which ensure free access or low-cost access to health-care for citizens and take into account age, pathology, and family group in doing so, must strive to achieve a necessary balance between equity and solidarity. This is of the essence if we want to achieve a health service which must of necessity continue being public in character and which is understood and experienced as a communitarian, social and individual good which must never be abandoned.

The Institute of Ombudsmen can provide a x-ray of the undesirable consequences of dominant economic doctrines which seem to substitute the values of an axiological scale with those of an economic scale. In this way efficiency takes the place of justice; the search for wealth that of fairness; and economic growth that of solidarity, and all this as though they were opposing values which are incompatible and non-complementary. But in actual fact efficiency can be achieved with justice, wealth with fairness, and growth with solidarity.

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Health Systems Compared

I like to believe that as human beings became socialized into groups of one kind or another an understandable tendency to care for one another arose, and care in times of sickness must have been seen as a normal expression of concern for those who were in some way vulnerable or diminished. The recognition of the importance of these acts of caring that extended to healing are very much a part of religious faiths all over the world, and many faiths must record acts of succor and care for the ill and wounded similar to that of the Good Samaritan. Herodotus[1] writes of the obligation of a citizen to attend to an ill person: "*It is not lawful to pass a sick man by in silence, without taking an interest in his complaint*". It is very much a part of our faith to care for the health of those who need it, although many of the injunctions to care for others are given to specific individuals. Luke the physician refers to the seventy who went forth into every city and place with instructions to heal the sick, and St. Paul, in alluding to the various spiritual gifts, makes special mention of the gift of healing.

This attention to healing as a special gift or responsibility goes even further back in history. The Assyrians and Babylonians assigned the responsibility for medicine as a specialized craft to the priesthood, and we know that the code of Hammurabi of some 4,000 years ago defined very clearly the rewards and penalties that were to be attached to medical practice. If the patient died or lost an eye as a result of an operation, the doctor's hands were cut off. The emphasis was very much on individual care, although there is evidence that the Babylonian state considered environmental sanitation important enough to have drains and sewers in public places. The same focus of individual care appears in ancient Indian medicine, but I could also find reference there to the responsibility for the health of groups such as the armed forces. One king was said to have kept his doctor close by to look after him as well as the health of the troops.

It was inevitable that the attention to the sick separately and by individual practitioners would not be enough and would inevitably be accompanied by institutional systems that cared for patients. The most famous and durable of these systems is the hospital and in Europe we see the rapid development of these institutions under Christian direction after the conversion of Constantine. There is evidence of the establishment of hospitals in the East even earlier, but the point to be made is that the organization of a system of care based on institutions is to be found in the histories of all parts of the world. There would, of course, be differences in the types of treatment to be used and in many instances in the type of person to be treated, as it is clear that in most early societies, hospitals were essentially for the care of the sick poor while the rich were treated in their homes.

Hospitals are only one part of a health system, and as we look to compare health systems in a broader context, it is useful to have some concept of what is a health system, what are its functions, and what are the various typologies that can be compared. I understand the health system to be a social system, an integrated whole that depends on its functioning on the interaction among the various components. These components are essentially a set of financial, human, physical, organizational and informational resources, which, through their interaction provide better health for individuals and populations. As in any system, it is the interaction that is important and the value or output of the system is more than the sum of the contribution of the constituent components.

All health systems are firmly grounded or are perhaps derivative of the cultural milieu in which they operate, and the end results they produce in terms of health will also admit of variation to the extent to which health is culturally determined. Kleinman[2] in a classic conceptualization of health systems as cultural systems, emphasizes the difficulty of making comparisons

and it is clear that attempts to judge value of outputs run the risk of being arrogant in terms of establishing some hierarchy of cultures. He explains a concept that is often forgotten or ignored. He writes:

Most health care systems contain three social arenas within which sickness is experienced and reacted to. These are the popular, professional and folk arenas. The popular arena comprises principally the family context of sickness and care, but also includes social network and community activities. In both Western and non-Western societies, somewhere between 70 and 90% of sickness is managed solely within this domain.

This gives an idea of the small fraction of sickness treated in the professional arena. Yet our classification of the various types of care systems and our estimates of costs focus almost exclusively on this area. The differentiation of health care systems into the Western allopathic medicine and traditional or complementary medicine that has achieved such prominence in Western societies recently is based primarily on this small fraction. I propose to compare the systems within the Western model and then attempt some comparison between the western and other models.

Before examining the construction of the Western type system which is the one I know best, it is salutary to reflect that all health systems probably carry out certain basic care activities, and comparison between them turns mainly on the extent to which they discharge the basic functions of improving the health status, are equitable and respond efficiently to the legitimate expectations of the population in which they are grounded.

The health systems first and foremost provide for the promotion of health, prevention of sickness as well as the cure and rehabilitation after sickness and there is a wide armamentarium of technologies for discharging this function. They contribute to the cultural construct of illness. Disease represents a malfunction of a biological or psychological process while illness is essentially experiential. I was brought up, however, to link the two and represent disease as the lack of ease, the perceived departure from some equilibrium and in this context there may still be ease in the presence of physiological disequilibrium.

The systems are also responsible for what Kleinman describes as the "*cognitive and communicative processes involved in the management of sickness including labeling, classifying and providing personally and socially meaningful explanations*." Health care systems must also be agencies of record. The informational resources of the system represent not only the channeling of data into the system, but must also provide for the recording and codification about subjects as well as their environment in such a way as to allow for continuous reform, adaptation and functioning of the system itself.

Hanson and Callahan, in their book *The Goals of Medicine*,[3] in the context of priorities that should be established or at least kept in view in the process of reform that is sweeping the world, established four major goals which may be relevant or applicable to any health system. These are: the prevention of disease and injury and the promotion and maintenance of health; relief of pain and suffering caused by maladies; the care and cure of those with a malady and the care of those who cannot be cured; and the avoidance of premature death and the pursuit of a peaceful death. There may be nuances of emphasis, but I am convinced that the professional part of all health care systems would share these sets of goals and it would be difficult to compare them.

It is the Western or allopathic system that occupies most of our thinking, at least in the Pan American Health Organization and it is interesting to reflect on the development of the types of system that fit broadly within this category.[4] There is no doubt that these systems are now the essence of pluralism; they come in several shapes and forms.

I have been intrigued by the growth of pluralism in this and other similar social systems.[5] With the signing of the treaty of Westphalia in 1648 that signified the end of Europe's Thirty Years War, we saw the growth of statism, and the pluralist institutions that had flourished before began to wither. It is interesting that it took about two centuries to see the appearance of state control or strong intervention in an area as important as health care and the development of an appropriate state supported apparatus, when the state had become dominant in so many other fields. But within the last half century there has been a remarkable resurgence of pluralism in many spheres.[6] Now that we see the state losing influence or dominance as the prime or sole secular authority and the increasing power of a myriad of non-state actors in a wide range of fields that affect us, there is increased questioning of the role of the state in health.

It was Prince Otto Von Bismarck who in 1883 introduced the law in Germany that made insurance compulsory for medical care costs thus ensuring something approaching universal coverage. This was in the manner of a response to the social reform movement in which one of my medical heroes, Rudolf Virchow,[7] had participated vigorously. In 1848 he had written:

The state must do more. It must help everyone live a healthy life. This simply follows from the conception of the state as the moral unity of all individuals composing it, and from the obligation of universal solidarity.

It is well to note that Bismarck's gift to Germany and much of the world did not result in a single monolithic structure, but a series of

social funds which are nonprofit organizations regulated but not financed by government. These funds function as financial intermediaries between the organized contributors and the providers of care. This movement to social security spread slowly throughout the world and it was not until after the First World War that we saw the growth worldwide of the concept of the need for universal health care as an element of social justice.

The Soviet system of health care was an outgrowth of the urge for state control of social services, and the ideologically driven centralized planning of health care services had the goal of universal provision of free services. With the new form of social and political organization we have seen a breakdown in the institutional framework that supported the system and decentralization without adequate resources which have contributed to a deterioration of health status. The most marked result has been a major demographic crisis with a decrease in life expectancy mainly as a result of an increase in adult mortality.

After the Second World War there was a significant spurt in the growth of government responsibility for health care and the famous Beveridge Report of 1942,[8] laid the foundation for the British National Health Service which in spite of various adjustments essentially maintains its pristine character and provides from the public purse the financial resources needed to ensure universal coverage. Beveridge saw the improvement of health as a major instrument for the alleviation of poverty and in some sense was an echo of the proposals for the sanitary reform of Edwin Chadwick in the last century. The crux of Beveridge's recommendations was to *"divorce the care of health from questions of personal means."*

This type of approach did not spread to the USA where a fee for service system has persisted. In an analysis of the genesis and persistence of this system Starr[9] suggested that the traditional individualism of Americans, plus medical "professional sovereignty" that exercised influence in both economic and political arenas, were to a large part responsible. Starr's analysis prepared seventeen years ago was also prescient in that he posed the thesis that the profession's autonomy and dominance would be put in jeopardy by the very system it had created.

It is almost impossible to describe briefly the complexities of the USA system. In essence the funding comes from four main sources; there is public funding – either Medicare or Medicaid for the elderly or the poor: private employer/employee funding and then private funding by individuals who opt to insure themselves out of pocket. There are basically four main types of primary purchasers: the Health Care Financing Administration; State governments; private purchasers and businesses that have contributions from employees and the employers. In addition, there are two main intermediary purchasers – either private insurers or managed care organizations with provision of services through a wide range of public and private providers. One of the major defects of the system is that approximately forty million persons are not covered by any of the funding sources and find themselves without insurance and therefore without guaranteed access to services.

Thus there are essentially three main types of health care system operating globally. There is the Bismarckian model with emphasis on social security, and the social aspect extending to health; there is the Beveridge model as exemplified by the British National Health Service and then we have the market based approach that is the dominant feature of the system which obtains in the United States of America.

The systems that are most prevalent in Latin America and the ones with which I am most familiar are variants of the Bismarckian model. Londoño and Frenk[10] have recognized the pluralist tendency that exists and have divided these systems further. They describe the unified public model exemplified by Cuba and Costa Rica, the public contract model as applies in Brazil, the atomized private model of Argentina and the segmented model of the majority of the countries in which there are three clearly defined actors. In this segmented model the Ministry of Health, the social security system and the private sector all participate in the various functions necessary to deliver health care. All the countries have recognized that there is a need to reform their systems in order to achieve the goals of providing better health for individuals and populations.

Our approach to the reform needed in the Americas has been to emphasize the separation of functions in the various systems, and we recognize that there are three essential functions to be performed.[11, 12, 13] There is the organization of the delivery of the needed services, the financing and the regulation of the system. Our view is that the State through the Ministry of Health must assume the responsibility for the regulatory or steering role and that ideally there should be a single source of financing which in most counties will be an entity that incorporates the Social Security. The provision of the services may be in the hands of a variety of actors both private and public whose performance is monitored by the Ministry of Health in discharge of its regulatory role. The regulatory role of the Ministry of Health must encompass not only the personal care services, but also these functions are essential for public health. When one examines the health systems in Latin America and the Caribbean, it is this steering or regulatory role that seems to be the weakest and the least appreciated.

It is traditional to try to compare these systems in terms of equity,

quality and efficiency. This is not the place to analyze the large body of work on the nature of equity in health services and the ways it should be assessed.[14] But there is no doubt that the majority of the current ones are not equitable, and I make that bold claim because they contain and perpetuate differences, especially in terms of access that are unfair and unjust. Health systems are social systems and one of the essential characteristics of good social systems is that they be just. In some countries where there is the segmented system, with up to 50% of the population in the informal sector and therefore without participation in the social security there can be no equitable access to services. We are actively pursuing the possibility of micro-insurance schemes for these large, informal and usually poor populations. There are several other manifestations of inequity in terms of the urban/rural divide, the marginalization of indigenous populations and the treatment of women in their non-reproductive roles.

In a similar vein, the health care system that is essentially market driven cannot be equitable since large fractions of the population will not have access to services because of absolute or relative poverty. The approach to reform that we propose in PAHO would enhance equity because there would be universal access, and if the basic functions are performed by the actor to which that function is assigned, there should be quality and efficiency of care.

Systems such as the British National Health Service would appear to represent equity in terms of access and retain the egalitarian characteristic that underlay their establishment. Unfortunately, after fifty years of the system it is becoming clear that equity of access does not guarantee equality of health outcome. As a recent report on health in Britain stated:[15] *"Although average mortality has fallen over the past fifty years, unacceptable inequalities in health persist. For many measures of health, inequalities have either remained the same or have widened."* This shows that access to services does not represent the sole or perhaps major determinant of health status.

The various systems may also be compared in terms of the possibility of a central steering or regulatory role. The Beveridge model lends itself more easily to this type of control, and the many adjustments made over the past fifty years to the British National Health Service attest to the willingness of various governments to exercise that role. The Bismarckian model should also be amenable to a steering role being exercised by some government agency, and we find that at least in Latin America there are several attempts to do so with varying degrees of success. At least it is recognized that this role is critical for economic and social reasons. The market approach has not permitted the execution of any regulation by government except in some specific areas of public health.

I have always found it difficult to accept the various approaches to comparison of the quality of the output of the health care systems, especially when we refer most often to the personal care systems. The satisfaction of users of the system is a very limited tool, and the indicators that are used in population-based medicine are simply not applicable to personal care medicine. It is relatively easy to calculate the inputs, but the outputs especially in terms of the result of caring and curing are difficult if not impossible to establish. McDermott[16] divides the activities of personal care medicine into four categories: technologic use, Samaritanism, physiologic supportive management, and the technology–based capability to report negatives authoritatively and hence help maintain peace of mind. Many of the outputs or results of these activities cannot be measured by the indicators that seek specific and immediate changes. The cure of a patient with pneumonia or the relief of pain in one with a terminal illness defies the traditional measurements of health outcomes.

Throughout those parts of the Western world in which allopathic medicine is dominant, there is a constant concern for cost of the systems and whether any of them can respond to the legitimate expectations of the population they were designed to serve. In almost every country the costs of the health system as a percentage of GDP is rising, and while a legitimate but perhaps philosophical question is whether there is any optimal level of expenditure in the health care system the reality is that the opportunity cost of such expenditure is a cause for scrutiny and concern. But the more alarming fact is that no country will ever be able to invest enough in the health care system to satisfy all the demands or expectations of its people, and qualifying those expectations as legitimate or not does little to solve the problem. This is a question that transcends economics and reaches into the areas of the ethics and politics of resource allocation.

Callahan[17] addresses the issue in relation to the health systems in the USA which are the most expensive in the world and doubtless the same problem will be seen eventually in most countries of the world. He asks the question "what kind of life?" and explores the limits of medical progress. He writes; "*We have lost our way because we have defined our unlimited hopes to transcend our mortality as our needs, and we have created a medical enterprise that engineers the transformation."* The success of the technologies employed in the health care system has raised the expectations of the public. The notion that somehow the cost can be contained by finding some way of organizing the health care system,

or finding new and less expensive treatments is a mirage. The very success of the system leads to its problems. The nature of the human condition is such that there will always be disease at one or other time and the tendency has always been to see the cure or alleviation of such disease from the individual perspective. While no individual wishes to compete with another in terms of living longer, we are acculturated into wishing to prolong this life as long as possible and by any means. The sanctity of life and the intrinsic value of health as exemplified in Hippocratic ethics have been perhaps over-interpreted to mean that every means at our disposal should be used to extend that life. Callahan's view is that the debate has to turn on the extent to which the individual demand on the health care system should be subjugated to the need to apply resources for the collective good.

In establishing the fulfilment of expectations as an indicator of the extent to which health systems function appropriately we must be aware of the above. It is clear that the problem is not restricted to the developed societies. The ubiquitousness and pervasiveness of the information about the so-called medical triumphs is leading societies that lack even what would be described as basic care to hanker after these life changing or extending technologies. Callahan says *"It is ourselves who must change, those selves that have looked to medicine to deliver us from the burdens of a body that insists on its mortality. We will not be so delivered. Our task is to know what to do about that truth."*

The organization of resources within the professional personal care arena can also be considered a system of health care. I have already examined some of the different systems of personal care medicine that could be characterized as belonging to the Western or allopathic genre and which have also been referred to as the biomedical model of health care. But we know that there are other systems and many of them are gaining increasing cognizance where western medicine was formerly dominant. It is interesting to note that in some ways we are going back to the essentials of Hippocratic medicine that emphasized the interrelationship of the various internal and external influences on health. Health care had to be shaped according to these concepts. But the discoveries of Descartes and Newton led to the mechanistic paradigm that has dominated medicine and health care systems virtually since the sixteenth century. The universe and most of what was in it were viewed as a mechanical system with parts that functioned to great degree independently.

Capra[18] describes it well:

For the past three hundred years our culture has been dominated by the view of the human body as a machine, to be analyzed in terms of its parts. The mind is separated from the body, disease is seen as a malfunction of biological mechanisms, and health is defined as the absence of disease. This view is now slowly being eclipsed by a holistic and ecological conception of the world which sees the universe not as a machine, but rather as a living system, a view that emphasizes the essential interrelatedness and interdependence of all phenomena and tries to understand nature not only in terms of fundamental structures, but in terms of underlying dynamic processes.

This biomechanical approach has led to the dominance of systems that give preference to diagnosis of "disease" and the emphasis on cure. This model has resulted in

strenuous efforts to have more and more care come into the formal system of professional attention rather than remain in the domestic or folk domains. This type of health system is different to that which I understand to be the standard approach in other cultures. From the analysis of the Chinese traditional system given again by Capra it appears that the emphasis there has continued to be on balance and harmony and emphasizes prevention. He quotes from the famous *Nei Ching*:

To administer medicines to diseases which have already developed…is comparable to the behavior of those persons who begin to dig a well after they have become thirsty, and of those who begin to cast weapons after they have already engaged in battle. Would these actions not be too late?

However, we observe a steady growth of systems of medicine that are being referred to as alternative or complementary and are increasingly coexisting with allopathic medicine. I do not refer to growth in the folk domain, but to the part of the care system administered by professionals. There are several attempts to classify alternative medicine and the Office of Alternative Medicine, National Institutes of Health, describes seven broad headings which include: alternative systems of medical practice, as well as bioelectromagnetic applications, mind/body control and manual healing. The alternative systems have been classified into four sub-categories: acupuncture and oriental medicine; traditional indigenous systems; unconventional western systems; and naturopathy. These different care systems are definitely not a province of the underdeveloped countries, and there is a growing appreciation that pluralism of systems does not apply only within the western model. Pluralism of systems has been the norm in large countries like India and China for generations, and the question is being asked whether a similar movement in the West represents some measure of dissatisfaction with Western biomedicine or a significant and growing shift in cultural values with more attention being paid to things natural and spiritual.

It is impossible to compare these systems of alternative medicine with one another or with the Western allopathic system in terms of equity, quality or efficiency. If client satisfaction is a criterion of the extent to which expectations are being met, then these systems are improving because increasing numbers of persons are seeking them. The data on their use or the demand for them do not allow us to make a judgement as to whether there is equity in terms of access.[19]

Mr. Chairman, the theme of this conference is economy and health which I interpret to mean the relationship between health and economic growth of countries. Health systems are important in this regard for two reasons. The cost of health care systems is a concern for all countries – rich and poor alike – and has been a driving force for many of the efforts at health system reform. The USA spends approximately 15% of its GDP on health care and the figure for Latin America and the Caribbean is about 7.5%. The other and perhaps more important one is that investment in health is important for increasing the stock of human capital that is so essential for economic growth and the alleviation of poverty. Health is important in and of itself, but as Amartya Sen[20] posits, health is instrumental in enhancing the human capability that is essential for relieving poverty which is represented as a deprivation of basic capabilities. It is doubtful that the traditional health care system is the most important contributor to health status, but its contribution will increase as more and more emphasis is placed on having it focus on the preservation of health through greater accent on promotion and prevention, and the more effective use of the power of information in all aspects of health care. We have the expectation that such an approach to health and health care systems will indeed produce for us the abundant life of which St. John wrote.

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AFTERNOON SESSION

TONY ANATRELLA

Cultural Models of Health

Introduction

The social images which circulate within societies and the mass media place emphasis on questions and issues relating to health and health care. They bring out the expectations and the anxieties of today's world to the point of making health and health care the central point of all existential questions. But does not medicine, although it can indeed do much for the wellbeing of man, perhaps run the risk of being reduced to a religion of earthly salvation?

To summarise the models of health and health care in the contemporary world I would like to examine:

1. The present-day trends of cultural debate.
2. The recurrent themes with which we must work.
3. The cultural challenges involved in health and health care.

1. Present-day Trends

Present-day trends are dominated by the discovery and the control of the human organism to ensure medical effectiveness, which is, however, often constrained by various unknowns and by economic impediments, that is to say factors which work for inequality.

1.1. The Progress of Medicine

The advances achieved by medicine, by pharmacology and by life conditions have all opened up a large number of opportunities to combat numerous illnesses and delay death. Biological discoveries, and at the present time in the genetic field the increasingly detailed developed of medical iconography, the improvement of medicines and drugs, and the evolution of surgical techniques, all provide answers and forms of treatment for illnesses which have hitherto been incomprehensible and without real and effective remedies. The social image that springs from this means that from these results have been born hopes that open up new aspirations to health in those who want to take advantage of them.

1.2. Greater Wellbeing

In the face of these incontestable successes, which should give rise to joy within us, contemporary medicine has acquired an image of power and effectiveness on our social thought horizons. This dual image gives the impression that death can be avoided as soon as we are able to treat infections, change defective organs, and that medicine will be able to bring about greater individual wellbeing, something which is increasingly striven for in the developed countries. In commercial societies we have before us a medicine of comfort based upon the various needs of the consumer, which go from the demand for drugs and medicines to deal with life conditions and existential worries on to cosmetic surgery to change one's own look in line with the image that every person has of his or her own body, and finally reach the choice and selection of the characteristics which one would like one's own children to have.

1.3. Insecurity

However, it remains the case that even given the successes achieved in this area and the request for medical care put forward by individuals, certain questions still stand out. We cannot conceal the appearance of new epidemics and new illnesses which are the result of changes in our conditions of life, modifications to the environment, and ecological alterations brought about by technology and science. Massive deforestation in Africa, in Asia and in Latin America has destabilised the bacteriological and viral equilibriums which have become detached from their basic receiver and have acted to spread illnesses and diseases. Industrial pollution and the innumerable residues of human activity are now modifying the climate of the planet and altering undersea structures, and in the same way are destroying animal and plant species. The food-producing industries are producing effects whose consequences for nature, animals and the health of man have not yet been measured. The debilitation, for example, of the immunity system and of male reproductive systems – which in industrialised countries have lost fifty per cent of their fertilisation powers over the last fifty years – is a disturbing sign that things are going wrong. In this way a feeling of insecurity and uncertainty is spreading in people's minds, with a resultant need to defend oneself from dangers and the risks not only of nature but also those caused by man, his research and his actions.

1.4. Poverty and the Humanitarian Challenge

Lastly, in third world countries, health-care services lack in a significant way the means by which to treat most illnesses. In low-income countries, which have to deal with economic adjustments, it is becoming difficult to deal with the three most important problems that face

them: the management of the problems and difficulties connected with the absence of hygiene; the identification of treatment thanks to the emergence of specific diagnostic equipment and methods and effective forms of treatment; and finally contained infectious pathologies, concern with degenerative and proliferating illnesses, the identification of pathologies caused by industrialisation, urbanisation and under-employment. Growth and greater wellbeing are very restricted for a large number of countries when basic medical care are provided with increasing difficulty. This is even more true the more countries suffer from wars over frontiers, civil wars, or ethnic conflicts. The development of humanitarian and medical aid organisations demonstrates a sensitivity in relation to the desperation of those who are cruelly made the objects of suffering and illness caused by war and economic disruption. These different organisations, which have specialised in the field of a special human problem such as health and health care, have taken the place of the religious congregations which were once concerned on a broad front with the health-care, educational, school and cultural aspects of different populations, and especially the most underprivileged populations, and employed in so doing an overall vision of existence. Health has become a major human challenge and we need to perceive in this development an advance of the human conscience within the framework of the solidarity of a shared humanity – something held very dear by Christianity – towards those who are humiliated and afflicted in their dignity.

In these conditions, the image of invisible health and omnipotent medicine returns to a more humble vision of things. But profound inequalities exist which accentuate the differences within society and between rich and poor countries. Are we forced to recognise that human health does not have the same value in both contexts?

2. The Recurrent Themes of Health within our Culture

The health-care arguments and strategies which are implemented at a practical level display a will to protect and save lives whatever the conditions of existence of the person concerned. But this noble aspiration is conditioned by the idea that one has of life.

2.1. The Primary Importance of Life

The development of programmes, but also of health-care monitorage at a local and worldwide level, is the expression of a need to always protect and promote life. The art of knowing and healing, not to speak of a moral attitude of generosity towards, and concern with, sick people, are a constant feature of medicine. We have to know how to love people and have a sense of love for life in order to practice the art of treating and bring relief to those who need help, who suffer, and are sick. The primary importance of life dominates the large number of hopes which are today to be found in the field of health. These hopes are justified by the advance and development of discoveries and technology which can be applied to the field of medicine. We rediscover this desire to live better and to enable other people to live better in the large number of forms of request and supply in the health-care field.

The primary importance of life is understood as an approach in favour of safeguarding health which runs the risk of deteriorating as a result of the precariousness of human existence, but also because of the damaging effects to life provoked by man through his various actions, and through war. Here we are at the heart of the paradox where the primary importance of life, as a health-care value, is often in contradiction with war-making strategies to which civil populations fall victim and who must be helped in inhuman conditions. The primary importance of life is also opposed by techniques that are used to suppress life at its beginning and at its end, or by the use of biological manipulations which can at times undermine the meaning of the integrity of the human person. From this picture one can gain a image of man who arrogates to himself power over life and death based exclusively on the power and capacities of his technological progress and advance. The axiom of this technological "morality", detached from every reference to an anthropological or moral approach, could be defined in the following terms: because the act is technically possible, moral problems must not be raised. We thus witness a movement away from reference to universal moral values to reference to technological effectiveness. The upholding and defence of the primary importance of life is here ambivalent because it is restricted to a merely instrumental and subjective perspective.

2.2. Health is a Philosophy

Attention should be drawn to the importance of the multiplication of productions of the mass media (radio, television, the press) in the field of health and health care. This is because they allow greater awareness by people of the need to take care of the quality of their way of living in order to avoid the outbreak of numerous pathologies. The spread of acquired and precise knowledge in the medical field means that every individual is informed and thus is able to help, and enter into discussion with, a medical doctor about what he needs, even though such knowledge derived from books is often wrongly interpreted by the patient who does not have the specialist training to enable him to use such knowledge, beginning with the first step of a correct diagnosis.

We live in a world of medical, psychological and psychiatric concepts which in the developed countries bear witness to the circulation of numerous health-care messages which condition minds to such an extent that they reduce existence exclusively to worries about health. Requests with regard to health have become an art of living which takes the present-day form of the earthly salvation of a man who would like to be full of energy and protect himself against the dangers of contemporary life. Prevention in health matters, in relation to road accidents, drug-addiction and sexually transmitted disease can play a determining role in the promotion of more responsible forms of behaviour on the part of individuals and of solidarity-inspired activity on the part of the society to which they belong. But the multiplication of works of prevention in various directions expresses a fundamental lack of the overall education of individuals, which is not always ensured, to encourage people to adopt

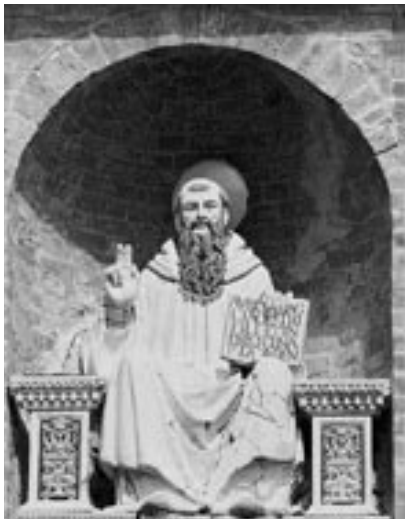
in a reasonable way a meaning of realities and responsibilities which are always seen in terms of universal moral norms.

A certain form of ascesis underlies the contemporary philosophy of health, and this provides information on the relative risk of a practice or a product, implements a strategy, and invites each one of us to engage in self-determination. This is an individual ascesis which has no other goal than that of maintaining an existence so as to preserve it for as long as possible without at the same time being an economic burden for society. Health-care ascesis which goes from hygiene necessary to the very poor to restrictions on consumption left to the free initiative of individuals, does not involve a deepening of spiritual life (as happens in the case of the Christian faith through self-control, temperance and the search for happiness through living the virtue of hope), but merely allows the protection of one's own life. Because of this need for protection in relation to the anxiety that we will fall ill, become contaminated or polluted, health has become an obsession which massively concerns individuals and the screens of the mass media. Of course it is necessary to take care of one's own health and to pay special personal attention to the financial problems which can lead to illness, but we can observe the development of almost ritual practices designed to ward off illness and its effects. The growth of insurance for the financial coverage of most health-care risks is undoubtedly a good thing, at least for those who can afford such insurance, but this, too, belongs to the idea of defending oneself so as not to be exposed to the risks of existence. In this way health has become a philosophy of life whose primary objective is continuing to be in good shape. The end of existence, in this outlook, is to obtain good health through a lifestyle which involves physical exercise, a good diet, and the lowest possible number of existential problems and difficulties.

2.3. Concern with Oneself

The attraction which contemporary society feels for health is a part of the present-day approach in terms of values towards individual existence. In this we can perceive a positive aspect of considering the meaning of the human person as a goal. Today every person must be concerned with his own existence in order to take responsibility for it and carry it to fulfilment. The defence of one's own health is necessary in order to be able to lead a life which is peaceful and pleasant. But concern in itself, which is so important in taking care of the quality of one's own health, can be reduced to an individualism sought after and protected to the detriment of the needs, of the legitimate requirements, and of the sense of solidarity which are called for in relation to society as a whole.

Concern with oneself can be a translation of the meaning of the person thaks to which each individual can occupy the position which is his within society for the sake of the common good, where everything can benefit from the support of society when this is necessary. But it is certainly not the case that the contemporary concern with oneself is really the only expression of this personalistic and communitarian approach. It would seem rather, in many cases, an expression of the need to turn to oneself and to live by thinking only of oneself without worrying about the consequences of one's own actions for other people and the social body. To become convinced of this one need only give examples of drug-addiction, forms of behaviour which are at risk, and sexual activity with more than one partner where the individual remains closed up within himself. At the same time all these forms of behaviour are a symptom of the difficulties which exist in the implementation of a real *self* (capacity to be oneself, to ensure one's own psychic continuity, and to be consistent) in numerous personalities and in particular in the case of post-adolescents (those between the ages of 24 and 30). The social and economic costs of the consequences of such forms of behaviour is enormous for society because they generate pathologies which require care and treatment. In this way, public health is penalised by individual forms of behaviour which could be avoided by educating people in the meaning of responsibility and the need for limitations which should be learned from an early age.



3. The Cultural Challenges of Health and Health Care

The cultural challenges in relation to health and health care involve the questions and issues of forms of regulation, of access to care and treatment for everybody, of the competence and expertise of medical doctors and their capacity to shoulder their responsibilities, but also of the risks which new forms of technology and the manipulation of life and living beings bring to the fore.

3.1. The Economic Regulation of Health and Health Care

Health-care expenditure increases as the use of technological methods and instruments become ever more sophisticated. Their use and employment is highly expensive and allows more effective diagnoses and forms of treatment. Without doubt we would make a mistake if we used these new medical techniques very little given that they allow us to treat and cure a very large number of pathologies.

But medicine, which hitherto has been regulated by the benefits it gives to patients, is witnessing a process where its way of assessing things is changing and where it it is becoming primarily dependent upon the accounting logic of commercial society. These are economic criteria which enable us to evaluate and judge the needs and requirements which we have before us. They are criteria which seem to dominate and take precedence over moral values. It should be clear that

the primary purpose of medicine is to treat, as long, of course, that such treatment forms a part of a financial plan which cannot be gone beyond. The risk we run is that we will have a development of medicine operating at two speeds and divided between those who can afford to pay and those who cannot; between health-care equipment which works and that which does not work; and where there is a selection of the people who should be treated in which treatment of an elderly person which is effective but expensive is abandoned in favour of a younger person in order to remain within the restrictions imposed by a budget.

We find ourselves in a system where we run the risk of losing the meaning of the human person in the name of economics. This can be seen in our own societies where the most under-privileged and the most isolated, such as those who live in the country, do not have equal access to health-care services. This situation becomes worse in poor countries whose health services are often beneath the required hygiene level and which have only a few resources available.

The economic logic of health produces a feeling of injustice amongst those who cannot benefit from the instruments necessary to their treatment, and in relation to those people, who, through their behaviour, promote pathologies whose consequences have to be dealt with by society as a whole. But this accounting logic is accompanied by a large number of administrative hindrances for medical doctors, who, before being physicians must also be economic managers.

3.2. Health-Care Risks: Medical Errors and Food Security

For the contemporary mentality, health-care risks have become too great when considered in the context of medical errors and food security.

1. Medical errors, mistaken diagnoses or medical incompetence caused by a lack of training have hitherto been attributed to illness or to matters of chance. Today we know that the death of a certain number of patients is due more to an error in the medical assessment of their condition or to mistaken treatment than to the consequences of their illness. The advance of emergency forms of medicine, which are often presented in a positive light in television programmes which shape the health-care horizons of television watchers, gives rise to the idea that there can be a rapid and immediate medical action which produces tangible and comforting results. However, this is often very different from the realities of hospital services which are often overloaded and lack suitable personnel and equipment. Medical doctors can also conceal their mistakes behind an omnipotent knowledge which leaves people in ignorance about medical errors and accidents.

It is terrible to see a person admitted to hospital for a benign illness who then dies because of another cause as a result of mistakes committed by the doctors. For this reason, medical doctors should be more careful in the evaluation and control of their activities, and this in the interests of their profession as a whole. Otherwise the patients or their families will no longer tolerate their errors, something which can be well understood, and will increasingly take legal action in order to obtain justice in relation to the treatment which has been given. This is a disputable point of view. Here, too, we can see a logic of consumption according to which the individual expects medicine to confer a right to getting better and to service in line with the image of effectiveness which is present within commercial society.

2. Food safety is another health-care worry which troubles public opinion. The industrial farming of animals to be eaten, fed on various forms of flour, hormones and antibiotics, lies behind the new illnesses which have arisen in this kind of production – a production very concerned with the biological structures of living creatures. Transgenic manipulation changes the structure of certain plants and this has consequences for other plants. It will lead to the growth of bacteria which were previously contained and will give rise to other pathologies. In the same way the spreading of chemicals on the soil pollutes water supplies and makes water no longer drinkable. The massive use of pesticides destroys a part of the fauna, from birds to bees, and on to those insects which live off aphids. Lastly, animals which were once herbivores have become not only carnivores but are even fed on the same meat from which they were born...

The food industry, too, is hit by the bad influences or products which lose their nutritive quality because they are subject to chemical processing. This is true in the case of fruit and vegetables which are grown the whole year round with purely technological techniques and not in line with the rhythms of the seasons. They look good but most of the time they have no taste or smell.

Massive industrialisation and the wish to produce everything in the hope of giving rise to higher levels of consumption gives rise to an aberration of food products which are not of good quality and which have a negative effect on public health and increase illness. This phenomenon creates a sense of insecurity and generates constant doubts which no one seems to be able to control given that we are prisoners of a system of production reduced to chemical and pharmacological manipulation and a commercial system which, for economic reasons, ill-treats nature and loses the art of nutrition.

We should not forget that our health depends upon the way in which we are taken care of and treated, and that we become what we breathe and consume. Man's interventions in relation to nature at times destroy viral and bacteriological reserves and barriers. They also free new infectious agents which will provoke the illnesses and diseases of tomorrow. In this context there is an increasing wish on the

part of individuals to defend themselves against the health-care risks connected with medical practices and food production.

3.3. The Manipulation of Life and Human Beings

Physical illnesses, epidemics and various infections have always been a part of health-care concerns. The possibilities today of acting on the processes of life and of living creatures opens up new horizons. Here we will dwell only upon questions and issues connected with the wish to have a child, cloning, and procreation.

3.3.1 The Wish to have a Child

The wish to have a child is increasingly characteristic of contemporary individualism in cases where an adult wants to conceive a child commencing from the starting point of his own personal hopes and expectations. A child at any costs and by any route, the child wanted by a single woman, or a child sought after by people of the same gender, all these make children hostages who are intended to console worried people or justify a way of life which is incompatible with what it means to be a parent or a family. Today, there exist the technical means to favour the birth of a child in every situation and medicine and society run the risk of meeting all these requests without seeking to address themselves to the objective conditions which should serve as a means by which to assess the wishes expressed and the methods used. Our societies in this way foster the conception of a child not for his own good but because he will be able to satisfy the narcissism of adults. The planned and selected child can be confused with the adult who will live in relation to that child as though he were its double or extension, without attributing to that creature the characteristics of a child and recognising the nature of its needs. For this reason, a large number of adults lose the meaning of upbringing because they live out their relationship with their child in an egalitarian way as though another person were themselves to whom they need teach nothing at all. In this context the child will be increasingly modelled on the basis of medical, psychological and affective imperatives rather than through education on the basis of pedagogic, intellectual and moral needs and requirements so that he learns how to locate himself and act in relation to reality.

3.3.2. Cloning

Cloning runs the risk of changing how we see man. Indeed, how can we not think that one day people will think that it is possible to produce a double of themselves in order to have a second identical person, to be substituted when they die, or from another point of view take an organ from a cloned human who will be sacrificed so that another man may live in a better way. This idea advances in parallel with contemporary individualism. If the law allows cloning for reproductive purposes and on the basis of cell culture beginning with a human embryo, this means that one kind of man will be the slave of another, who in turn will be a sort of superman. We would also change the meaning of what human relationships are. A society in which it is necessary to give to others in order to live presents a picture which in itself is very social, but a society in which cloned human beings are reserves for organs or directed to certain tasks soon becomes a society which is a society based on the power of the master over his slave – something which Christianity liberated us from in the name of the uniqueness of the human person, his liberty and his equal dignity. Once the individual accepted the idea of giving of himself and sacrificing himself for the good of society – today, society is sacrificed for good of the individual.

In this way, the contemporary

medical approach runs the risk of producing a vision of pieces of the body and biological products which are completely separated from an overall vision of the life of the human person. All forms of manipulation are possible: abortion, and indeed euthanasia, are presented as forms of intervention on the flesh which will not be, or will no longer be, seen as being human. However, life, from its beginning to its end, cannot be divided.

3.3.3. Procreation Seen as Involving the Danger of Transmitting Life

Medical iconography will upset our perceptions of conception, and embriogenesis will do the same in relation to pregnancy prior to birth and after birth. This is because we are witnesses to a process during which the life of a human person develops in stages. One is not dealing here with a cyst, of a piece of meat, but with a human life which evolves and grows. When children and adults are shown photographs obtained by means of the highly sophisticated techniques of medical iconography they rapidly perceive that the destruction of this life involves attacking an individual over whose life or death society arrogates to itself a right. In ancient times, and in particular during the Roman period, selection took place at the moment of birth and the child was abandoned in a public square. The moralists of the time justified this act and twenty centuries of Christianity were required to effectively combat such a practice. We are still in front of the same debate which this time, however, refers to an earlier stage in life because we are dealing with the growth and development of the foetus. It is not unusual to hear adolescents declare that they were terrified when they heard that their mothers had sought an abortion when they were still in their mother's wombs. They have the impression that they are in fact survivors.

To conclude, let us dwell for a little while on the impact of the dominant health-care approach to the sexuality of adolescents. Such people derive strength from their age group when they are fragile, insecure or suspicious in their personalities. At the same time they are sensitive to the intrusive nature of certain individual attitudes or social models. They complain that they

are not free or believe that their physical integrity is attacked. At times they have a bad relationship with medical care and treatment and in particular with everything relating to their sexuality. Girls have reservations with regard to contraceptive methods in an unconscious way and perceive an instrusion on the part of society which establishes health-care norms for sexual relations. These are health-care norms which have taken the place of previous moral norms. Media and hygiene morality has taken the place of morality based upon an anthropology and the universal values which John Paul II has described in *Veritas Splendor.* This phenomenon of pragmatic morality influences impoverished, superficial and merely narcissistic personalities – practice spings first and foremost from utilitarian considerations and not from the meaning which should form the basis for reflection about one's own existence.

Health-care norms in relation to contraception and abortion are experienced as the concern of a medical doctor, as something which are to do with the influence of parents and adults, and as a social law which, in a way which is more restrictive than moral rules, declares what must be done in order to live out a correct sexual relationship – a relationship which is protected and not fertile. This invasion of the social approach of individual sexuality is more oppressive than the moral approach and does not allow young people to take control of their own sexual lives beyond the limits of these health-care norms. For this reason, there is a kind of allergy to contraception in most adolescents who are girls, who indeed do not manifest a need for it for the following three reasons:

1. They do not see the need for contraception given that they do not have an active sexual life. But it can happen that under the influence of emerging emotions which cannot be controlled they engage in a precarious sexual relationship and find themselves pregnant and declare: "I did not think you could get pregnant like that". Here, too, we encounter complete subjectivism.

2. They do not perceive contraception as a sign of liberation, in the way that previous generations wanted to detach their maternity from their femininity (even though it is intrinsic to female sexuality) and wanted to affirm their enjoyment in the same way as that of the man. For female adolescents, contraception appears more of a constraint than a sign of freedom.

3. They need to emancipate themselves from these social imperatives in order to reach the personal meaning of their sexuality. For this reason, contraception is incompatible with their system of self-perception and identity.

We can observe that it is often adolescent girls without secure emotional lives who express themselves in these kinds of sexual conduct (so that somebody is interested in them) which in turn lead to clearly unwanted pregnancies. Most of them prefer to keep their babies. Abortion would add a drama and an additional negation to their affective situation. For them, the writing of death into their bodies when they could continue to give life is intolerable.

This kind of present-day sexual education, which is accelerated by the talk about the prevention of AIDS, encourages three states of mind: sexual impulsivity, the futility of sexual relations, and confusion in relationships. These three states of mind are the consequence of an approach to contraception and abortion where the child is presented as a risk and a danger, and they are also the consequence of a homosexual approach and its mentality which denies the differences between the sexes in the name of a subjective sexuality which destroys objective realities and points of reference. As a reaction to this vision of sexuality which is merely instrumental and solely of a health-care character, there appears a need for quality in relationships, a need for a greater understanding of what human sexuality means, and a need for the role of procreation, kindred ties, and filiation.

3.4. Are we Undergoing an Epistemological Revolution in Biomedical Thought?

It is difficult to know if we are living through an epistemological revolution in medical thought because we are only at the beginnings of important changes. Basing ourselves on the observations of Mirko D. Grmek[1] and presenting his arguments here, we can see that two elements are especially revealing: the new possibilities that exist to act upon the key events in human life and the formulation of a new understanding of natural phenomena.

The biomedical research which has been carried out over the last decades has allowed the manipulation of the origins, the genetic character, and the end of individual life which goes beyond the previous ambitions of medical doctors and which at the same time opens up exciting and yet also worrying prospects. The various procedures of artificial fertilisation, the opportunities of knowing very early about genetic anomalies and even of intervening directly on the genome of an individual, involve theoretical and practical implications which go beyond the traditional medical frameowrk. The same takes place as a result of the instruments used to bring about states between life and death and to ensure that the human body survives artificially. This new command over birth, over individual destiny, and over death, raises sensitive ethical problems and difficulties and requires a very serious reflection on certain fundamental metpahysical concepts and ideas. In a situation where serious risks go side by side with unhoped for promises, predictive medicine, genetic therapy, the transplanting of organs, and the use of sophisticated kinds of prosthesis, prospects open up which are so new that to deem them to be revolutionary does not seem to be exaggerated.

As regards the elaboration of a new understanding of natural phenomena, let us remember that most

of the scientists of the nineteenth century thought that the world was made up of matter and energy in the same way that the scientists of the seventeenth century believed that it was composed of matter and spirit. In the nineteenth-century vision of the world, spirit was seen as the emanation of matter. Today, thanks to the development of cybernetics (Norbert Wienner, 1948), which has allowed us to understand more successfully the flow of communications and the procedures which regulate living creatures and also certain machines, we are beginning to understand the existence of a constituent of the real, *information*, which is neither matter nor energy.

Indeed, what do we mean by the term "information"? It refers to the attribution of a meaning to facts. Thus, for example, no material and energy form of analysis can enable us to understand the meaning of the genome of a living creature. This genome has a profound meaning which exists solely in relation to a process which deciphers it. There is no genetic transmission without the action of a living cell which reads the information contained in the chromosomes. Life can only exist in virtue of a continuity in the chain of living creatures.

It was known that there existed a way of interaction based upon meaning, but this was confined to the field of culture and it was placed in opposition to what takes place in nature. It was thought that civilisation was based upon the reading of numbers and of letters, in short upon language and numerical transformation, but all natural events were interpreted as confused consequences of similar transformations. In order to "decipher" nature it used to be sufficient to know the general laws of physics and chemistry without any special code. In the same way, life could not be – within a scientific explanation – anything else but a series of similar transformations. Hence, for example, the opposition (which at one time was irresolvable) between preformism (a biological theory according to which a living organism is completely constituted in the germ) and epigenesis (a biological theory, in opposition to preformism, according to which an embryo develops through the subsequent differentiation of new parts). Neither of these two theories could explain genetic transmission through the fusion of two gametes. Today, if the material support of inheritance is seen not as a structure destined for analogical development but instead as a programme, then the two points of view are reconciled and one finally reaches a satisfying explanation of the formal continuity to be found in the material discontinuity of living creatures.

This new interpretation of natural phenomena is no longer limited to genetics. It is already employed in neurophysiology, and new interesting prospects are opened up with regard to general pathology. In biological processes there is something which can not be reduced to the laws of matter and energy. This something is historically determined and structured like language. The notion of information provides a new dimension to the relationship between the body and the spirit. In dealing with this question we should take into consideration the history of mankind and its impact on the language and the appparatus which creates it and deciphers it. It is no accident that at the end of the twentieth century we find the cognitive sciences at the apex of biomedical research.

Conclusion

The advance and development of medicine, of pharmacology, of biology, and of health-care techniques has given rise to a large number of hopes with regard to the prevention, treatment and cure of illnesses which previously could not be dealt with. Our conditions of life have profoundly modified our environment and favoured the appearance of new pathologies which are beyond medical control. Nonetheless, a feeling of omnipotence has been projected onto health-care techniques to respond to the wish to live and to reproduce in human societies. In this context, man runs the risk of seeing himself as the lord of life. The actions on the processes of life and living creatures accentuate this expectation and encourage the image of health as a place of wellbeing beginning with which most existential problems can be tackled and faced up to. We have witnessed a positive appreciation of health and a shift into the medical field of existential anxieties when people find difficulty in living and in accepting their lives. The various depressive states which society has to face up to, although they often represent a mental condition to be treated as such and which can be observed in melancholy, in the cases of neurotic and relational depression are not all solely the reflex of a psychic disturbance as in the case of existenial depression when the person does not know how to organise things, give a meaning to things, or live out his own existence beyond the religious dimension.

Contemporary man, in particular in the West, certainly calls on medicine to make him forget about the worries of his life and about death which should be seen as an unpleasant event and not as the end of a life, and to give him therapeutic comfort in order to help him live and face up to the contingencies and the existential anxieties which are inherent in human life. Life runs the risk of becoming medicalised with the right to suppress it when human existence becomes difficult to live out. In this way we see reappear a pagan vision of existence which has fear of suffering, of the child which is still to be born, of old age, of death and the future, and for which the religious dimension, with its revealing of the meaning of human life, does not exist. But changes can affect biomedical thought with the discovery of exchanges through genetic transmission and cellular action which reads the information contained in the chromosomes. We are no longer in a situation of opposition between matter and the spirit but face to face with a language which ensures continuity in the chain of living creatures. This new horizon opens up fine prospects for anthropological and theological reflection and cannot but renew the sense of the dignity and the uniqueness of the human person.

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Note

[1] *In Histoire de la Pensée Médicale en Occident*, vol. 3 (Seuil, Paris, 1999).

ANGELO SCOLA

Religion, the Economy and Health

1. Setting Boundaries to the Subject

The intricate complexity of the subject which fully emerges from the rich programme of papers and contributions requires a necessary setting of boundaries, not least because the category "religion" (in the singular) – which represents the summarising point of view with which I have been invited to address myself to the contents of this international conference (namely the economy and salvation) – is on the one hand rather difficult and on the other is referred to in the programme in a variety of forms and ways.

A particularly significant datum of contemporary culture: with this description health, the central concern of this meeting, is examined in its inevitable relationship to the economy, which, in turn, is considered starting with its current characteristic of globality.[1]

How religion can throw light on this relationship? This is the question which I will try to give an answer to in this paper – an answer which obviously enough will be summarising and of a purely introductory character. I will not do this, however, without first having made clear that I will not proceed in terms of the various individual religions – special space will be given to them during this conference – nor *directly* from the standpoint of the Christian vision of this relationship, to which attention has been paid in the opening speech and which will be subject to a detailed and intricate analysis (with reference to history, the Magisterium, dogma, morality, and pastoral care) during this conference.

We will refer here, instead, to the *religious experience* as such (its religious meaning), seeking to understand *what* in a complex, multi-ethnic, multi-cultural and multi-religious society – in which in addition there exists a tragic disparity at an economic level between the North and the South of the planet – *it can say* about the *relationship between health and the economy* and throw light upon that relationship.

At a practical level we will proceed in this paper in the following way: in examining the personal and corporate "subjects" of the world of health (the patient, the family, society, the health-care worker, health-care institutions, and government bodies) we will attempt above all else to clarify in what ways health really is the cultural datum of contemporary society. The importance of the religious experience (the religious sense) will thereby immediately emerge. Secondly, we will ask where and how the religious experience interacts with the economy, characterised as this latter is by globalisation. Lastly, in the third stage, we will attempt to clarify how the religious experience throws light upon the relationship between health and the economy.

2. The Request for Health and the Religious Request: an Inseparable Nexus

I do not wish here to go into the – decisive – question of how one can define the health of man beginning with the concept of it which emerges from medicine analysed with reference to history and above all to contemporary practice. I will not dwell therefore upon the negative aspect of its definition (absence of illness) nor upon that definition, which is rather more difficult, which is usually deemed positive (the overall wellbeing of man).[2] I want, rather, to begin with an elementary human experience which is repeatedly present, albeit not without decisive socio-cultural differences, in all places and at all times.

A particularly effective expression of the elementary experience of the need for health is to be found in a famous passage from the Book of the prophet Isaiah. King Hezekiah had to endure the trials of a serious illness after committing a blameworthy action and in his lament he calls upon the Lord in the following famous canticle: "in the noontide of my days...for the rest of my years...I shall look upon man no more among the inhabitants of the world. My dwelling is plucked up and removed from me...like a weaver I have rolled up my life he cuts me off from the loom; from day to night thou dost bring me to an end. I cry for help until morning; like a lion he breaks up all my bones...Like a swallow or a crane I clamour, I moan like a dove. My eyes are weary with looking upward. O Lord, I am oppressed".[3]

The dramatic perception of death which draws near – death being the extreme point of the loss of health – now expresses itself in the overbearing cry addressed to God: "restore me to health and make me live".[4] Here health as a datum of the human experience appears in incisive fashion.[5] How can we not perceive, indeed, in the mortal illness of the king that fragile destiny which exposes man to illness, suffering and death, even though he wants life with all his soul and body, and life for ever? How can we identify what health is more effectively, surprising it in the heart of the dying person, to the point of a dialectic interaction between his capacity for the infinite and his inevitable finiteness? Fur-

thermore, keeping the biblical account uppermost in our minds, if we examine the nexus between evil and illness, our question is further illuminated when it is presented as being absolutely decisive in the experience of each and every man. Nor will it escape us – in the paradigmatic light of this piece – how health beseeches a relationship with the other, and first and foremost with the Author of life,[6] calling upon him to take care of the unfortunate man who has fallen victim to a fatal illness.

The request for health, which is constitutively bound up with questions about pain and death, brings out the need to *continue for ever* and thus requires intensive care and treatment in the form of the intervention of another person in favour of my wellbeing. In a word: health draws attention to a set of factors which demonstrate how it is the radical expression of the decisive question of the self. More than ever it raises the ultimate question: "Who am I?",[7] revealing at the same time the *enigmatic nature* of man.[8] Which category, beyond that of the enigma, can define a being who *is* but *does not have* within itself the basis of its being? Who really is one who possesses, by nature, an identity which is so *ec*-centric as to be able to say "Me" only if he accepts that he is dependent upon another? In particular, with reference to the subject of this paper, which experience leads to an awareness of this constituent enigmatic quality more than that of the loss of health?[9] To see things clearly, it is precisely this essential character which brings into play the totality of the self in order to explain the great weight that the question of health has in our contemporary society.

Health is a cultural datum of today's society, above all in the North of the planet, precisely because it is a datum of elementary human experience. Upon it depends the very survival of freedom and thus advanced society dedicates to it a large quantity of resources of every kind – from affective resources to economic resources – to the point of its becoming, for good or for evil, one of the distinctive elements of the quality of life. Falling seriously ill is to discover that one is exposed to the void at the moment when one recognises in oneself a unique and never to be repeated value. The imperative supplication of Isaiah, which springs from the depths of his mortal illness, becomes expressed in a desire to live for ever which in all the peoplesof the world of every culture almost takes the form of a right: "O nature, O nature, why do you not provide us with what you promised us? Why are you children the victims of so many deceits?"[10] Indeed, it often becomes an explicit dispute with the Author Himself of life, who, not infrequently, because of the impact of illness which always precedes death, is accused of perfidious tyranny.[11]

There is no *pietas* or compassionate solidarity, whether it has the ancient historical imprint or – as today a certain fashion seems to suggest – the Buddhist impress which manages to extract from the flesh the acute sting of illness and death. And this to such an extent that the sceptical form of existence – from the shallow variations so well stigmatised in the Kierkegaardian figure of the aesthete to the more sophisticated forms of the nihilism to be found in Montale – seems today to dominate the broad mass of men who in practical terms present once again the terrible Sartreian figure of the self: *man is a useless passion*.

Only at an apparent level are we far from the subject and concerns of this paper, namely health and how medicine organises itself in relation to health in order to deal with it. In reality, we are confining ourselves to getting to the roots of health. Indeed, if the request for health is a request that life is given to the full as the whole of our "self" seems to promise, then there is no clinical act or form of health-care organisation which can contain the irresistable explosion of the need/desire for the radical wellbeing of the patient, who, whether he wants it or not, throws into the face of the health-care worker the enigma of man.

In order to define this dominating need to live for ever which explodes in the request for health on the part of the patient, we could not find a more appropriate expression than the word "salvation". The cultures of all epochs, of every latitude, have coined terms, but above all they have produced customs, forms of behaviour, and civilisations, which confirm the reality of this fact.

Health can never be separated from salvation – it is the very enigmatic nature of man which, in making him an *ec-ecentric* being, imposes upon him the essential and perennial request for salvation.

Now, to say that an unbreakable and inseperable nexus exists between the request for health and the request for salvation is nothing other than to recognise that everything which bears upon the sphere of health belongs *ipso facto* to the religious dimension of man. As health brings into play, in terms of life and death, the question of the self, it is also by this very fact a dimension of the religious sense: indeed, this latter is that unsuppressable level of self-consciousness which springs from the irruption of the *ultimate why* posed about oneself and reality.[12]

As a first decisive conclusion it follows from this that the conviction that religion and health are not two extraneous realities which have to be seen in their relationship to each other but elements which complement each other at an original level is in reality well founded. Their intrinsic bond presents itself as being insuperable precisely when one begins with the recognition that salvation is at the same time at the heart of the request for health and at the centre of the religious question.

3. Health: a Sacrament of Salvation

We can well suppose that for men involved every day in the increasingly complex world of today's medical institutions, who are compelled to come to terms with the facts and data of a large number of empirical sciences, with the products of advanced and sophisticated technology, with burdensome economic and financial situations, with legal systems which are often contradictory, and with relational issues which are often full of psychological complications, what has been said above runs the risk of seeming to be a clumsy attempt to produce precarious cosmetics. It is an easy undertaking to refer to the irreversable change which medicine underwent during the last century and which was provoked by Claude Bernard's decision to transform a general therapeutic art into experimental medicine,[13] in order to hide the subject that it cares for and treats – through a rigorous sequence of clinical acts –

camouflaging that subject behind the pretext of an impossible objective neutrality. The valuable experimental nature of medical science and its high technological level will not prevent therapeutic action from reasserting itself in all its breadth and from taking form in the encounter between health and salvation. Indeed, this site will be inexorably proposed to the health care worker by the silent and imploring look of the dying and by the defenceless crying of children, by the resigned sense of abandonment of the elderly person or by the trembling powerlessness of a man in the fullness of his years who asks for care and treatment. Nor will the sirens of utopia – to which today's medicine seems to fall victim when, in considering death as "an accident of the journey", it convinces itself that it is able to definitively defeat death – be able to reduce the request for salvation to the illusion that eternal life can be the outcome of an indefinite prolongation of current life within the mortal body. The experience of suffering, of illness, and of death render human finiteness naked at the very moment at which they explain it as being a representation of eternity: "you heal us while you wound us, you heal us of the dream of totality, of the epidemic of invulnerability".[14]

To speak about finiteness as a representation of eternity means, in terms of the subject of this paper, to speak about health as a representation of salvation. If we could outline here in an explicitly Christian approach a theology of pain and death to be matched by a suitable reflection upon health, we would be led to develop above all else the (blame)-illness-death nexus in order then to reflect upon the event of Golgotha by which Christ, by one means or another, swallows death from beneath it[15] in the unique and never to be repeated form of his dying[16] (it is the particular form of death which combats the extreme duel with the usual form of death in order to defeat it: *mors et vita duello conflixere mirando*), in order to talk, finally, of the way in which Christ died in terms of death as the *appearance* of death.

The outcome of such a reflection would allow us to conclude, against the background of a category of the history of Christian thought concerning the eucharist – that of appearance or the apparent – that health is a sacrament of salvation. The logic of the (sacramental) symbol would thus allow us to understand what ontologically is to be found in unity – health, despite the complexity of medical practice, would be a place for the effective achievement of salvation and the subject who asks for it (the patient), in the same way as the person who takes care of him (the health-care worker), would encounter once again his full identity in the mission by which he takes part, in freedom, in the mission itself of Christ the Lord. In this context, the answer given by Jesus to the sisters of Lazarus is extraordinarily appropriate: "this illness is not for death but for the glory of God".[17]

So that all this does not remain at an abstract level it is enough to observe that illness, suffering and death in such an approach are not understood as mere biological events, and care and treatment are not seen solely as a sequence of technical-experimental acts. Instead, both are also and above all else circumstances which present themselves to individuals, bring about freedom to the deepest level, precisely in medical doctor and patient alike. At a practical level if by "care and treatment" is meant that set of interpersonal relations which are directed towards the health of the patient, by "therepeutic art" is meant the study and implementation of all those means which are suitable for care and treatment, and by "clinical act" is meant every medical action with a technical-experimental basis, then we can say that care and treatment, which characterise the specific relationship between the medical doctor and his patient, is that *place* where the clinical act becomes a "sacrament" of the therapeutic act. Care and treatment, which are always correlates of the search for healing, then express in its wholeness the therapeutic art of the medical doctor which operates through the clinical act. To me it seems that it is necessary to anchor basic medical orientations, the organisation of the clinic, the therapeutic decisions and their relationship to research to this vision of health which knows how to take on – without a delirium of omnipotence but in a simply involved and technically rigorous way – the whole of the request of the patient: *restore me to health and make me live.*

4. Economics and Health

a. The Ethical Side of the Economy

Kolm declares that it will be a happy day when the majority of economists come to recognise that "nothing which is human is extraneous to me".[18] With the diffusion of busines ethics today there is a multiplication of studies which advance the general idea that economics is a confluence, if not a fusion, of two approaches – the ethical approach and the engineering approach – which indeed have characterised the discipline of economics since its beginnings.[19]

The most perceptive economists seem to have left behind them the idea advanced by Pareto which involved a separation of the notion of efficiency from that of fairness and distinguished the sphere of production from the sphere of distribution. For very good reasons many economic theorists have gone beyond the well-known thesis of Robbins who asserted that "because economics is concerned with the effective employment of means with respect to goals that it holds to be given, it is totally neutral with regard to ethical questions".[20]

What interests us here is to point out that today ethics have risen in relation to economics and now occupy an important position within this discipline. But it should be strongly emphasised above all else that this affirmation of ethics comes from within economics itself and is not something which springs from elements outside this branch of study. In a special way it comes from the discovery that interpersonal relations constitute an economic category. This is the thesis of "relational goods".[21] In this way ethics are called into play by economics because of their own effectiveness. At this level there thus already emerges the economic importance of those relational goods which in various forms – and at the highest level in terms of health as a sacrament of salvation – are constituent elements of those areas which are concerned with illness and health in general.

b. The Nexus between the Economy and Health

Beginning with a consideration of the object of the economy we easily discover its nexus with health. Indeed, the dynamics of production, of exchange, of consumption and of financial activity-passivity – to limit ourselves to pointing out the central axes of the object of the economy – identify, at least starting from modernity, constituent elements of the organisation of health care as well.

The nexus between health and the economy both from the point of view of the subject and that of the object is inherent.[22] Indeed, on the one hand *economic activity* in general springs from a disproportion between needs and resources,and, at least starting with the modern era, involves an attempt to produce and distribute goods (and services) with the minimum expenditure of resources in order to satisfy the largest possible number of such needs.[23] On the other hand, *health* brings into play that radical need for continuity – and thus that attempt to achieve a cure which seeks, in the final analysis, to avoid death – which, in itself, requires an incalculable number of resources. Needs and resources thus emerge as being at the heart of the economic dimension to health care. But the radical nature of the request for health which is brought into play is so great that the economic relationship to be found within it between health and resources has a tension which can lead to aporia. A careful analysis of the relationship between health and the economy, connected in turn to the relationship between needs and resources, not only identifies its intrinsic quality but also demonstrates its high potential for dialectics and conflict. One can express in an elementary way this state of things with the obvious observation that *health has costs but is priceless*. That it has costs indicates its inevitable relationship with the economic sphere, but that it is priceless expresses its so to speak subversive role in relation to the economic sphere, which, instead, cannot but aim at a minimum deployment of resources to satisfy the highest number of needs.

However much this observation may appear to be a simplification, the statement that health has costs but does not have a price brings out on the one hand the unresolved problems to be found in the relationship between health and the economy, and on the other hand can demonstrate, through the examination of the theoretical system which underlies such problems, how the religious experience throws light upon this decisive, but intrinsic and not extrinsic, relationship which characterises civil society.

With regard to the first point it would not be helpful here to dwell upon it given that such unresolved problems are all well known to you. You especially, indeed, both as individual health-care workers and as the respresentatives of health-care institutions, encounter their dramatic importance every day. Furthermore, the programme (although to an even greater extent the full intention of this "Fourteenth International Conference of the Pontifical Council for Pastoral Assistance to Health Care Workers"), especially in its second part, addresses itself to such problems in an explicit way where it proposes a dispassionate diagnosis of the question and adopting the pre-eminently Christian approach of the sharing of goods also offers a possible prognosis. The organisers of this international conference have not failed to connect this to a study of the models of economic management to be employed by Catholic health-care institutions.

We will dwell for a short while, instead, upon the theoretical structure which underlies the still unresolved problems or the contradictions of the organisation of health-care in its contemporary relationship with the economy. This will allow us, as has already been observed in this paper, to illustrate what the correct relationship really is between the religious experience, the economy and health, that is to say to provide a conclusion, albeit of a summarising and introductory nature, in relation to the subject which has been entrusted to me.

c. The Relationship between Needs and Resources in the Field of Health Care

In this paper an attempt to avoid a theoretical structure inappropriately reduced to an *unum* – to use an expression dear to the tradition of Western realism – with regard to the relationship between the economy and health has already been made. Health, indeed, by bringing into play a need/desire of inalienable value for the person and his relationship with civil society, does not seem to be able to accept as an exhaustive criterion the *minimum calculation of resources* as an ideal measurement which is to be placed in the largest possible spectrum of needs.[24]

Now it is true that resources are always, and in the field of health as well, objectively limited, if only because of the inexistence of means capable of eliminating death. It is also obvious that the economic principle and the practice which results from it of the employment of a minimum of resources to meet needs to the utmost cannot but be followed in normal practice in the field of health care.

However, whilst in other areas of human co-existence this criterion can be almost always applied, in the field of health, which is something which is priceless, it on its own is inadequate if not actually injurious. And anyway the situation which is before everybody's eyes demonstrates the objective difficulty in adhering to this merely technical-economic evaluation. How many families are there which lose whole patrimonies in the often illusory attempt to extend the life of a relative? Furthermore, how can the minimum level be establishment in this field or at least who should estbalish this minimum level and in what way? It seems evident that the nexus between the economy and health is not in itself able to provide a suitable answer to these questions.

Today, both through the thesis of relational goods and through the system of the models of the organisation of health care which are more realistically in line with the relevant stage of economic development, a health-care policy is making strides which is more aware of these difficulties. A significant example is provided to us by a knowledgeable expert of the world of health care. Charles Scriber, in writing about the need to think about the system of care and treatment in terms of "performance", has observed that as long as there has been strong economic growth and an abundance of resources it has been possible among other things to achieve a co-existence of contradictory values and it has also been possible to un-

dergo a reduction of institutional tensions and conflicts of power.[25] The logic of resorting to ever new means (resources) held sway. During the last twenty years, however, the economic crisis has brought about an increasingly rigorous approach to needs and to their scale of importance.

The two logics are increasingly the protagonists of today's world. They express, amongst other things, the coalition between health-care workers and patients, on the one hand, and the coalition between the funders of treatment and the producers of goods on the other. The first, indeed, ask that resources are adapted to needs, but the others, in contrary fashion, require resources to be adapted to financial capacities.[26] Everything is aggravated either by the absence of umpire-style figures and of clear collective policies or by the predominance of government institutions, and this means that the state of poverty is more oppressive and more serious and that the elementary right to health is threatened. Kleiber proposes that in an epoch of globalisation the question of medicine – at least with regard to the advanced societies to be found on our planet – should be tackled with reference to the thesis of the correct allocation of limited resources. This would lead to a suitable health-care performance, that is to say to an improvement over time in the relationship between invested resources and results obtained within the context of objectives shared by the whole of the health-care community, and more specifically, of the whole of civil society.

Such a health-care policy, amongst other things, by drawing upon a system of decisional heirarchies would inevitably bring into play a thicker network of relationships between all the subjects involved in the organisation of health care, that is to say medical doctors, patients, the sick, health-care administrations, and academic and political authorities. It would thus seem that the relationship between health and the economy, precisely through a correct utilisation at the technical and economic level, manages to balance in the best possible way all the factors in play, including those of an interpersonal character.

The reason why I have allowed myself to engage in this invasion of another field is that the thesis of Kleiber – whose balanced character will certainly not escape you – does not in the end escape the tension of conflict between the two terms of modern origins because by not offering an objective criterion by which to identify the minimum in the relationship between needs and resources which guides the correct relationship between health and the economy it ends up by subjecting the first to the second once again.

d. The Overcoming of the Conflict between Needs and Resources

How can we overcome, therefore, this aporia which seems to characterise the organisation of health care at a global level? How can we save the overall need for health which is an expression of the need for salvation without falling into utopian Titanisms, but also without engaging in intrinsically wicked offences to the dignity of every single human being from conception to death? We could also ask this question in a different way. From what does the aporetic nature of the relationship between medicine and the economy spring, a nature which has been explosive ever since the beginning of the modern era?

Please allow me proceed very rapidly. Our judgement may be reformulated in a summarising way. With modernity (understood as a mere historical category and not as an ideolgical category!), when the progressive process of secularisation advanced taking the form of a separation between health and salvation and in seeing care and treatment as mere clinical acts in a way which sacrificed the therapeutic art which was implicit in them, the relationship between health and the economy took on an aporetic character which the very high technological standards today required by Western medicine have made truly dramatic. We can first of all ask: does there exist, so to speak, a vice at the origins of this state of affairs? Perhaps the original vice shared by both medicine and the economy and thus destined in a certain sense to duplicate itself when one comes to consider their intrinsic and inevitable relationship, lies in the fact that both (the economy and medicine) take part in that special operation specific to modern sciences of being based upon *the exclusion of the subject*.[27] In the name of an impossible neutral objectivity, medicine and the economy have also sought to abolish the subject both as a person and as a community at its various levels (from the primary level of the family to the more elementary forms of civil community, from the sphere of national communities to world organisations). In the field of health,the institutions marked by a well identified presence of the subject capable of maintaining within the world the salvific pregnance of the request for health – I am thinking here of the hotel dieu and of the hospital – have been increasingly replaced by companies whose task is reduced to the mere planning, control and checking of the administration of a series of clinical acts which are carried out within them.

Thus one comes out of the aporia with a unique and inescapable imperative, and more specifically: to reintroduce *the subject* in forceful fashion into the world of health care and into the economy, and more in general into all the spheres where the human experience takes place. The absolute priority of *anthropology* immediately comes to mind here, and thus one sees how ethics *in relation to* health and *in relation to* the economy are always and only presented as a vehicle for an anthropology.[28]

And an anthopology is suitable when it deals with the dramatic nature of the self (in technical terms the "dual unity"), thereby bringing out its meaning.[29] Because of this inherent structure, indeed, each one of us always exists within a polarised unity, in line with the triple articulation of spirit/body, man/woman, and individual/community. Here the final destiny of man is at stake and the question posed by Leopardi which has already been quoted emerges with force: "And who am I?". On the horizon of the human experience, therefore, there thus appear in inescapable fashion religious meaning and religious experience, called to provide an answer and to point out the road so that the tensions undergone are, in so much as this possible, livable by the individual and by the community in a constructive balance.[30]

The anthropological question is in a certain sense very simple (indeed,

elementary!): every man brings into play his freedom in every individual act he makes, beginning with the two co-ordinates in which the whole of the human experience is written – his affections and his work. Affections and work bring into play through the daily experience of relationships and circumstances the three polarities which constitute the self and thus in the final analysis the vision of life which each man possesses. One could also say, therefore, that in each individual act man inevitably reveals his own religious sense and meaning, bowing before the ineffable mystery or the most banal of idols, which T.S.Eliot rightly identified as being licentiousness, money, and power.

5. The Religious Experience: a Road by which to Overcome the Aporia between the Economy and Health?

At this point a few lines are sufficient to express our conclusion. The request for health, which is priceless, can find a suitable response only through a conception of man which is able to explain death in a personal, free and definitive way. Only in this way can one avoid on the one hand the indiscriminate and utopian absolutisation of his nonetheless legitimate request to last or to obtain victory over death without falling into the Titanism of the modern "healthist" ideology. This Titanism involves the search for an indeterminate and acritical prolongation, in line with the dogmatic application of the physical principle of lasting, of earthly existence within this mortal body. Such a utopia cannot accept in any way a limitation imposed by the economy of the resources which should be applied to the need for health. On the other hand only a free, personal and definitive answer to the problem of death is able to avoid the economy – and above all else its strong actors – from having resources destined to the organisation of health care to such a point that there is an arbitrary fixing of limits to the health of the other, perhaps on the basis of mere calculations of profit. That resources in the medical field as well are in the end limited could be at the most an inescapable fact to be accepted, but if it is considered in unequivocable fashion it can only produce violence and conflict. One need only think here of the scandalous divergence between the North and the South of the planet which is also evident in matters relating to the organisation of health.

The religious experience which offers my freedom an answer to the problem of death – and which does not flee from the question of durability and continuity because it expresses the request for health as a sacrament of salvation – in fact allows an exit from the aporia and can balance the relationship between health and the economy. In order to express this thesis to the full I would have to enter decisively into the mystery – which has already been referred to in this paper – of the death of the innocent Jesus Christ[31] on the *bruised post of the cross* as something which resolves the problem of death. One would then have to demonstrate how *this* death takes on my death and imposes on the person who takes care of my health the imperative to heal, without, however, fearing that healing understood as a salvific possibility of definitive length should bow before the dramatic and most personal act constituted by the death of the individual. It is, indeed, that inevitable and very elevated moment when time for that person ceases to be a representation (sacrament) of the eternal because the face itself of the eternal becomes the embrace of the Father who carries out his salvation by drying "every tear".[32]

These considerations are not an example of alienating pseudo-poetry, nor can they be reduced to deceiving forms of consolation produced by human powerlessness when faced by the intricate economic jungle in which our health-care institutions must exist. On the contrary: the religious experience, precisely by defining health as a sacrament of salvation, offers us criteria by which to regulate the very great personal and social responsibility towards the patient which is implicit in the economic dimension of health-care activity. Such a concept of illness and death, and thus of health as well, actually regulates the proportion of resources allocated to needs in a correct way because it allows a drawing up of that heirarchy of goods and above all else that sharing that omits no factor in placing in pride of place the subject in his unique and never to be repeated value and in his constitutive relationship with the other, without, however, engaging in unrealistic utopias when it comes to the question of possible resources. And we observed at the beginning of this paper how the economy itself is today discovering the economic importance of relationships which it defines in terms of "relational goods". Obviously enough these criteria imply, as indeed do all the criteria of all the spheres of human existence, the initiative of personal and social freedom so that from time to time, in an overall way, form is given to a correct policy of health. Such a policy should know how to link the good of the person – who has a fundamental expression in health – with that of the civil community. And the economic dimension cannot impose at any cost its constitutive minimalist relationship between needs and resources but has to accept that the growth of resources, like their heirarchy and their utilisation in relation to needs, is shaped by the objective value of the person. In particular, use should be made of the criterion of participation and the sharing of goods in line with respect for the right of everybody to health.

To place the subject once again at the centre of things, that is to say to restore the rightful importance to anthropology, thus means that this latter finds in ethics a route by which to encounter the economy applied to health. The criterion of the sharing of goods as an ethical criterion which implements the anthropological-religious vision of the relationship between health and the economy will thus be able to find fertile terrain for development in the social doctrine of the Church. And it is precisely in her

constitutive principles of solidarity and subsidiarity, in the criteria to be applied in the universal destination of goods, in the social version of the commandment not to steal, in the right relationship of fairness between need and merit – which even characterises the political dimension of every economic activity – that one sees the path offered to the intelligence of the individual health-care worker and the health-care institution by which to invent a suitable model for the place of care and treatment.

For all this to come about it is indispensable that the subject works in a way which brings his or its identity in an overall and integral fashion into play. The Christian tradition in the field of health can be rediscovered in all its strength and can become itself a great resource, in addition to being an effective route by which to escape the sand bars of that aporetic relationship between the economy and health which began with modernity.

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Notes

[1] On this subject from an ethical point of view see P.J.CORDES, 'Etica della Globalizzazione', *Nuntium* I (1997), n. 2, pp. 62-68.

[2] An example of the complexity which is to be encountered in defining the idea of health can be seen in searching for the term "health" in the dictionary. In the dictionary by G.DEVOTO and G.OLI we read: "'Health': I. Condition of physical or mental wellbeing due to a state of perfect functioning of the organism...; generic. The physical condition of the organism...; 2. literary and archaic: "salvation"'" – G.DEVOTO and G.OLI, *Il Dizionario della Lingua Italiana* (Florence, 1990), p. 1680. See also the headings "health" and "salvation" in G.LINA, E.LOCCI, C.ROCCHETTA and L.SANDRINI (eds.), *Dizionario di Teologia Pastorale Sanitaria* (Turin, 1997).

[3] See Is 38, 10-14.

[4] Is 38, 16.

[5] I reflect upon these issues in A.SCOLA, *"Guariscimi e Rendimi la Vita" (Is 38, 16). Salute e Salvezza: un Centro di Gravità per la Medicina* (Siena, 1999).

[6] Cf Acts 3, 15.

[7] G.LEOPARDI, 'Canto Notturno di un Pastore Errante dell'Asia', vv. 78-9.

[8] See here A.SCOLA, 'Gesù Cristo, Fonte di Vita Cristiana', *Studia Moralia*, 36 (1998), pp. 12-13.

[9] "Man suffers because he desires, and above all what he desires it is not in his power to construct", F.BOTTURI, *Desiderio e Verità* (Milan, 1985).

[10] G.LEOPARDI, "A Silvia", vv. 35-9.

[11] See F.DOSTOEVSKY, *The Brothers Karamazov*, part II, book v: "You see, Haliosha, it may be that it will actually turn out like that, that when I manage to live to that moment, or rise again to see it, than I too, perhaps, I will erupt with all the rest in seeing that mother bound to the massacre of her little one: "You are just, O Lord". But I do not want to speak out in this way. As long as time remains to me I want to care for myself and thus, to that supreme harmony, I offer a net rejection".

[12] On this point see JOHN PAUL II, "Udienza Generale", in *Insegnamenti*, VII/2 (1983), pp. 811-816.

[13] Cf C.BERNARD, *Introduction à l'Etude de la Médecine Esperimentale* (Paris, 1920).

[14] H.U.VON BALTHASAR, *Il Chicco di Grano* (Milan, 1994), p. 124.

[15] Cf 1 Cor 15: 54.

[16] Cf H.U.VON BALTHASAR, *Teodrammatica*, t4 (Milan, 1986), p. 457.

[17] Cf John 11:4.

[18] C.S. KOLM, 'Che ne è della Scienza Economica'', *Rassegna Economica*, 2 (1988), p. 289.

[19] Cf A.SEN, *Etica ed Economia* (Bari, 1998), p. 9.

[20] L.ROBBINS, *Saggio sulla Natura e l'Importanza della Scienza Economica* (Turin, 1947), p. 20. On the relationship between ethics and the discipline of economics see K.Rothschild, *Ethics and Economic Themes* (Gower Hound, 1993); G.Myrdal, *L'elemento Politico nello Sviluppo della Teoria Economica* (Florence, 1981); S.Zamagni (ed.), *Saggi di Filosofia della Scienza Economica* (Rome, 1982); E.Scarpanti and S.Zamagni, *Profilo di Storia del Pensiero Economico* (Rome, 1992); S.Lombardini, *La Morale, l'Economia e la Politica* (Turin, 1993); and A.F.UTZ, *L'Etica Economica* (Cinisello Balsamo, 1999).

[21] For Pierpaolo Donati, a sociologist of the family, a shared good becomes relational when "it can be produced together, is not excludable for those who take part, is indivisible and is not conceivable as a sum of individual goods": P.Donati, 'Il Ruolo delle Iniziative di "Terzo Sistema" nelle Politiche Sociali', in C.Borraga, *Il Terzo Sistema: una Nuova Dimensione della Complessità Sociale* (Padua, 1991), p. 72.

[22] Cf G.MANZONE, 'Allocazione delle Risorse Sanitarie alla Luce della Dottrina Sociale della Chiesa', *La Società* 8 (1988), pp. 571-586; J.JOBLIN, 'La Distribuzione delle Risorse Economiche e la Salute', *Dolentium Hominum*, 13 (1998), I, pp.64-66.

[23] Cf P. DE LAUBIER, 'Anche l'Economia ha Bisogno di Salvezza', *Nuntium* (1997), n.3, pp. 119-125.

[24] One could ask whether this notion does not in itself imply a devaluation of economic science which, as such, should recognise that "the final measurement of economic value is the need to satisfy (not the work necessary to produce a good)" (P.de Laubier, 'Anche l'Economia', p. 21), and a reduction of economics to a mere technique for the administration of resources which in actual fact is detached from the life of civil society.

[25] Cf C.KLEIBER, *Questions de Soins* (Lausanne, 1991).

[26] This set of issues and questions is typical of the hospital structures of our days where often professionals with different views of reality and very different interests come to work together. One need only think here of the conflicts which arise between managers and medical doctors.

[27] "In a sadly prophetic way, in relation to the Hippocratic *tekné*, appear those declarations of that medical doctor, intoxicated by emergent technologism, who defined his patients as "really strange people: they wait for you to look at their tongues and take their pulse and most of them expect that you will ascultate them"...Here there come into mind the bitter reflections of Campanacci: "my father ascultated by placing his ear directly on the chest of the patient; I ascultate with my stethoscope, at twenty centimetres of distance; my don ascultates with a phonendoscope, a metre or two away...This distancing of the sick person for me is the sign of the real danger that threatens modern medicine – that it loses sight of man": C.CATANANTI, 'La Antropologia alla Base della Medicina: un Dibattito Antico e Attuale', *Medicina e Morale*, 46 (1996), 6, p. 1147.

[28] Cf. A.SCOLA, *Questioni di Antropologia Teologica* (Rome, 1997), pp. 215-220.

[29] Cf H.U.VON BALTHASAR, *Teodrammatica* t2 (Milan, 1982), p. 317; A.SCOLA, *Hans Urs Von Balthasar: uno Stile Teologico* (Milan, 1991), pp. 101-118.

[30] Cf H.U.VON BALTHSAR, 'Uno Sguardo al Mio Pensiero', *Communio*, 105 (1989), p. 40.

[31] Cf *Mt* 27:4.

[32] Cf *Is* 25:8.

DIEGO GRACIA

The Economy and Medicine in the Twentieth Century

The precedents: the theory of intrinsic value

In order to understand the modern economy it is necessary to begin with the scenario of the classical economy which can be found in the great classical, Greek, Roman and Medieval tracts on the subject. Aristotle dedicated a number of important chapters of the fifth book of his *Ethics* to the subject of the economy. These were concerned with the study of the virtue of justice. His thesis was that things have an intrinsic value and that the economy manages this value which is to be found within things and which is expressed in their use. In this scheme of things, intrinsic value is the beginning and the foundation of the "use value" of a thing. Its volume can be realised in monetary units in order to make the exchange of products possible. Money, therefore, is the way in which use value is transformed into "exchange value". These are not two separate values but the same use value expressed in monetary units. Currency, therefore, has no other value than that of being a unit of measurement – it is, indeed, solely a unit of measurement. Things have use value and in addition this value is intrinsic, and thus it is that the transaction is correct when they are given value according to their function or use *(kreia)* and not according to their exchange value within the market. For this reason, prices are not made by the market but a result of the natural function of the things in question.

Hence money has no other function than that of being a measurement of values; indeed, a unique and universal measurement. Thus it is that Aristotle believes that one cannot ask to be paid interest on money. When one lends money to a person what the latter must do is to return the value of the loan, but the person who makes the loan must not ask for interest because this would amount to a request for a use value which money does not actually possess. Hence the term "usury". Economic ethics, therefore, are concerned with determining the use value in a correct fashion and not in requiring interest to be paid on loans of money. This means that usurers and bankers were seen as being immoral, in the same way as all those who dealt with pure market forces such as merchants were considered immoral. What these did was to buy products at a low price where there were most abundant and sell them at a high price where they were scarce. This meant placing taxes on such products or commodities not for their use value but for their exchange value, something that was considered immoral. For this reason, manufacturing industry, commerce and banking were seen as morally suspect activities, or were held merely to be immoral. The truly moral process by which to produce wealth was the land, something which took place in an agricultural society. Thus it was that rulers, the nobility and the clergy owned the land. They were morally unassailable. Everybody else was morally suspect, and this was especially true of the Jews.

This theory implicitly created a social structure. The owners of the land, that is to say of real wealth, were the highest class in society. They were the holders of the "intrinsic value" of things which was certainly increased by work, and for this reason the labourer deserved a payment for the value which he added to what he worked on. This was the function of the working-day and the wage paid. Owners and workers together managed the "use value" of things. The "exchange value" remained in the hands of merchants and men of commerce, people who were seen in a very bad light because they often took advantage of the scarcity of a product in order to sell it at a higher price than its theoretical use value. This also was seen as a form of usury. Another form of usury was to require interest on money, the practice of usurers and bankers – categories who were the morally blameworthy and negative categories of the ancient and Medieval economy.

This economic model also generated a system of health care. Only the upper classes could have access to medicine of a certain quality. The workers, agricultural labourers and the poor encountered difficulties in gaining access to a medical doctor and meeting their health needs. There are a number of different testimonies to this effect. It was for this reason that the Church established a network of charitable hospitals in order to take care of all these desperate people. This was done in the name of the principle of christian charity. Charitable institutions were essential during a period when the ownership of goods was in the hands of a very few people and when everybody else had to make do with a fed here necessary to their mere survival.

1. The economy and medicine during the modern era

Criticism of the economic theory outlined above began with the theologians of the last centuries of the Medieval period and continued dur-

ing the centuries of the modern age. It became increasingly obvious that the exchange value of products could not be identified only with their use value. For this reason, wealth could not only be identified with the ownership of land or with the labour which was mixed with it. Exchange, too, could produce wealth. Wealth was not the same as ownership of the land but came to be identified with work. This was the thesis of Adam Smith, the thinker who formulated liberal economic theory. Economic value was not determined by function or use but by labour. For this reason, economic wealth was to be identified with productive labour. Smith says this in the first lines of his work where he argues that the annual labour of every nation is the basis from which there comes the production of all the things necessary and convenient for life, which the nation consumes annually and which always amounts to the immediate product of this labour, or to that which is acquired with this labour from other nations. As a result, the nation will be better or worse supplied with everything necessary it is capable of producing according to the greater or lesser volume of this product, or that which can be bought with it, and this in relation to the number of people which consume it. This involves a moral approach which is based upon concepts of labour, savings, investment in production and parsimony in consumption. In this scheme of things it is not true that money does not have a value or that commerce is an unproductive activity. For this reason, not only use value be stimulated. Exchange value must also be fostered and such a process is important and moral. At the same time use value is not intrinsic but the consequence of the natural use value of things and of the labour which is added to add to their use value.

All this meant that the ownership of land began to lose all of its ancient importance. Wealth was no longer to be located in the ownership of land. It was important to work and to produce. The rich man, now, was the person who owned the means of production.

After Adam Smith the thesis came to hold sway that the value of commodities is nothing else than that established by the free market. Thus presupposes a radical inversion of previous Aristotelian postulates. The value of things is not an internal property which determines their use but the exchange value dictated by the market. It is the market which says what things are worth. Any other procedure is mistaken because it means that products are more expensive and of less quality. The first premise, therefore, is that exchange value is moral, indeed it is the only moral consideration. The alleged metaphysical use value of the ancients does not exist. Only exchange value exists. At the same time, money is not only the measurement of exchange value but also has within it a great exchange value, and is thus a product like any other. Furthermore, there is a money market. Money can be bought, sold and lent all other products. And equally logically, interest can be asked on money given that money itself has a market value. It is the market which determines the value of money, and for this reason interest can be requested on loans.

As we can see, this system is the opposite of what preceded it, and it sees as being good what in the past was seen as being bad. In practical terms this is a total inversion. Now it becomes moral to leave the market free from external pressures so that it can regulate itself. External interventions are therefore seen as immoral because they distort just interplay, as in the case of monopolies. Hence the liberal fight against monopolies which in classical theory are not immoral but actually necessary. What tends to be immoral is the free market. Now, however, things are inverted. Monopoly is immoral because it hinders the free interplay of the market. Furthermore, competition now has a fundamental ethical position and from being something which was previously morally negative it becomes something which is morally positive.

This acquired an enormous importance in medicine. First and foremost because for centuries medicine had operated as a monopoly. Liberal thought held that the health-care market should – like other markets – be supported and regulated by the laws of free exchange, without any kind of external intervention. This was the basic principle of so-called "liberal medicine" which wanted a relationship between the medical doctor and his patient which was not regulated by the state but which followed the principles of the free market – a sick person needed the technical help of the medical doctor and freely chose from the supply offered by the health-care market. This is what was traditionally understood by the term "liberal medicine", or by the concept of the free practice of medicine. Any intervention by the state was seen as being artificial and damaging. For the whole of the nineteenth century we can see how medical deontology condemned the idea that the medical doctor should be transformed into a person receiving a salary (that is to say a person belonging to private or state institutions). Later, when health insurance coverage became responsible for almost the whole of health-care offered, in some countries, such as France, medical doctors were opposed to so-called third-party payments – that is to say a system where health insurance or the state paid the medical doctor rather than the payment being made by sick person himself directly.

Using this model of liberal medical practice as a yardstick, within nineteenth-century societies it is possible to identify three kinds of medical care. The first is that of rich families who have such financial means that they do not encounter difficulties in paying medical or surgical fees. They were those who adapted themselves without any problems to liberal practice. Then there was another and broader sector – that of the middle classes who had to cover the out-of-the-usual costs of an operation or a prolonged stay in hospital through private insurance. They adapted themselves to the liberal model, albeit with certain corrections. Lastly, there was a third sector – that of the poor, who could not have access to the liberal health-care system. For them the liberal system always had a last resort – that of "charity". The state had to supply health care to those who were not able to obtain it out of their own means. Charity, to be sound, had to function in a purely supportive capacity. Equally, it was seen, by definition, not only as being "anti-economic" activity (given that the sick did not pay for the treatment and care that they received) but also as something that was "unnatural" and "injurious". This meant that the

charitable institutions were always very poorly equipped. For the rest, things were very inadequate. It was once again the Church which promoted a very large network of charitable institutions for those in need and the sick. Hundreds of charitable institutions were established by the Church during this period, and there were scores of religious organisations which arose during the last century to take care of the poor.

From an economic point of view, for the whole of this epoch economists saw charitable institutions as dangerous and immoral. The market always ended up by balancing the supply of labour with the demand for higher wages on the part of the workers. When the two factors were in balance full employment was the outcome. In the liberal economy it is not considered possible that unemployment could be voluntary. This is the reason why every unemployed person was considered a social disgrace, a "vagabond and loafer". In taking care of these people the charitable institutions were thought to be engaged in nothing else than making their condition even more chronic. This is the protest that is to be continually found in the great works of liberal economics beginning with Adam Smith, Thomas Malthus and David Ricardo. The charitable institutions, in their opinion, could deal with this situation of the poor only at an apparent level because in the long term the only thing they really did was to prolong the suffering of certain beings who were condemned by nature to extermination.

For Malthus, this is what the experience of the English poor laws taught, a subject to which he devoted an entire chapter (the fifth) of his book, the reading of which is a severe experience. His fundamental thesis was that although the poor laws were established with the most charitable of intentions, there were strong reasons for thinking that they had not obtained the results which they originally aimed for. This was because although they mitigated certain cases of especially acute extreme poverty they nonetheless increased the overall poverty of society. In the thinking of Malthus the poor laws tend to worsen the general situation of the poor. First of all, they evidently tend to increase the population without increasing the means of subsistence. The poor can marry although the possibilities of maintaining their families in an independent way are low or non-existent. For this author it could be said that these laws to a certain extent created the poor that they maintained, and given that the resources of the country must, as a result of the increase in population, be distributed in smaller parts for everybody, it followed that the work of those who did not receive the help of public charity would have a lower purchasing power and thus the number of people compelled to draw upon this help would inevitably grow. Secondly, Malthus believed that the quantity of resources used by this sector of society which in general could not be seen as the most valuable part of the community reduced the allocations given to the most active and worthy members of society, thereby forcing some of them to sacrifice their independence. And if the supported poor were to live better than they did in reality this new distribution of money within society would tend to further worsen the situation of those who were not so helped because it brought about an increase in reserve prices.

Malthus deduced two consequences from this line of argument. First, that the poor laws should not have existed, or, to put in differently, that charity was injurious. And secondly, wherever such situations of charitable institutions did exist they had to be "severe" so that they were not considered comfortable refuges to hide in during periods of difficulty, given that with such a policy the evils of the situation were merely aggravated. This explained the real acute poverty in which such institutions of poor relief carried out their work during the previous century – something which is constantly borne testimony to in the literature of the time.

The Church never accepted this way of seeing things. She believed that it was necessary to help the poor and for this reason promoted an enormous number of works and initiatives to help the poor, the sick and the elderly. What the economy was not able to provide and produce remained the responsibility of charity.

2. From charity to social justice

This was the cry of the revolutionary movements which spread throughout Europe in 1848. The result of this development was the appearance of left-wing social movements, represented in paradigmatic fashion by the socialist parties and the trade union movements. At their basis was an economic and social theory opposed to liberal thinking. After a certain fashion one was dealing here with the resurrection of the ancient theory of the intrinsic value of things. The price of products could not be left to the free interplay of the market, which, indeed, was immoral. Things had an intrinsic value which could not be left to the workings of market forces. Liberal capitalism was thought to distort intrinsic value and its distribution. The economy, therefore, could not be left to the free market but had to be planned. Once again one encounters a return to monopoly, albeit in a mode intense way than was present in classical theory. The state was to become transformed into the great economic monopoly power. Only planning and economic monopoly control could now be seen as being moral. And the free market was immorality by definition.

Hence a consequence of the very greatest importance. Health care had to be guaranteed by the state and be equal for everybody. Where liberals employed the term "charity", now reference was made to "justice". Care was seen as a right derived from the principle of justice and not a mere work of charity. From paternalism, therefore, one moved to social justice. This was the great revo-

lutionary cry of the proletariat during the second half of the nineteenth century. This was certainly the case in socialist countries. In Western countries this movement favoured the birth of a new set of human rights, the so-called "economic, cultural and social rights" in which the "right to health care" was included. Thus health care appeared as a right rooted in justice which in turn was based upon a radical change in the way in which governments addressed health-care questions and issues. From a "police" approach the move was towards a strictly "political" stance. Georges Rosen has studied the role of the "medical police" *(Medizinalpolizei)* of the German absolutist state of the seventeenth and eighteenth centuries with great precision and exactitude. The democratic revolution and then the social revolution meant that this medical police was transformed into "health policy".

Politics began to have an importance for medicine and medicine began to have an importance for politics, and this to such an extent that Rudolf Virchow was able to write in 1848 that: "medicine is a social science and politics is nothing else than medicine on a grand scale". This health-care policy expressed itself in various ways, and two may be referred to here: the increasing importance of "social medicine" and the beginning of the state systems of medical insurance, at least for the poor and the working class. To this should be added the high levels which statistics and health-care engineering reached during the second part of the nineteenth century. Thus one gains an approximate idea of the set of contents of the new "health-care policy". Medicine moved from being a private question (the aspiration of liberalism) to being a public and political responsibility. Health care was transformed into a very important part of the policies of "social justice". This did not mean the old-fashioned contractual freedom of doctrinal liberalism, but, rather, social equality. Justice was now social equality – social justice.

3. The Keynesian model and its influence on health care

The economic theory which made possible the birth of systems of social security, amongst which is to be listed compulsory insurance for illness, was Keynesianism. Keynes was the man who tried to cast off the idea that the liberal economy was the same as *laissez-faire* or a pure and jungle market. The fundamental idea, for Keynes, was aggregate demand, something bound up with consumer demand but also with investment by the state. The state had to regulate economic activity, even though this had to be done through the market. This was not a matter of substituting the market but of activating it, and in the final extreme of regulating it. The emphasis now became placed upon demand rather than upon production, and this is something which brought about a radical change in moral attitudes. Whereas classical liberalism laid stress upon frugality in the use of consumer goods, upon savings, and upon investment in production goods, and upon hard work, now the exact opposite was the case: what was considered correct and moral was consumption, and saving was seen as a vice, as miserliness, etc. This was the antithesis of the position adopted by Adam Smith.

In undermining the belief of the ancient economists in the voluntary nature of unemployment, Keynes offered a new way of acting in relation to distress in general: the creation by the state of broad systems of social security which covered the negative eventualities of the lives of men. Bismarck had already pursued this policy in Germany. In England the first Lloyd George

government enacted the law on national insurance which in the realm of health care gave rise to a system similar to that operating in Prussia through the *Krankenkassen*. In 1915 Sweden began a process which began with the law on pensions and which with the passing of years led to a model of society which Marquis Childs baptised in 1936 with the name of "the Sweden of the middle way". Imitating these previous initiatives, President Roosevelt passed the "Social Security Act" in 1935 which protected the elderly, the unemployed, and children in need. A little time afterwards seven Keynesian economists of the Universities of Harvard and Tufts published an economic programme for America in which they proposed major political investments in goods and services, including the health service. Moving in the same direction, the National Resources Planning Board issued in 1943 a detailed report entitled "Security, Work and Relief Policies", in which it laid emphasis upon the need for a policy after the war which would involve increased public works, expanded social security, and the implementation of other policies in similar vein.

Keynes was British and the most important consequences in the realm of medicine to spring from the Keynesian model were to be found in the United Kingdom during the 1940s. In 1941 the British government entrusted a famous economist and friend of Keynes, William Beveridge, with the task of producing a monographic study for an overall system of social security. After sixteen months of work, Beveridge in November 1942 presented the government with a report which bore the title "Social Insurance and Allied Services" in which he proposed certain policies which very probably went well beyond his original remit. The system of social security proposed by Beveridge included unemployment pay, pensions, widow's pensions, payments to invalids, and sums for weddings and burial. Together with social security, which was directed towards workers and their families, there was also national insurance, that is to say national welfare, which was intended to cover the needs of those who were not insured. In addition, there was also

the national health service. The Labour government in 1945 and 1946 enacted a number of very advanced acts of social legislation which were largely based upon the Beveridge Report. Amongst these was the "National Health Service Act" which came into practice in 1948. Thus there came into existence the National Health Service within the Western world, which protected the whole of the population in every context. The fact that it was introduced by a Labour government has led people to think that its goal was perhaps to extend social justice through the protection of economic, social and cultural rights. However, there are good reasons for believing that without Keynes and his economic theory this project would never have seen the light of day.

The transformation of the health-care model indicates how much the concept of medicine, indeed the definition of medicine, had changed. Indeed this is what happened immediately after the Second World War. On 22 July 1946 the Constitution of the World Organisation of Health was signed. This was a new organisation placed under the control of the United Nations which was responsible for the health and wellbeing of people. In the preface to the document health is defined in the following way: "a state of perfect physical, mental and social wellbeing, and not merely the absence of infections or illness". Never before had someone dared to define health in such terms. From the followers of Hippocrates to the end of the nineteenth century the definitions of health and illness had altered and changed, but nobody had ever identified health with wellbeing and not only physical but also mental and social wellbeing. This was in 1946 when the Anglo-Saxon Welfare State became the order of the day for all the Western democracies after their victory over National Socialism, and the definition of health with reference to the terms "welfare" and "wellbeing" begun to be established. Keynesian economics and the Welfare State have an idea of health as something bound up with welfare. The definition of the WHO lacks meaning if it is detached from its historical context. This meant that the correlation previously established between neo-capitalist economics, the consumer society and the political system of the Welfare State had another element added to it, and more precisely: "welfare medicines".

4. The limits to the right to health care

The question of the limits to the right to health care became pressing from the 1970s onwards. Two phenomena arose during that decade which were of the utmost importance. One was of an economic character – the great economic crisis of 1973. This to a certain extent involved the death of Keynesianism. The other phenomenon was of a more medical character: technological progress meant that it was possible to keep alive people who until a short time previously were destined to die. The young Karen Ann Quinlan, for example, lived in a permanent vegetative state for ten years. Was there an obligation, in the name of justice, to provide her with every kind of medical care and treatment? This fact, it might be observed, was nothing else but a particular example of something that medicine had transformed into a norm – anti-Darwinian action. If nature, as Darwin asserted, selects the fittest and condemns the weakest and the least fit to death, then medicine acts in exactly the opposite way. This meant that the number of the chronically and terminally ill (mentally retarded children, the gravely infirm, the elderly etc.) became ever greater, something which brought with it the so-called "cost explosion". Once again the question was posed as to whether justice requires that all these sick people are taken care of using all means available. What limits should be placed on their treatment? From what point of departure does the obligation to treat and care for them cease to be total (or one of justice) and become one which is incomplete or a matter of charity?

The answers, as is obvious, have been different but all of them have agreed on certain points. The first is that with regard to certain social goods considered as being of primary importance there can be no restrictions in terms of their provision because this would be inhuman. Secondly, that in all other contexts reasonable systems of savings and systems providing for the distribution of scarce resources are necessary. In this last case the analysis of costs/benefit rations has been used because there must be a constant attempt to optimise expenditure. This means various things. First, that with regard to health-care resources which are always "limited" (this is something which is constantly the case wherever health-care consumption is unlimited) it would not be acceptable to direct sums devoted to other headings of the budget to the health-care field if the cost/benefit ratio is greater in these areas than in the health-care field. Thus, for example, education or housing policy can have a higher cost/benefit ratio and in such a circumstance it is a sound policy to invest money in these areas. Secondly, in the health-care sector the limited resources which are available must be devoted to those activities, through the employment of lower costs, produce a greater health-care benefit. For example, if it is necessary to choose between a campaign of vaccination and a heart transplant there can ben no doubt that the cost/benefit ratio requires priority to be given to the first policy, even though such such a choice involves injury to, and even the death of, certain individuals. Thirdly, there are health-care services which in all justice cannot be provided given their low cost/benefit ratio. This happened a short time ago with heart transplants, or lung and liver transplants. This also seems to be the case with regard to cerebral deaths, permanent vegetative states, and so forth.

There can be no doubt that these conclusions involve an important correction of the previous doctrine. Indeed, they have led to a redefinition of the health-care model. It does not seem that social justice requires us to achieve the "perfect wellbeing" of everybody but only that "primary health care" which allows men to live a "life which is socially and economically productive". This is the move from "the medicine of wellbeing" or "pedagogic medicine" of the previous stage, that is to say from medicine as a consumer good to medicine as a production good. The "complete wellbeing" of the definition of 1946 is now divided into different "levels", and more specifically in three levels – the first, the second and the third. In the previous model the primary level or community medicine was less developed, whereas the third or hospital level occupied the most important position. Its functional effect, like its capacity, to produce was very low because it did not correspond to needs and resources. For this reason, it is not even possible to affirm that it was *just*. When the health-care needs of a population are analysed and resources are quantified it can be immediately seen whether they correspond in an acceptable way to thee three levels. Thus the health-care needs of a community are usually composed in the following way: 86% primary care; 12% secondary care; and only 2% tertiary care.

The best distribution of economic resources is in line with this schema. This is because primary care provides the highest return, secondary care rather less, and tertiary care very little. The return is measured here through the cost/benefit argument. For this reason, we should say that a health-care system is more unjust or its distributive justice within it is lower the more the tertiary level is advanced and the less the primary level is developed. Here we can say that in today's world three models are at work: 1) that of the developed countries, which have managed to look after both the first and the third levels quite well; 2) that of the undeveloped countries, where the tertiary level is absent but which have reached an acceptable first level (such as China); and 3) the semi-developed or developing countries which have invested all their resources in hospital care and have neglected primary care almost completely. This last model is certainly the most anti-economic and the least just.

Conclusion

We have seen how down history different economic theories have followed each other and that they have conditioned, and at times determined, the practice of medicine. It does not seem that this process has finished. Perhaps it will never come to an end. It is probable that we have not learned to provide an answer to the great question of economics – that of the value of things. Different theories have followed each other and some have placed emphasis on use value and some on exchange value. But it seems that value cannot be defined in either of these ways. The value of things is to be defined in terms of the life possibilities that they generate. Wealth is neither to be defined in terms of use value nor in terms of labour, nor with reference to market value, nor by taking into account effective demand, and all the rest, but in terms of life possibilities. We become richer the more individuals or societies have life possibilities. This is important because it introduces many factors into economic activity which did not form a part of classical theory. For example, a poem, a work of philosophy or a prayer are life possibilities, although they are not usually seen as economic products. The economy must be seen for what it really is – an instrument at the service of the goals of human life. Here, indeed, we encounter the great philosophical and ethical question: the ends of human life. The economy is nothing else but the reasonable management of the means which serve these ends. And whatever they may be, what is clear is that one cannot fall into the error of confusing ends with means or means with ends. We can thus repeat here the phrase of Jesus handed down to us by St. Mark the Evangelist: "the Sabbath was made for man, not man for the Sabbath" (Mk 2:27).

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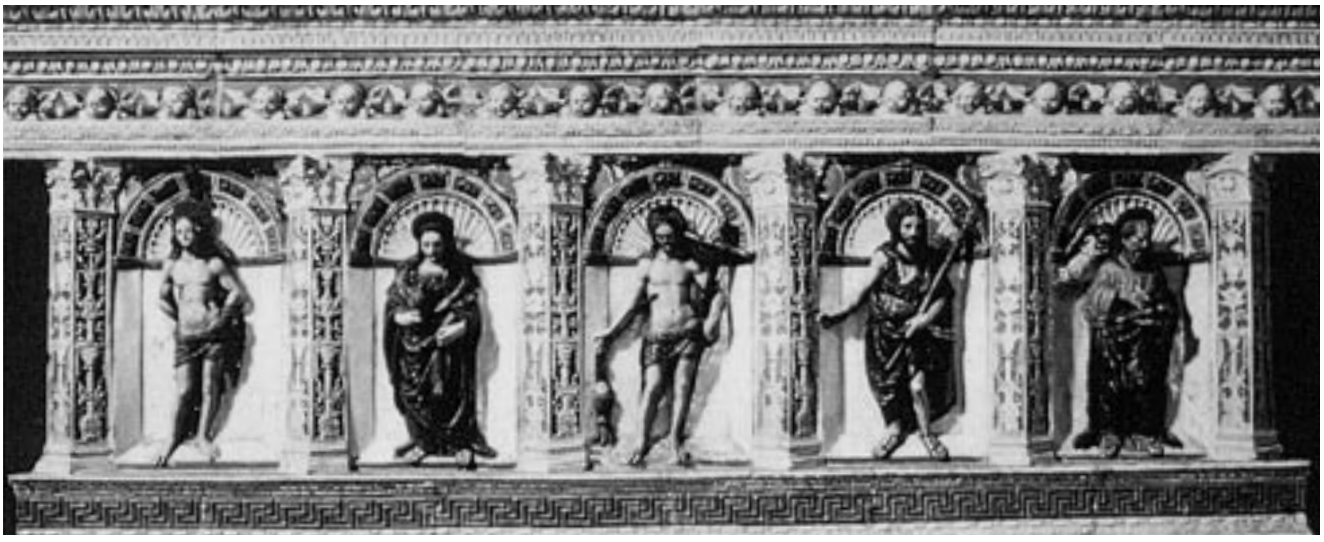

DIARMUID MARTIN

Reflections from the Social Teaching of the Church

The choice of the theme of this International Conference of the Pontifical Council for Pastoral Assistance to Health Care Workers could not be more topical. We live in a world in which economic concerns and interests all too often dominate. Pope John Paul II has indeed warned about the possible danger of "absolutizing the economy" (cf. *Centesimus Annus (CA)*, n.20, *Ecclesia in America*, n.20).

One of the major challenges of the emerging globalized economy is precisely how do we sustain the essential component elements of the global common good, especially those which are non-economic goods (cf. *Pacem in Terris*, n.139)? How do we manage this in a global economy where, very often, no individual country can today do so on its own (cf. *CA*, n.58). What happens when there is a changing constellation of protagonists in the economy? What will future and varying combinations of private and public authorities look like in the globalized, market-driven economy most likely to exist for the foreseeable future?

The social teaching of the Church provides a useful conceptual framework within which it may be possible to provide answers to these questions. But the social teaching is also facing new challenges that require additional research and reflection. Very often this teaching will only be in a position – and this may be more in keeping with its precise role – to ask the right questions, rather than to provide ready-made solutions.

The first contribution, of course, that the Church's Social Teaching brings to the debate concerns the very notion of health itself. Health and medicine are linked with fundamental anthropological questions, with the definition of the human person. Health policies cannot treat the human person as if the production and consumption of goods were the basis of social life and society's only value (cf. *CA*, n.39). Health is a quality of each human person, a fundamental good which he or she needs and desires. The capacity to enjoy good health reflects that great dignity with which God endowed the pinnacle of his creation, the human person.

But the lack of full health does not remove the fundamental dignity which belongs to each person; indeed, suffering has great meaning, and especially for Christians. As Pope John Paul II wrote in his Apostolic Letter *Salvifici Doloris*, suffering "seems to be particularly essential to the nature of man. It is as deep as man himself, precisely because it manifests in its own way that depth which is proper to man, and in its own way surpasses it" (n.2). While we all wish for good health, our greatest and most sublime thoughts and deeds are often most apparent in our suffering. Because of our transcendent Creator, human dignity belongs to each individual person, no matter what his or her physical or mental condition, for this dignity is not measured by utility or efficiency. In fact, "the world of suffering possesses as it were its own solidarity" (n.8). This common suffering compels us to seek for answers and Jesus Christ reveals "the truth of love through the truth of suffering" (n.18). Above all, it is this love that ultimately motivates the human person's concern for well-being and health.

It needs to be recalled that, in wishing for health, the human person is not an isolated individual seeking his own self-preservation above all else. God created humankind as a single family (cf. *Message for World Day of Peace 2000*, n.2), in which each individual bears certain responsibilities for others. Health is a social phenomenon that concerns not only the protection of individuals and their rights, but also the promotion of the common good. Many health problems can be resolved only through effective measures

of social medicine, whether this be through education, preventive medicine, widespread vaccination or the fostering of adequate national and international health care policies.

The goods of creation were given for the benefit of all of humankind. In *Tertio Millennio Adveniente*, Pope John Paul II notes a central element of jubilees as described in the Old Testament. "If God in his Providence had given the earth to humanity, that meant that he had given it to everyone. Therefore the riches of Creation were to be considered as a common good of the whole of humanity" (n.13).

This fundamental principle of the universal destination of created goods (cf. *Gaudium et Spes*, n.69) is especially applicable today to health care. Health care is one of the major focal points of inequality in today's world. When we speak of "the goods of creation" we are speaking not just about physical goods such as land, raw materials and capital. Today we are speaking above all of *knowledge, human capacity and the fruits of human ingenuity* (all of which, of course, are gifts of God). Pope John Paul notes: "Whereas at one time the decisive factor of production was land and later capital – understood as the total complex of instruments of production – today the decisive factor is man himself, that is his knowledge, especially his scientific knowledge, his capacity for interrelated and compact organisation, as well as his ability to perceive the needs of others and to satisfy them" (*CA* n.32).

The inequalities that exist with regard to access to knowledge useful – indeed essential – for health care are greater perhaps than those which exist regarding any other essential element of the common good of the global community.

In a modern economy, it is important to note clearly that the market is simply a setting for trade, and as such a means to an end. Of course, it is an important means, but it must be measured by *its objective ability to achieve its own set aim:* efficiency of production and distribution. The evaluation of market mechanisms in the health care sector should not be based on an ideological position for or against markets, but proceed by way of *verifiable and quantifiable facts.* These facts must concern what such mechanisms achieve, but also what they leave unachieved, in terms both of the *quality* of the services provided and the *extent of access* they guarantee. Health care is one of the goods of God's creation and hence must be accessible to all.

We know that knowledge and information are rewarded in the modern economy. But its true driving force is the human person, with his or her creativity, ingenuity and capacity to innovate. The most important economic investment that can be made today is in *enhancing human capacity,* in permitting humans to become the persons which God intended them to be. Enhancing this capacity enables them to realise their God-given potential. Poverty and exclusion, on the other hand, may be seen as obstacles to the realisation of this God-given capacity.

Investment in people no longer belongs just to the area of social policy or mere philanthropy. It constitutes an essential dimension of investment in sustainable and sound economic progress. In recent years we have seen more clearly the link between the economy and the social order in today's society. The social consequences of the recent economic crisis in South East Asia have been quantified alongside the economic consequences. We see the number of people who have lost their jobs, millions in just a few months in Indonesia alone. The number of children who have had to leave school to support their families affects basic social goods such as education and health.

But we are also seeing that there were not just *social consequences* of that economic crisis, but also *social causes.* Economic growth without strong social infrastructures will always remain a weak construction. Growth, without social cohesion and without the investment in human and social infrastructures which guarantee cohesion, will always be fragile. Growth just for growth's sake would be what I call the law of Babel, based on the Biblical symbol of humankind's desire for a certain type of infinite growth but which results in human scattering and division. Growth must be tempered by considerations of quality, sustainability and justice.

How do these principles, which apply to all economic questions, apply in particular to health care and what does the Church's social teaching have to say on such questions? Here we come back again to our earlier reflection on the respective roles of public and private, the market and the State, as well as a broader participative society.

In *Centesimus Annus,* Pope John Paul II writes that "it would appear that, on the level of individual nations and of international relations, the free market is the most efficient instrument for utilising resources and effective responding to needs." This admission is immediately qualified, "But this is true only for those needs which are 'solvent', insofar as they are endowed with purchasing power, and for those goods which are 'marketable', insofar as they are capable of obtaining a suitable price. *But there are human needs", the Pope continues, "which find no place on the market. It is a strict duty of justice and truth not to allow fundamental human needs to remain*

unsatisfied and not to allow those burdened by such needs to perish" (n.34, emphasis added). Later in the same Encyclical, Pope John Paul II again notes that "there are collective and qualitative needs which cannot be satisfied by market mechanism. There are important human needs which escape its logic. There are goods which by their very nature cannot and must not be bought or sold" (n.40).

The Pope accordingly recalls that "it is the task of the State to provide for the defence and preservation of common goods such as the natural and human environments, which cannot be safeguarded simply by market means" (*ibid*.). It is obvious that, when speaking of the "human environment," he is speaking also about health. Summing up, he stresses that "the State and all of society have the duty of defending those collective goods which, among others, constitute the essential framework for the legitimate pursuit of personal goals on the part of each individual" (*ibid.*).

In addressing the role and the responsibility of the State, the Pope does not say that the State on its own must provide all the elements of the common good. Rather he stresses the importance of the principle of subsidiarity, according to which "a higher order should not interfere in the internal life of a community of a lower order, but rather should support it in case of need and help to co-ordinate its activities for the rest of society, always with a view to the common good" (n. 48).

In this regard, when referring to services for the sick, the Pope notes that "needs are best understood and satisfied by people who are closest to them and who act as neighbours to those in need." The sick, the refugees, immigrants and the elderly "can be helped effectively only by those who offer them genuine fraternal support in addition to the necessary care." Health care, in the future, will be provided for by a judicious mix of interventions of the State, the private sector (including business) and voluntary and charitable organisations.

Let me, however, note a tone of warning about the use of the term "private sector," which is important to remember when we face such realities as the privatisation of health care. The term "private sector" can be used ideologically by different sides in public debate. On the one side, there is a tendency to emphasise that "public goods" are the concern of "the public sector", and that private involvement, especially any profit motive, is out of place. If government alone were the only appropriate vehicle for providing public goods, we would tend towards statism (which would indeed "crowd-out" many Church-run private health care facilities). The private health care facilities of religious inspiration are living proof of the value of an active private sector in providing the "public good" of health. The same can be said of Church schools in education.

There is also a problem when the opposite ideological position affirms that the private sector is a purely private matter, is "no one else's business" and should be left to itself or with as little government interference as possible. Private, profit-inspired institutions must certainly be part of an overall health policy and are often models of quality and efficiency. But it is clear that a simple market-inspired health policy will not guarantee universal access to adequate health care in any nation,

and much less so on any global scale.

As I have previously noted, health care is one of the principal examples of inequality in today's world. There have been remarkable improvements world-wide in life expectancy and infant mortality, to the extent that longevity can be considered a special gift of God to our times. But life expectancy in some African countries has dropped dramatically to 36 or 37 years. Vast amounts of money are being invested in health-care research. But only about 10% of such research is devoted to the diseases prevalent in those areas, especially in the tropical regions, where 90% of high risk mortality exists. To put it more bluntly, 90% of current medical research is directed to the diseases of the rich and 10% to the diseases of the poor. The extraordinarily high cost of medical research means that it is driven more and more by profit motives. And there is very little profit in the type of social medicine needed to fight common infectious diseases such as malaria or tuberculosis.

I am happy to learn of the initiative of the World Health Organisation to promote a new collaborative approach of public and private, national and international in the fight against malaria. Such new voluntary alliances will be an important step in fostering the emergence of a truly global community, in a world which there is no single universal authority with responsibility for the fostering of the common good. Pope John Paul II has recently stressed that "the law of profit alone cannot be applied to that which is essential for the fight against hunger, disease and poverty" (Speech, 23 September 1999). On the same occasion he also noted that the traditional teaching of a "social mortgage" on private property must today be applied to "intellectual property" and "knowledge", when the common good is at stake. This has important implications for the management of patenting in medical research.

Another area of inequality in access to health care concerns the differences in access for men and

women. This a fundamental question of human dignity. God created humankind "male and female", each with equal dignity. The figures concerning maternal death are particularly striking, where the vast majority of such cases take place in developing countries whereas most doctors in wealthier countries may never encounter a single case during their entire career. And the response to this emergency does not require highly expensive technical means, but is linked above all with much more simple dimensions of primary and preventive health care. The services of the Catholic Church, which places such an important value on motherhood, should be pioneers in improving services to fight maternal death and morbidity.

Health care policies must be placed more and more at the centre of investment for people, including within a new concept of development policy. If investment in people is the key factor in re-launching an economy in difficulty, then it is absurd, for example, to propose programmes of structural adjustment which involve disproportionate cuts in precisely those areas, such as health and education, which enhance human capacity. Means have to be found to lead nations out of situations where they spend more on debt-repayment than on health and education expenditures combined. Debt relief programmes must be structured so that debt reduction is accompanied by increased and focused spending on health and education, responsive to local needs.

Thankfully, the more recent models of economic adjustment and debt relief stress the need to ensure that the funds saved through debt relief or the reduction of non-productive expenditures *effectively* go to the social sector, and especially to the poorest. This will not happen overnight or automatically. To translate debt relief into poverty reduction, requires that the funds released be clearly set aside and that their use be monitored, under transparent control, of governments, donors and civil society, to ensure that they are used impartially and efficiently.

When speaking of efficiency and transparency, allow me to draw attention to one problem about which I feel strongly, and has been taken up courageously in recent years by many Bishops, especially those of Latin America: *corruption.* It is the poor who pay the price of corruption, who are deprived of their basic rights when funds are misused or directed elsewhere through corruption. Money diverted to corruption is not available for essential social services. Corruption is at the root of the poor quality of health services, especially those for the poor, and not only in developing countries. When health care services are badly managed, once again it is the poor who pay the price. When limited funds are not efficiently used, it is the poor who pay the greatest cost.

Efficient health care, I have repeated, is an essential element to the common good of societies, local and global. Efficiency involves not only economic efficiency, but also the quality of serving and coverage provided. But the economic aspects are very important. In many parts of the world there is a reduction in public funding available for essential social services, while the better-off find ways of covering their needs through privatised structures. There is a dramatic reduction in the funds available for international development co-operation, with serious consequences health-care in the poorest countries. We will only be able to create a sustainable, long-term foundation for an economy for health if we can generate a new consesnus and a new culture of international solidarity, in which the needs of the poorest become the interest of all. This will require a cohesive effort by all involved in the years to come.

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GIUSEPPE CINA

Health and Salvation in Dogmatic Theology

Dogmatic theology only begun to be concerned in an explicit way with the relationship between health and salvation a few decades ago. Before that time it was moral theology and spiritual theology which dealt with the subject, and they directed their attention principally to the question of man's responsibility towards his own health and towards that of his neighbour. Today, as well, it appears that it is primarily ethics – indeed bioethics – which is referred to when there is a discussion of the subjects of health and illness, and of the quality of living and dying.

The reasons which have led dogmatic theology as well to reflect upon the relationship between "health" and "salvation" are perhaps to be found in the new organisation of the theological disciplines approved and promoted by Vatican Council II, and in the changed cultural horizon of our societies in relation to health. But above all else it was the return to the concept of "salvation" which took place in the years following Vatican Council II[1] which acted to stimulate the inquiry of theology into this area of study.

In this paper the aim is to reflect in a theological sense upon the relationship which exists between "health" and "salvation", and to do this with special reference to the question of economic investments made by a society in the realm covered by the defence and promotion of health. This involves asking ourselves the meaning of the condition of health in relation to the salvation which works through Christ and the Holy Spirit. This question can also be expressed in the following terms: what contribution can theology offer to the defence and promotion of health, the promotion of treatment, of therapy and of the art of medicine, given that its specific subject is "salvation"?

It seems to me appropriate and suitable to make clear at the outset the nature of the meaning which contemporary culture and present-day theology give to the concepts of "health" and "salvation". Only subsequently will it thus be possible to clarify the nature of the relationship which exists between these two realities.

1. The Concept of "Health"

Hans-Georg Gadamer has recently drawn our attention to the difficulties involved in seeking to define the condition of health: "We have a rough idea of what illnesses are, because they are so to speak characterised by the rebellion of "what has gone wrong". They manifest themselves as an object, as something which offers resistance and which should therefore be removed. This is a phenomenon which can be observed carefully, judged from a clinical point of view, and all this making use of all the methods which are made available by knowledge objectively rooted in modern science. Health, on the other hand, in a curious way eludes this process – it cannot be examined because its essence is to be found in its concealment. Differently from illness, health has never been a source of worry or anxiety. Indeed, we are hardly ever conscious of the fact that we are healthy. It is not a condition which invites us, or admonishes us, to take care of ourselves. It involves the surprising possibility that it will be forgotten about."[2]

We can to a certain extent be helped in understanding the meaning of health by referring to the linguistic roots of the term "health". Indeed, it is to be observed that "both in the Roman form and in the Germanic and Slavonic forms (Rom: *salus, salute, salut;* Got: *hails;* paleoslavonic: *celu*) the term has Indogermanic roots which refer to "being-complete". Being-complete, being-identical-to-oneself, means two things. First of all, it means being free from everything that compromises or impedes completeness; and secondly, being-complete involves the achievement of the whole "potential" which is available, the obtaining of an objective through that which is specific to man."[3]

With reference to Western culture, it is my opinion, in relation to the subject before us, that a very recent and stimulating essay by Giovanni Reale is of great interest to us. This essay is entitled: *"Corpo, Anima e Salute. Il Concetto di Uomo da Omero a Platone"* ("Body, Soul and Health. The Concept of Man from Homer to Plato").[4] Here the meaning of the wholeness of the human person is returned to. More specifically, the state of health is understood as the "right measure", balance, harmony and fullness of the person. Through a detailed analysis of the writings of Plato, the author demonstrates how the great Greek philosopher begun with the concept of health provided to him by the medicine of the time and proceeded to broaden it and to root it in the principles of his philosophy, thereby reaching deeply into the metaphysical bases of being. The axis around which the concept of health revolves is seen as "convenient and right measure".[5] The author comes to the conclusion reached by Jaeger: "the task of the medical doctor is to restore hidden proportion when that proportion is disturbed by illness. In the state of good health it is nature itself which

re-establishes that proportion, or, to put it another way, nature itself is the right proportion. The very important concept of "mixture", which in reality means a kind of right balance of the forces of the body, is closely bound up with that of "proportion" and "symmetry". Nature works like an "intelligent norm".[6] At this point Reale observes: "these concepts of "proportion" and of "symmetry", like those of "more" or "less", are closely connected with the concept of "measure", indeed "right measure" – this is the key concept of Plato's metaphysics in which, indeed, is rooted his concept of health".[7]

For Plato, therefore, the concept of health depends on the "right measure" or proportion of the parts of the whole organism of the human person, and this is the essential ontological character of the reality itself. The conclusion is that it is not possible to treat the human body without directing attention to the body taken as a whole. But in the same way it is not possible to treat the body, or a part of the body, without also treating the soul, or rather the completeness of what really constitutes man.[8]

The accuracy of this approach is confirmed by recent medical research which demonstrates with ever greater clarity that the outbreak of illness, whether physical or psychological in character, is also the point of arrival of a long history whose complex ramifications are not always easy to decipher, where, however, it is clear that the ultimate roots of the malady are to be found unfailingly in two orders of things: the body and the spirit, the physical organism and the psychic-spiritual organism. There is always a connection between these two dimensions, even though the specific origin of the malady is to be found in one or other of them.

The health of a person, therefore, should be seen from a dynamic point of view, as a tension to establish a balance between the different dimensions which go to make up the human person. Health is *pluridimensional* in the sense that it involves the entire man as a unity and in the arrangement of dimensions. It can, however, be studied and studied indeed at different levels, from the psychophysical level to the level of interaction between the psyche and the body, or in terms of the sound equilibrium between the individual and the community. Health, however, should be understood in its entirety. This, in turn, should be examined in terms of the "meaning of life" and is situated at the level of the spirit – the wellbeing of man depends in essential terms upon the living out of a meaningful existence.[9]

Health, therefore, is an *evolutionary-dynamic* and not a fixed and stable "state", although at the same time it is a point of arrival, a path to follow, a vocation which should be responded to in a dialogue with the other experiences of life, and more specifically: joy, suffering, illness, successes and failures, disappointments and achievements, and so forth. *The human subject responds* to the condition of health because it is not a condition which merely "befalls" man, an event which he should simply observe. It requires man to adopt a stance in relation to it. In this case, too, man is a being "who decides himself" or rather decides on his own the way in which he wishes to manage this situation.

A suitable understanding, therefore, of this condition of man means to write it into one's own personal "biography", to make it enter one's own conscience, and to make it an object of decisions which form a part of a framework of values through which one lives out one's own existence.[10]

2. "Salvation" in Recent Theology

It is interesting to observe the intensity and the breadth with which contemporary culture talks about "health": today's man does not only want to live, he also wants to live "to the full". For the first time in the history of mankind one has the sensation that illness can be defeated, or at least many forms of illness. This conviction has been embraced not only and not simply because of the renewed optimistic trust in the progress of science and technology which began to gather steam towards the end of the last century as a result of the long-term impetus of the Enlightenment. Indeed, from this point of view it should be observed that today's man has become rather hesitant and cautious.

The more important reason for this seems to be found in the increased awareness of the personal and collective *responsibility* of man himself towards the conditions which aid or work against the physical-mental and spiritual wellbeing of man. We know that we ourselves are the creators of many illness, or that they are brought about by an erroneous individual or collective lifestyle, or by an unhealthy attitude adopted by society towards nature, not to speak of the role played by the unjust distribution of economic and health-care resources at a planetary level. A large number of other causes could also be invoked to explain this state of affairs and many of them are to be traced back to the responsibility of man.

This wish to live to the full has its origins in the very deep desire to "wish for ever", in that *wish for the infinite and entirety* which leads us to "write upon time something which goes beyond what is perishable",[11] to rise above "the human paradox which seeks to write the absolute into the relative and the transient".[12] The sick person who asks for health and healing has a question which conceals a strong yearning to last, to go on living, to be able to enjoy the light of life for "yet more time". Especially when a person falls seriously ill, or is still young or relatively young, he has the impression that he still has not yet carried out his "life project", that he is still "called upon" to achieve something unprecedented and essential which is still "lacking".

Biblical revelation interprets the origins of this desire for the infinite as being a consequence of being created in "the image of God", created to live in His presence, in a close relationship of alliance and friendship. Biblical man, trained in the school of divine revelation, is aware of this creative and salvific will which makes him and sustains him. The interventions made by God always seek to give life and to give it "in abundance" (Jn 10:10).

It is precisely the experiences of poverty and misery, of pain and of death, which stimulate man's propensity to dig ever deeper into the meaning of that mysterious desire for life which dwells within him. Before becoming aware of how he needs to be saved from sin, biblical man perceives his own inadequacy in relation to the reality of living, to "exiting" ("exodus") from situations of slavery, of ill-being, of

misery, of oppression, of illness, and of death.

And here it is that we come to the theological concept of "salvation".

The tradition of the Church in terms of her theological reflection and thought, and beginning with St.Augustine, has funnelled the salvific interventions of God into the concept of "grace". This concept has been understood in different ways down the centuries according to life, human and social circumstances.[13] In recent decades numerous studies and conferences have made their appearance, especially in the Catholic world, and these have asked themselves what meaning today's theology attributes to the fundamental categories of "grace" and "salvation".

Indeed, one had the impression that the existing interpretations narrowed the meaning of salvation to the inner and individual dimension and paid scant attention to historical and experiential elements, to social and collective aspects, and to the external and corporeal dimension of man and of nature. There was a criticism, that is to say, of the employment of this concept on the grounds that there was a lack of sufficient attention being paid to the practical and the tangible, and this in such a way that the work of grace was almost "relegated" to the sphere of the "beyond this world and the inexpressable", and perhaps to be found on the margins of a "mystical kind of experience...which does not touch the practical life of man and this world".[14]

The observation advanced by certain theologians to the effect that salvation "should not be seen beginning with the inner dimension of man, as a 'new creation'", but as "God who communicates, God who dwells within man in order to bring him into His own life"[15] was more incisive. This taking part in divine life is what man, in actual fact, tends towards from the first moment of his creation. That intimate element of happiness, of wholeness, of fullness of life, can be achieved only in God. This "supernatural" level should not only be located "at the end" of the human journey – it is to be projected along the pathway that leads to God. The "natural" whole life of man and the world is directed towards the supernatural salvation provided by God. There can be no separation between life which is only of this earth and life connected to salvation. All the important experiences which are undergone in this world are instruments, halting places and terrain where man is called upon to develop his own purpose and end. There is thus also an "ability to experience" salvation: the humanum is directed towards salvation, he is already involved in it, because an authentic human experience always implies an experience of grace and salvation".[16]

For this reason, theology after Vatican Council II came to lay emphasis upon the *historical dimension of salvation.* Theology prior to Vatican Council II emphasised the future dimension of salvation (it should be observed that reference here is made to "emphasis" and that an awareness of salvation during this earthly life as well was not absent), but subsequently it has discussed and approached salvation with reference to all the stages of human life.[17]

Salvation should not be seen solely in terms of the inner dimension of the human person but also in relation to his external side, to his physical nature, to his practice of communication, to his social character, and to the exercise of his responsibilities towards himself and towards the community. It is thus *the corporeal and social dimension* as well which is involved in salvation – salvation also concerns society taken as a whole.

For this reason, salvation is understood as a *"conquest of freedom"* involving liberation from enslaving conditions from a political, economic, social, psychological, as well as moral and religious, point of view. The theological currents of recent decades – albeit not without some examples of intemperance – have re-illuminated this aspect of salvation, seeing it as the promotion or achievement of freedom. I am referring here to political theology, the theology of hope, liberation theology, and cosmic theology.[18] There is also reference made to salvation as "fullness of meaning", and this in the context of Western society where the condemnation of a loss of a horizon of meaning caused by a scientific-technological civilisation which ignores the deepest and most typical dimensions of the human subject is more than prominent. Salvation understood as "liberation from evil" does not so much refer to the creatural limitations binding man but to moral evil, to selfishness, to something which in a widespread and structured way impedes, obstructs and slows down the achievement of the full achievement of the perfection of the individual and of society as a whole.[19]

A similar set of observations may be made in relation to the soteriology *of the condition of health and illness* in the sense that reference should be made to the historical ways in which the relationship between health and salvation has been perceived during the long life of the Church. In the brief space afforded to a paper given to a conference such as this I will limit myself to an analysis of the present-day situation and try to propose an answer to the question: in what way does contemporary man, in relation to his condition of health or illness, experience the salvation which has already begun, to the point that such an experience is able to offer an *analogy* and a *principle of understanding* of the salvation of God, or rather of that full fulfilment of human living, that "living to the full", which comes from God's gift?

3. The Relationship between Health and Salvation

One of the theological affirmations which are at the centre of Christian anthropology is that coined by St.Ireneus of Lyons who declared: "the glory of God is living

man: here we encounter the greatness and the splendour of God – that man, that is to say, finds life, real life, healthy life" (*Adv. haer.* IV, 20, 7). The will of God as manifested in the fullness of his Son made flesh, Jesus of Nazareth, is "his passionate and unfailing wish to live for ever in free and mutual communion with a happy and good humanity".[20]

Still, the history of salvation is an account of God "the lover of life", who creates, heals, promotes and constantly raises the level of life of his creatures until they are made participants in His own divine life.[21] The Christological revelation of the God of the Old Testament carries out, crowns and bestows the fullness of meaning to this image of God. It is in this sense that Jesus summarises the reason for his advent: *"I have come so that you should have life and should have it in abundance"* (Jn 10:10). Such is the face of God of Jesus Christ – a God who is not in the least "concerned" with Himself, but totally directed downwards towards his creation and towards man himself, who is at the centre of that creation. "The unconditional dedication of self is the supreme criterion for every verification of the truth of God".[22] And it is in this total self-giving of God that the existence of man has its basis and roots.

In the revelation provided by the Bible, therefore, there is a developmental concept of life, its "becoming" which grows towards a "fullness" of life made up of the participation of the creation in divine life. It is in this context that the "healthy" condition of the creation and of man, in its dialectic of "health" and "illness" and of well being and ill-being, should be placed.

In this process of the "becoming" of the creation, two aspects are especially meaningful when one comes to consider the creation from the point of view of health – the fact of the *finiteness of what is created* and the *responsibility* borne by man in this evolutionary process.

According to the biblical understanding of the creation, God created nature and man "from nothing". This is because both of them had their origins in an "other-than-themselves"; they did not have their bases in themselves and they did not enjoy absolute independence. They are finite and limited realities which have to achieve their fulfilment, their perfection – they are realities engaged in "becoming" in the sense that they must progressively reach their authentic being, their final realisation. The perception, therefore, of the finiteness of man and of the creation, together with an awareness that they were created "from nothing", enables man to understand that man and the whole creation cannot be perfect or realised because they are "something other" than God. Man and the creation are necessarily in a condition of imperfection, on a journey towards their own realisation.[23]

This evolutionary understanding of the cosmos and man provides a certain clarification of the reason why the suffering and physical pain of both man and nature exist. But it also illustrates the features of precariousness of our condition of health and its complexity. Indeed, it enables us to understand that a certain tension between our present condition and the condition which is to follow is "natural", a sign of "healthiness", and of wellbeing.

The second element that emerges from the biblical understanding of the creation is the fact that God achieves His plan to share His divine life with man for ever by *seeking the free consent* of man to such a project and thereby stimulating his *"sense of responsibility"* for the achievement of that goal. Man must freely want the project that God has planned for him. Furthermore, the fulfilment of that plan requires man to refer to God because it is a project

created by God which springs solely from His free and sovereign initiative. Man on his own would never be able to carry out this design – he has to reach it as a "gift" of God. For this reason, man was created "in the image of God" so that his communion with God could be authentic and his relationship with God real.

Man, therefore, must face up to two kinds of existential and theological problems. First of all, he must accept living in a tension between present absence and the wish for fulfilment, something which in fundamental terms is a tension between an unlimited desire for life and the limited character of his present condition, between finiteness and transcendence. A second reason for this tension is encountered by man as soon as he realises that his complete fulfilment, the achievement of life to the full, is an absolutely freely given gift of God which does not in the least depend upon his own human abilities and opportunities. And yet God wants man to accept this project freely and with love – man, therefore, must become himself freely by entrusting himself to the Other. This must be a "more" than himself, owed to the freely-given generosity of the Other, and explains that form of "distrust" with which man approaches God's project of which the account of the original sin (Gen 3:1-7) is emblematic.

The history of the creation and the history of salvation are an account of this work which God wants to carry out together with man – God works in "synergy" with man so that man can recognise and accept the design of God and together with God co-operate in its realisation. This is what the biblical concepts of "creation" and "alliance" strive to clarify. God and man work at different levels. At a founding and transcendental level the work of God takes place; at an immanent level man performs his own activity. They are neither separate nor parallel levels. It is rather the case that the transcendent dimension envelops the immanent level, infuses itself in it, and makes it possible and operational. The immanent dimension takes place within the transcendental dimension, and the latter is inserted into the former. And this so that God does not work "at the side of" or "above" man but inside him, entering into him and stimulating

him towards a "more" than what created nature on its on is able to achieve.

The presence of sin (Gen 3) increases the tensions which already exist in nature and man to which I have already referred in this paper. The approach involving suspicion which man has towards God, and thus his subsequent non-obedience to God's will, increases that sense of distance between aspiration and fulfilment and "diffidence" towards God. This is because the "resistance" to receiving and accepting the elevation of the transcendental dimension now no longer comes from created nature but also from a condition of sin, which in turn is rejection, rebellion, the non-acceptance of the gift of taking part in divine life.

The revelation of God and His salvific project helps both the creatural dimension of man at the level of his limitations and his finiteness and his condition of sin. For this reason, the history of the realisation of the plan of God becomes a "history of salvation", of liberation and of redemption, and not only a history of the promotion and elevation of life. The history of the creation, to summarise the point, is inserted into a soteriological horizon.

This is a revelation which takes on the characteristics of the self-communication of God Himself, and not only at the beginning of the creation – it is constantly present, accompanies the creation, and maintains the creation in a state of being (*"creatio continua"*). God's participation in the story of man becomes, so to speak, increasingly intimate and achieves its culminating moment in the Incarnation of the Son of God. The Incarnation, in reality, is the moment of "transition" (paschal mystery) not only of God towards man but also of man towards God – man enters into the mystery of God, into His life, and shares in His life.

4. Slavery and Illness: Emblematic Places of Irredemption

Seen in the right light, the history of salvation, whose goal is the introduction of man into the life of God, has its starting point in liberation from situations of irredemption: moral evil and theological evil, the evil of creatural imperfections and evils caused by finiteness. Indeed, the Bible narrates stories of liberation from political and social enslavement, from mental and spiritual slavery, and from religious and moral servitude. Thus we encounter: subjection and illness, telluric upheavals, epidemics, forms of idolatry and a lack of loyalty to the Covenant, injustice, oppresssion, selfishness, ambition, vanity and pride.

From the many situations of suffering and irredemption described in Holy Scripture, in the Old Testament there emerge situations of *slavery* which are marked by an especially high profile. In the New Testament, in different fashion, the situation is more varied and complex. However, the presence of liberation from *illnesses* of every hue and colour is very marked in the New Testament. And all this to the point that one can perhaps see slavery in the Old Testament and illness in the New Testament as emblematic points for the launching of the history of salvation.

A reading of Exodus in this instructive light is offered to us by one of the last works left to us by Luis Alonso Schoekel, a leader in the field whose passing was much lamented by many. This authority entitled his work on the Exodus: *"Salvezza e Liberazione: l'Esodo"* ("Salvation and Liberation: the Exodus")[24] because he wanted to emphasise that although it is certainly the case that "salvation" is the goal

of the journey of Exodus, it is also in the immanence of the "liberation" that this fact has its beginning. Indeed, with regard to man the definitive fulfilment or realisation of his existence does not take place unless the historical and earthly dimension is integrated into the transcendental dimension. The aim of the story narrated by Exodus is that of "salvation", the life of relations and communion with God, expressed by the categories of the "service", of the "worship", which is to be rendered to God (Ex 3:12). But this goal is achieved through three moments which the clear biblical author identifies in the *exit from slavery* in Egypt, the *journey through* the desert, and the *entrance* into the land of Canaan. However, the specific character of the "salvation" which God wants to provide to His people does not yet appear in these three moments, namely – communion with Him. And yet this is the motivation behind the redemptive act of Jehovah as indicated in the first account of the call to Moses (Ex 3:12), in the threats of punishment made to the Pharoh if he does not let the people of Israel depart (Ex 3:18; 4;23),[25] and made clear again more than anywhere else in the celebration of the Covenant (Ex 19). This is because it is in such a communion with God that the people of Israel find their authentic salvation. Indeed, once they have taken possession of that land they will stay there only, and as long as, they remain loyal to the Covenant. As soon as they break their pact of loyalty to God, the people of Israel lose their land and their freedom. Thus it is that the condition of freedom and of possession of lands and goods are not salvation in themselves but the conditions for their acquisition. This has its essential centre in the relationship with God. The immanent fact expressed in Exodus by the liberation from slavery and the gaining of lands has and maintains its value as long as it is seen and lived out in relation to the transcendent dimension -that is to say with reference to the relationship between the people of Israel and Jehovah.

The experience of "exiting" from the condition of slavery and "entering" the land of Canaan "becomes transformed into a theological archetype of a biblical soteriology".[26] Given that this is a vital system of

understanding the other events of the redemption of the people of Israel, it should be inserted into the theological framework of Exodus.

The account of Exodus also provides other *theological elements* which are present in the various experiences of liberation. These emerge, for example, in an awareness of faith which ascribes liberation to God, albeit with the presence of human agents. Although the protagonist of the event is God, this is not a mere "exit from a negative situation of existence" but a work of "salvation" which involves the transcendent dimension. The collaboration of man is expressed by his call to engage in a work of "mission" – in the mission of man is defined the work of mediation carried out by man.

Other important facts spring from the *intermediate stage* of the crossing of the desert. This is a time which is rich in profound human and religious experiences where the elementary needs of living such as eating and drinking, clothing and co-operation, are rediscovered. There is a rediscovery of the grandeur of the simple and the daily. There is an awareness of the value of loneliness as something which can facilitate the encounter with God. Indeed, it becomes a place of teaching and instruction where God educates his people, "tests" it to "know" it, so that the people of Israel in turn can "recognise" God and His project. It is a place which in itself is empty of men and history, but with the passing of the people of Israel it is filled with history and meaning. Citing St.Paul (1 Cor 10:11) Alonso Schoekel observes: "it happened to them and it was written for us".[27]

The *New Testament* also deals with the fundamental event of the new covenant – the paschal mystery. This experiences its culminating and summarising moment in the "triduum" of the passion, death, burial and resurrection of Christ. Through the instrument of the paschal mystery "it was God's pleasure to let all completeness dwell in him" (Col 1:19-20). The same liberation from death achieved by Christ takes place in order, says St.Paul, to "bring you into his presence, holy, and spotless and unreproved" (Col 1:22).

And yet the meaning of such liberation through death cannot be understood without reference to the previous events of the life of Jesus Christ, in the light, that is to say, of his work as the Messiah – the death of Jesus cannot be considered "detached from his history and the practice of his life".[28] Today bible scholarship and theology do not so much attribute an "autonomy" to the apostolic life of Christ as regards his passion and his death but more a connection between the two stages of his life: "the connection between the life and death of Jesus becomes a logical consequence of a certain historical journey: speaking and working with the highest authority to serve salvation which takes place in the present, Jesus generates opposition and creates a circle of enemies. But his death on the cross is explained first and foremost with reference to his activity which foreshadows salvation".[29] There is thus a mutual illumination between the days of his ministry and the days of his passion.[30] And the meaning of the actions and words of Jesus can be well borne in mind by placing them within the context of his life considered as a whole.

The words and the actions of Christ bear witness to the fact that "the time has come and the kingdom of God is near at hand' (Mk 1:15) – with him the time has arrived when the lordship of God over the world and men is expressed and takes practical form in a radical and definitive way. Jesus makes this sovereignty of God present through his own person who works "in works and words" (Lk 24:19) – he "speaks with authority" and acts "with power" (Lk 4:36). His words become concrete in his "works". These are of various kinds: healings, the casting out of devils, and happy communion with publicans and sinners. But in substantial terms they come together in being and expressing liberation from evil on the one hand, and introduction into a new form of life in communion with the Father and fraternal solidarity on the other.

Of particular relevance is the part dedicated by the Gospels to the *healing signs* of Jesus. Bible scholars observe that "out of a total of fifty-three accounts of miracles" present in the Gospels "more than thirty are accounts of healings carried out by Jesus... After removing the matching accounts it is possible to identify about nineteen episodes of healing. In the Gospels these healing actions of Jesus are usually described with a specific biblical terminology – *dynàmeis,* "powerful actions"; *seméia,* "signs"; and *érga,* "works" (of God). It can be said that the traditional image of the figure of Jesus handed down to us by the Gospels and reflected and expressed in popular and common thought is "therapeutic" in character".[31] The Church developed this faith in the figure of "Christ the medical doctor" by drawing upon his own parable of self-identification: "it is not those who are in health who have need of the physician but the sick" (Mt 9:12).

What is the significance of such a high number of acts of healing which surround the figure of Christ in the Gospels? What meaning does Jesus himself attribute to these healing and curative actions and to the casting out of devils? In answering the first question the observation made by Von Balthsar seems to be very relevant: "the sick draw near when the physician arrives", as if to say that when the medical doctor is absent the hope that they will be cured is also absent. And it is the arrival of the Saviour which makes man aware of his miserable condition which Jesus wants to redeem.

With regard to the significance of this healing action, it should be observed that it renders present the salvific action of God which liberates the creature from the dark forces of evil, which, in turn, com-

bat the project of the creation and the Covenant. "Indeed, there exists an instrinsic relationship between the reintegration of the sick and disabled into their physical health and the salvation promised by God to believers".[32] They are, therefore, the sign of the lordship of God, something which is being affirmed. The time has come for the active realisation of the promises of salvation. In his action Christ renders present the work of the Father, who, in turn, seeks the overall salvation of His creatures. For this reason, the healing carried out by Jesus is not to be compared to the action of a mere healer. Jesus seeks the overall and complete healing of man, and is concerned with his spiritual and corporeal dimension, with the healing of infirm limbs and wounded hearts, and the re-establishment of social and religious relationships – thus physical healing is at the same time spiritual healing. This overall and complete healing is expressed in various ways in the texts of the Gospels. For example, in the words of Christ: "it is your faith which has healed you" (Lk 17:19; Mk 2:1-12; 5:34; 10:52; Mt 8:13) or in the decision of the healed person to "follow" Christ (Mk 10:52b) or to commit himself to "service" (Mk 1:31).

At the same time, biblical scholars also refer to a certain "poverty" of the prodigious acts present in the New Testament, and in the sense that in essential terms these signs are rather rare, they are often carried out in a rather reserved manner, and their effects are temporary. These are elements which in pedagogic terms seek to avoid the expectation of miracles and escape from the creatural and human dimension. Furthermore, such a poverty of signs enables Christ to follow the path of the cross, introducing thereby an understanding of the concept that salvation, which has already been implemented in essential terms by the resurrection of Christ, must nonetheless co-exist with the weakness of man, with sin, and with the limitations imposed by the finiteness of what is created. Man constructs his own existence in a process characterised by "death" and "resurrection". Health is thus moved away from being an absolute aspiration by maintaining its functional value as the "more" of salvation.

5. Salvation: Work of the Trinitarian-God

However, it seems that there is an objection which retains all its force: how can we reconcile the being of God "with us", His accompanying us on our journey, with the continued presence of the conditions of sin and pain? Can man – the world, the creation – be "in God" and at the same time live in conditions of extreme limitations, of misery, of suffering, of injustice, of oppression, and of rejection of God? How can we take seriously the idea that salvation has "already" arrived if nonetheless we are still "awaiting" its realisation? What is really meant by St.Paul's statement: "our salvation is founded upon the hope of something" (Rom 8:24)?

It is well known that the New Testament interprets the passion of Jesus first and foremost in the light of the Old Testament. Amongst other things, it lays emphasis upon passages from Isaiah, and in particular upon the "songs of the servant of Jehovah", and especially upon the fourth song (52:13-53) from that Book. When we bear this in mind, verse 8:17 in Matthew, where the evangelist understands the therapeutic and health-giving activity of Jesus in the light of this song of the prophet, certainly provokes thought. Christ, observes the evangelist, heals our infirmities, frees us from our illnesses, and "takes upon himself" these trials and tribulations. The Incarnation of the Son of God

"progresses", one might say, in its realisation, proportionately to how Jesus enters into the concrete texture of our daily existence and takes upon himself our most painful conditions. According to the powerful expression to be found in the Letter to the Hebrews, though learning "obedience in the school of suffering" Christ reached "full achievement" (Heb 5:9). "He must needs become altogether like his brethren" (Heb 2:17; 4:15). It is interesting to observe this connection which Matthew, following the passage from Isaiah, establishes between the way in which Jesus heals illnesses – he heals by "taking upon himself" such conditions – and his painful passion which is also read with reference to the song of Isaiah (Mt 27:29, 31, 38, 60; 26:63).

This "taking upon himself of our illnesses" and the taking on of our sins are thus striking and prominent moments where the New Testament reveals the extent to which the incarnation of the Son comes to be grafted "into" us, or rather the extent to which we come to be inserted "into Christ". The great hymns of the letters to the Colossians (1:15-17) and to the Ephesians (1:3-14), together with the prologue to the Gospel according to St.John (1:3-10), tells us how the whole of the creation has already taken place "in Christ". It has been inserted into divine life.

The risks of a pantheistic conception of life or our sense of loss when immersed in the fire of the divine life are avoided through the full mystery of the Trinitarian mystery of God. This revelation confers new light not only on the mystery of our "being in Christ", but also on the dramatic human condition, where, however, the redemption has "already" taken place in substantial terms.

Bruno Forte has observed that "only the Trinitarian God guarantees the world the possibility of existing *in* God while being *other* than God – a God who is rigidly montheistic, similar to the Greek One, places the world in front of itself and outside of itself, and for this reason if the world is something it is identical with Him (pantheism), or, if it is not identical with Him, it is nothing (nihilism)".[33] He also sees dangers in the "bipolar" God-man conception, in the possibility on the part of man, which is not in the least

theoretical, to raise himself to the level of the maker of the creation: the "you will become like God" predicted by the Tempter (Gen 3:5) is realised in the unbalanced relationship of the free and contingent subject of history with the environment in which he is placed.[34] One need only think here of an issue which is evident in the world of health and health care, namely the dangers which humanity now has before it which are provoked by the possibility that genetic engineering will in various forms be applied to the manipulation of man himself.

"The revelation of the Trinitarian mystery not only deepens and renews the vision of God but also profoundly changes the way of conceiving man and man's relationship with nature. Given that the Eternal is not merely a transcendent and sovereign counterpart of the world but in itself a relationship of love of the Father, the son and the Holy Spirit, it is in this same network of intradivine relationships that space is offered for the freely-given and divine initiative of giving existence, energy and life to the world. Beginning with the paschal event, the supreme revelation of the Trinitarian mystery, it is possible to see not only the world in front of God but the world *in* God and God Himself at work in the world, without however changing into the world... In the intradivine relationship is placed the ultimate root of the mystery of the world, the alterity in which to the created being is given existence as other than God although permeating God".[35]

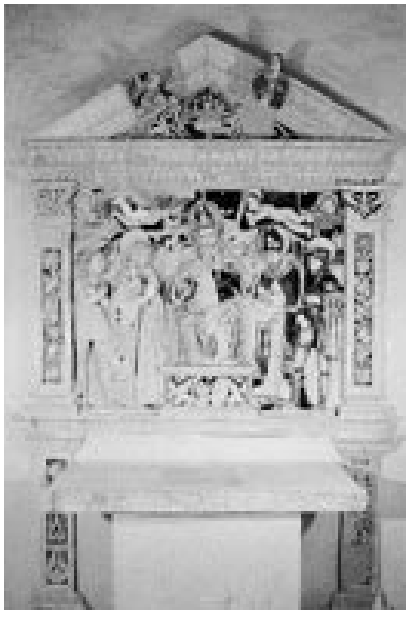
If, then, the creation has already totally occurred "in" Christ, it follows that not only the universe, in its variety and wealth of life, is contained in God but also its tensions and its difficulties, and its pains. The whole of the creation, to summarise, is "stewarded, fed, conserved and grown in the mysterious and welcoming breast of the Trinitarian relationships: God is really the mystery of the world, in a network of vital relationships which take nothing away from divine transcendence, and can be wounded only by the sin of man, as a drama of the rejection of the gift of life which comes from eternal springs".[36] From such a Trinitarian perspective one gains a better grasp of the singular expression to be found in the letter to the Romans: "the whole of nature, as we know, groans in a common travail all the while" (Rom 8:22). The situations of pain and precariousness which afflict the creation and the nature of man have, so to speak, a double countenance. Outside a perspective of faith they give the impression of being the beginning of the devastation of man and of the whole of the creation. But in the eyes of faith a different reality appears: the work of Christ the redeemer has placed our universe within a horizon of hope. This is because these events are not the sign of the dissolution of the creation or the human person, but "birth pains", the external sign of the birth of new life, of the "fullness of life" (Jn 10:10). They are, indeed, the sign of a birth through pain, in such a way that pain itself "already" manifests life which is being born.

Conclusion

How, at this point, should we describe the *meaning that the dialectic of health and illness acquires from the point of view of escatological "salvation"?*

I would like to return once again to B. Forte and to his reflections on "space" and "time". B. Forte interprets "space" as the "exteriority" of the human person, and thus his corporeal nature, and sees "time" as his "interiority", or rather his spirit – the soul that manifests itself and realises itself in his corporeal nature.[37]

The dialectical movement of "health-illness" is expressed in the



corporeal nature of man. The condition of "health" is manifested in the correspondence between corporeal nature and spirit, the constitutive dimensions of man. This is because the "healthy person" is he in which there is a correspondence between his interior reality (spirit) and the manifestation of this in the corporeal dimension. In the healthy person, that is to say, the body is effectively in syntony with the spirit: between spirit and body there is equilibrium, harmony, and the body expresses and realises in a suitable way the profound and interior reality of man. Vice versa, in the condition of "illness", in different fashion, there is a lack of correspondence between corporeal exteriority and the interiority of the spirit: the "ill" person is he in whom an obstacle hinders that correspondence, breaks that harmony or equilibrium, and the person is different at an "exterior level" from what he is at an "interior level".

The theological dimension of "suffering" to be found in the dimension of "health" is understood by faith as soon as it is seen that in theological terms the human subject exists "in" Christ – his inner self is the place of the divine force by which he is created and redeemed. He lives because of this relationship, of this dependency. And it is in the corporeal nature of man that this inner presence is manifested at an exterior level: if the body is the realising and manifesting place of his spirit, of his inner reality in which God and His grace are present and operative, then the body will also manifest and realise his "being in Christ".

For this reason as well biblical revelation perceives a relationship between physical illness and sin: in physical disorder the Bible detects a disharmony introduced into man by his rejection of the project of the Creator. And in the same way the New Testament, too, sees in the "drink of water" (Mt 10:42) given to the thirsty person in the name of Christ the presence of an action which "opens the door to eternal life", and this is because in that gesture of care and concern the inner nature of man "takes physical shape" and reveals "the divine image of the loving Father".[38]

But it should also be added that physical pain "accepted and lived out with inner adherence to the Creator can become converted into an

instrument of redemption and equilibrium of created space, and of this miracle of unprecedented beauty the pain of the Crucified One is the most eloquent proof there is!"[39] Here, indeed, the correspondence between the external and the internal is provided by the adherence of the suffering God-Man to the will of the Father, to the salvific design that the Father has for humanity and which is realised through His Son and in the Holy Spirit – such is the real and profound "interiority" of the "Son of Man", that which Christ first of all and above all else effectively wants and loves. The authentic situation of "health" and "salvation" of the disciple also comes to the fore in this light – in the correspondence between his own wish and will on the one hand, and the wish, the will and the life project that God the Father has in relation to us on the other.

In this perspective we find maintained the meaning of a healthy philosophy and a medicine based upon that philsophy which are discovered and rediscovered. That is to say, health as a state of equilibrium, of harmony of the parts with the whole, and of the corporeal dimension with the spiritual dimension. This reading, however, is transcended when theology reads it anew from the point of view of salvation, the escatological and transcendent dimension of health, the welcoming of the life project created by God. It seems, therefore, that the study of the relationship between health and salvation provides an interesting example of that dialogue between philosophy and faith which is called for in the encyclical letter "Fides et Ratio" of John Paul II.

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Notes

[1] C.MOLARI, 'Salvezza', in G.BARBAGLIO and S.DIANICH (eds.), *Dizionario di Teologia* (Paoline, Rome, 1979), pp. 1441-1436; G.GRESHAKE, 'La Salvezza di Dio' in K.H.NEUFELD (ed.), *Problemi e Prospettive di Teologia Dogmatica* (Queriniana, Brescia, 1983), pp. 275-302.

[2] H.G.GADAMER, *Dove si Nasconde la Salute* (Italian translation, Raffaello Cortina Editore, Milan, 1993), p. 107.

[3] G.GRESHAKE, *op. cit.*, p. 275.

[4] G.REALE, *Corpo, Anima e Salute. Il Concetto di Uomo da Omero a Platone* (Raffaello Cortina Editore, Milan, 1999).

[5] *Ibid*., p. 225.

[6] W.JAEGER, *Paideia. La Formazione dell'Uomo Greco* (Italian translation in La Nuova Italia, successive editions 1936-1959), quoted in G.REALE, *op. cit.*, p. 225.

[7] *Ibidem*.

[8] *Ibid*., pp-345-349.

[9] A fine interpretation in this sense is offered by V.FRANKL, Logoterapia a Analisi Esistenziale (Italian translation, Morcelliana, Brescia, 1977). For a wider perspective, open to "salvation", see H.U.VON BALTHASAR, 'Salute e Saggeza' in his *Homo Creatus Est* (Italian translation, Morcelliana, Brescia, 1991), pp. 85-100.

[10] F.ALVAREZ, 'Salute', in G.CINÀ, E.LOCCI, C.ROCCHETTA and L.SANDRIN (eds.), *Dizionario Teologico di Teologia Pastorale Sanitaria* (Camilliane, Turin, 1997), pp. 1081-1082.

[11] H.U.VON BALTHASAR, *Teodrammatica IV* (Italian translation, Jaca Books, Milan, 1983), p. 78.

[12] *Ibid*., p. 89. See the whole sub-chapter entitled "Assolutezza Relativa" ("Relative Absoluteness") in the same work, pp. 77-89.

[13] G.GRESHAKE, *op. cit.*, pp. 278-302. See also the bibliography in the same article.

[14] *Ibid*., p. 281.

[15] *Ibid*., p. 282.

[16] *Ibid*., p. 283.

[17] C.MORALI, 'Salvezza', p. 1430.

[18] *Ibid*., p. 1432.

[19] *Ibid*., pp. 1432-1433. Other interprative approaches are to be found in G.GRESHAKE, *op. cit*.

[20] P.SEQUERI, 'La Speranza oggi e il Fine dell'Uomo', in K.H.NEUFELD (ed.), *Problemi e Prospettive...*, p. 139.

[21] B.FORTE, *Teologia della Storia* (Paoline, Cinisello Balsamo, Milan, 1991), pp. 271-273.

[22] P.SEQUERI, *op. cit.*, p. 138.

[23] C.MOLARI, 'Considerazioni Teologiche', in G.Colzani, *Creazione e Male del Cosmo* (Il Messagero, Padua, 1994), pp. 117-118.

[24] Italian translation published by EDB, Bologna, 1996

[25] See also: Ex 5:1.3.17; 7:12.16.26; 9:1.13; 10: 3.7.24-26; 12:11-13, 16b.

[26] L.ALONSO-SCHOEKEL, *op. cit.*, p. 26.

[27] *Ibid*., pp. 154-156.

[28] D.WIEDERHEHR, 'L'Avvenimento della Salvezza alla Luce dell'Esperienza della Salvezza', in K.H.NEUFELD (ed.), *Problemi e Prospettive di Teologia Dogmatica* (Queriniana, Brescia, 1983), p. 173.

[29] *Ibid*., p. 179.

[30] *Ibid*., see especially sub-chapter 2 entitled "*Prassi Escatologica a Messianica di Gesù*".

[31] R.FABRIS, 'Bibbia e Mondo della Salute' in *Dizionario di Teologia Pastorale Sanitaria*, p. 126.

[32] *Ibid*., p. 127.

[33] B.FORTE, *op. cit.*, p. 209.

[34] *Ibidem*.

[35] *Ibidem*.

[36] *Ibid*., p. 211.

[37] *Ibid*., pp. 250-61.

[38] *Ibid*., p. 258.

[39] *Ibid*., p. 252.

GEORGES COTTIER

Morality and Economics in Health Care

Introduction

You have asked a theologian to speak to you about the question of the relationship between health care and the economy. This is a question which has become absolutely central in recent years.

I must first of all confess to my lack of expertise in this area, or rather confess to the limits to my expertise. I am not a medical doctor or a professional member of the health care world; I am not the administrator of a hospital, nor am I an economist. If I have a qualification to talk to you it is that of an interpreter of the *social doctrine of the Church.*

Indeed, this doctrine can offer us some principles and criteria for the orientations you should adopt. These orientations are far from being irrelevant when it comes to the defence and the promotion of the essential values of the human person and society.

The new context of the relationship between health care and resources is the outcome of a large number of factors. These are known about, but I will refer to a few.

Of these factors some are due to the general development of societies and others are specifically connected to the world of health care. The Marxist regimes developed a generalised welfare system. The fall of a very large number of these regimes, in which process economic exhaustion was not absent, has created a state of disturbing crisis which I will now discuss.

In industrialised countries, within a context of the forceful and at times aggressive affirmation of neo-liberalism, we can observe a certain calling into question of the welfare state, and this raises difficulties for what seemed to constitute acquired rights. We cannot ignore these general conditions, which have much to do with the worsening of the gap separating rich countries and poor countries.

The costs of health do not seem to stop growing at levels with which, it seems, governments are unable to keep pace. For this reason, almost everywhere we can see policies being forced to engage in a process of revision.

The progress and advances in medicine require ever more advanced (and thus more expensive) means and instruments in relation to diagnosis, treatment and support and are thus a primary factor.

The new demographic balance is another. Everywhere you look, including the developing countries, the age band of the elderly is undergoing a major expansion. This age band requires greater medical care and treatment. Furthermore, in some cases it is necessary to deal with very high levels of population increase. We should also bear in mind the marked growth in social evils such as alcoholism and drugs and the spread of particularly aggressive diseases such as AIDS. We observe once again that in a broad sense the costs of health also include those required by prevention in the form of education and hygiene.

One can well understand the fact, therefore, that government and society are concerned about the need to control expenditure on health. In itself the introduction of the criterion of profit into the management of a medical unit, as long as profit is seen as a measurement of good management, should not give rise to objections. However, the criterion of profit should also be subject to very severe controls.

How can profit be compatible with the dimension of free service which is implicit in the medical act? The concept of free service in itself must be clarified. Posing these questions, I will now refer to the idea, which is becoming ever more widely held but which we will have to assess and judge, that the hospital is a commercial undertaking. This means that it must be managed in a rigorous way through the drawing up of a budget and the supervision of expenditure, and that it is a place where a search for financial soundness is a necessity.

Will it thereby become a commercial undertaking and a commercial undertaking like others of the same category? With this question we enter into the field of ethics.

Ethics

Certain clarifications are useful. The ethical question arises within a context of pluralism, a phenomenon which takes place in particular at the level of conceptions about ethics. Does pluralism inevitably lead to a *cul-de-sac* given the fact that some of these conceptions are in contradiction with each other?

An affirmative answer should be given to this question when we come to consider theories which have been well developed and where in fact a disagreement about ends would mean a conflict without the finding of an exit. We are not in the least here denying the impact of theories on practice or minimising their power, because in itself an

ethical theory is directed towards practice – it not only wants to explain practice but also to guide it and direct it. But – and this it seems to me is a decisive point – ethical theories would not gain purchase upon men's minds if they did not seek to correspond to an *ethical sense* which is written into each and every man and which is prior to such theories. This ethical sense cannot be theorised but it is present in the state of *actual experience* and naturally guides behaviour.

It is to this ethical sense that we should appeal first of all. At the level of what we can call spontaneous ethics a practical consensus is possible when, at the level of explanations and explanatory theories, conflict cannot be avoided. To speak in this way about respect for human dignity, beginning with the practical order of what is spontaneously lived, allows a certain consensus, even when the explanatory theories of what is lived diverge or are in opposition. It is for this reason that we should take the rights of man as the point of reference for our argument. I will come back to this subject later on in this paper.

It is by rigorously laying down the limits to its field of research and by adapting its methods and its instruments to that field that a scientific discipline obtains its results. In other words, a pre-condition to the fruitfulness of scientific knowledge is this placing of limits to inquiry into a specific aspect of society, a particular sector, which is, so to speak, isolated off from every other possible consideration and angle of approach.

This is an epistemological procedure whose legitimacy should not be questioned. But precisely when its epistemological nature is lost sight of is there a propensity to project upon the complex and intricate reality involved those cut offs which are made to achieve the effectiveness of research. This kind of cut off is not an abstraction but its reification leads to an absolutisation of a particular discipline and confers upon it an induced directive function. Thus it is, for example, that a determining role is given to the diagnoses and the judgements of the economy – a process which involves the deliberate neglect of equally important components parts of reality. This reality is multidimensional and cannot be deprived of one of its elements without being betrayed.

We need to recognise the plurality of points of view as a pre-condition to achieving improved knowledge about a complex and overall reality. The separating out of a point of view, and the favouring of it to the disadvantage of other points of view, prevents us from having an objective judgement. This observation does not distance us from our purpose. On the contrary, it directly concerns ethics.

Indeed, if one goes in the direction of the exclusive sense of a particular form of knowledge, which has been previosuly referred to, it happens that in the name of this form of knowledge an attempt will be made to give an image or dictate a form of behaviour of reality which are in themselves sufficient. It will be said, for example, that the question of the costs of health is the exclusive concern of the economy and its criteria. And if, nonetheless, some space is conceded to ethical reflection then this will inevitably present itself as an extrinsic element, an mere additional factor, and perhaps for this reason a disturbing element.

Here we touch upon another fundamental question of anthropology concerning the nature of man and human society. Human nature cannot be subject to unilateral reductions without being betrayed. Its constituent complexity and multidimensional nature impose a necessity with regard to the knowledge that we have about it. In other words, in order not to lose direction the disciplines of knowledge which bear upon this aspect of human life

– which were previously separated off from each other – must be seen on a second reading in terms of their inter-relationships. The separating off of a view of the spirit in order to project it in a simplifying procedure onto reality is plainly to ideologise. This distortion is not without its consequences. Thus, because of an induced abstraction, the hospital is seen as a commercial undertaking which must obey the criteria of mere economic profitability.

What we need to affirm is that the ethical dimension is intrinsic to man and human realities. Ethical regulation is always present within human activities; it is immanent. If, in order to study an aspect of social life, an abstraction of it is made, then a deceptive extrapolation is engaged in through an attempt to deduce from it an amoral image of political, social or economic life.

Thus it is that in our pluralistic societies it is possible to achieve a practical consensus in relation to a number of fundamental values. "Practical consensus" – I mean by this phrase a consensus based upon a spontaneous moral sense which is prior to discussion about theoretical justifications. This discussion is not only inevitable but necessary. This is because it is in the nature of man to explain the reasons for his beliefs. It is the task of the different families of the spirit to draw up these justifications for themselves.

The concept of the *dignity of the human person* is without doubt the first of these fundamental values. This notion finds its full explanation in the *social doctrine of the Church*. It is also to be found, certainly without the homogeneous and unforced explanation which we give of it, at the basis of the "Universal Declaration of the Rights of Man" of 10 December 1948, and it is to this document that we can refer.

Article 25,1 reads as follows: "every person has the right to a standard of living sufficient to ensure his health, his wellbeing and that of his family, in particular as regards food, clothes, housing, medical care and necessary social services. He has a right to security in the event of unemployment, sickness, infirmity, widowhood, old age or in other cases where he

loses his means of support because of circumstances beyond his control". In this way the right to health and to medical care and treatment are affirmed at the same time as other rights which are more or less connected with it.

The constitution of the World Health Organisation (WHO) of 1946 lays down, in conformity with article 25 of this declaration, that "the enjoyment of the best state of health which can be reached is one of the fundamental rights of each human being, whatever his race, religion, political views, or economic and social condition". The definition given by the same international organisation is well known. Health is defined as being "a state of complete physical, mental and social wellbeing which is not only the absence of illness or infirmity". (It may be observed that this definition is not without ambiguities and can give rise to divergent interpretations).

What is said by the encyclical of John XXIII, *Pacem in Terris* (1963), n.11, draws near to article 25 of the declaration: "every human has the right to life, to his physical integrity, and to those means which are necessary to, and sufficient for, a decent existence, in particular as regards food, clothes, housing, medical care and treatment, and social services. As a result, man has the right to security in the event of illness, disability, widowhood, old age, unemployment and every time that he does not have the means of subsistence because of causes independent of his will".

The points of convergence of the two texts are evident. *Pacem in Terra* uses the expression "decent existence" and not "standard of life". It does not speak about wellbeing.

Vatican Council II adopts on more than one occasion the doctrine of the rights of man and their corresponding duties. Reference can be made to a number of instances. At n. 26, 2, *Gaudium et Spes* points out that "an awareness of the eminent dignity of the human person, superior to all things and whose rights and duties are universal and inviolable" is growing within mankind. Is this statement permeated by an excessive optimism? No it is not. But an awareness of a value is one thing; effective respect for it is quite another. The fact itself that we are very vexed by all the injuries done to this value is an expression of this living awareness.

Legitimate differences between men exist but they cannot go against "the fundamental equality of all men", and this equality must always be fully respected (cf n.29).

The declaration on religious freedom, *Dignitatis Humanae*, n.6, observed with reference to *Pacem in Terris*, that "every civil power has the essential duty to protect and promote the inviolable rights of man".

On numerous occasions the Magisterium of the Church has referred to the doctrine of the rights of man.[1] The right to health and to health care applies to individuals and populations. The list of rights is taken up in the message of John Paul II given at the time of the fortieth anniversary of the United Nations Organisation of 14 October 1985.[2] The apostolic exhortation *Christifideles Laici* (30 December 1988) makes an essential precise statement which emphasises the organic unity of the rights of man, beginning with the right to life, which is "the first right, the origin and condition of all the other rights of the person".[3] A few months later the Pope returned to this subject in his speech to the University of Upsala of 9 June 1989.

This text, which is of primary importance, should be quoted: "the dignity of the person can be protected only if the *person is seen as inviolable* from the moment of his conception to his natural death. A person cannot be a mere means or instrument for other people. Society exists to promote the safety and

the dignity of the person. For this reason, the primary right which society must defend is the right to life. Both in the maternal womb and in the final stage of life, one cannot remove a person in order to make the lives of others easier. *Each person must be seen as an end in himself*. This is a fundamental principle for all human activity: in health care, in the upbringing of children, in teaching, in the mass media. The attitude of individuals or societies in this respect can be evaluated according to the treatment of those who, for various reasons, cannot compete within society – the handicapped, the sick, the elderly and the dying. If a society does not see the human person as inviolable, a consistent statement of ethical principles becomes impossible, and the same may be said of the creation of a moral climate which favours the protection of the weakest members of the human family".[4]

From what has been observed above, it is clear that the human person is the end of social, economic, political and cultural structures and activity. The human person, we read in *Gaudium et Spes* (n.25,1), "who by his very nature has an absolute need of social life, is and must be the beginning, the subject and the end of all institutions".

Thus it is that the common good of society, which is to be defined as the set of the conditions of social life which allow man to reach his own perfection more fully and more easily, requires first of all the protection and the promotion of the rights and the duties of the human person. For this reason, the civil power has the duty to ensure that the legal and real equality of citizens, which depends upon society itself for its existence, is respected (cf *Dignitatis Humanae*, n.6). For the same reason, economic development must remain under man's control. It cannot be seen as the effect of the automatic interplay of the actions of individuals. The public authorities, at an international and national level, must act to prevent exclusion, marginalisation, and excessively evident disparities. They must perform the indispensable function of co-ordination and harmonisation.

These requirements, which concern the person, the nature of the common good, and the regulation of the economy, have consequences for questions and issues connected with the subject of health. The right to health means the right to social conditions which normally allow or favour health. The right to medical care and treatment belongs to every person who is afflicted by an illness or a handicap or who is the victim of an accident. These are inalienable rights. That is to say that they belong to every human bring prior to his political, social or economic condition. Equality is to be found at this first level.

Equality and Inequality

But as soon as we have recognised this fundamental equality we encounter differences and inequalities which seem to call into question the validity of the very concept.

There are inequalities which arise as a consequence of the division between the rich and the poor. One thinks above all else of extreme poverty, of total poverty, which in itself means that access to the satisfaction of an inalienable right is impossible. This impossibility, or even this extreme difficulty, afflicts individuals, certain social strata within society, and is to be witnessed in the relationship between rich nations and poor nations.

Thus we have a situation of injustice, against which we should struggle. This inequality here is not normal – it is the result of sin, errors, or ignorance about the needs of solidarity and social justice.

To struggle to defeat progressively the various forms of acute poverty caused by injustice is a serious and urgent moral duty. Special love for the poor constitutes a very high motive for action.

Another form of inequality arises from the divisions to be found in nature or in the organisation of society. One thinks here of childhood or old age, or with regard to social factors of the categories of workers exposed to harsh and thankless work or to high risks. We can also refer to the forms of care needed to protect motherhood.

There are differentiated sectors within the population, each of which requires a specific kind of medical care. These differences are the basis of the organisation of medicine. I have called attention to them because they illustrate an obvious truth: equality is not egalitarianism, this latter being something, indeed, which is often in opposition to justice. We encounter here the tendency, which is inspired by liberal ideology, to place all justice in commutative justice. But what is at stake here is distributive justice, and this is something which is based upon the relationship of all the component parts and which is to be understood in terms of the relationship between individuals and the common good. Their participation is differentiated, and justice and fairness are respected in proportion to how their legitimate differences are respected.

In a similar way, inequality in the forms of care required depends upon the seriousness of the illness or the infirmity, and even upon the personality of the sick person, his psychology and his situation. This is a complex reality which cannot be quantifiable in overall terms. One comes to what precedes the duty incumbent upon the public authorities to provide special help to those who are weakest and to the handicapped. “The option in favour of the poor”, for its part, dictates certain choices which are in opposition to utilitarian policies.

Another form of inequality arises from technical means and instruments, which are increasingly advanced and thus more expensive. This means that highly modern forms of treatment become the prerogative of certain privileged hospitals to the exclusion of others. This inequality can be overcome through co-operation between hospitals.

Despite this fact, the impact of inequality makes itself felt in another way: the most advanced technical means and instruments, because of their cost and the fact that they need highly qualified operators, have a limited diffusion. They are often insufficient in numbers to meet the demand, and this forces those who are in positions of responsibility to make certain frightening choices.

Is the choice arbitrary, is it dictated by motives based on gain? How can we give priority to one patient over another and at the same time respect the rules of fairness?

We need here to refer to ethics because the choice requires great rectitude on the part of the person who has to make it. The presence within the hospital of an ethical adviser who shares the responsibility for the decision and does not leave the medical doctor to a state of crushing loneliness is something to be really welcomed. Furthermore, solutions to the problem of the disproportion between the most competitive means and instruments available and the number of patients will always be of a somewhat provisional character and will have to be subjected periodically to revision. The reason for this is that we have to deal with processes in constant evolution which arise from the almost constant advances in medicine and the instruments which are available to it.

The factor of evolution introduces a certain relativity into evaluation and assessment in the sense that it forces us to engage in a periodic examination of the level of indispensable forms of medical care to be ensured within the context of a given society. This evaluation and assessment must be based upon a double criterion – that of the inalienable rights of the person and that of the real resources available. Everywhere a minimum level, whose magnitude will evolve with scientific and technical progress and economic growth, must be ensured.

The survey that has been given of the various forms of inequality to be encountered emphasises in the first

instance the complexity of the questions which have to be tackled. It is not possible to do this beginning with a single parameter. Furthermore, the forms of inequality are heterogeneous in character. Some must be fought against because they are the outcome of injustices; others must be respected because they arise from the nature of things; and yet others, in order to be overcome, need imagination because they spring from the scarcity of resources which seems to accompany technological progress itself.

Consensus

In these conditions, thought about the subject must lead on to the criteria which enable us to perceive the orientations and the validity of health care policies.

We have seen the rights of man as a firm point of reference because they are the subject of a practical consensus. This consensus, in practical terms, is based upon a certain foundation of truth because it can call upon the spontaneous ethical sense. By "ethical sense" I do not mean something that concerns the sphere of feelings, but ethical reason itself, in its primary state, prior to the conceptual elaboration of doctrine, acting, so to speak, as an immediate reflex. It is not the consensus which is the basis of the truth but, on the contrary, if there is consensus there must also be a light of truth as a support. Indeed, human reason naturally tends to truth and at the basis of spontaneous judgements there is this primary reference.

But even if it has the force of what comes first, this ethical sense involves in itself an aware and thought out elaboration. This, in turn, will confirm its strength or, if it is opposed, will tend to weaken it, and even, in extreme instances, to reduce it to silence.

For this reason, if we want to recognise the inestimable value of the expressions of the ethical sense we cannot be content with that sense alone. Such expressions must be subjected to analytical exposition way and supported by critical thought. "Awareness of human dignity has become more alive". It is not difficult to find elements which support this statement made by *Gaudium et Spes* (n. 73,2). Consciousness of the need for peace and the abandonment of war and violence as a means by which to resolve conflicts; the condemnation of torture; movements in favour of the abolition of the death penalty, etc. – all these bear witness to a sense of human dignity.

But at the same time such dignity has become the object of worrying forms of aggression – one thinks here of the legalisation of abortion or euthanasia.

The facts illustrate the ambivalence of history where nothing is finally established and where the holiest of things are necessarily threatened. Hence the need to defend with an argument which is solidly rooted in reason those intuitions and beliefs regarding the fundamental values of the human person.

The Conflict of Anthropologies

In reality the cultural situation in which we find ourselves is characterised by a conflict between anthopologies. It is at this level that the major directions of health policy are primarily determined.

Despite the obtaining of a consensus whose importance I have underlined, the rights of man are not able to completely ward off doubt. I am not referring here to violations, but to interpretations that lead to a fragility to which only thought about their bases will be able to provide the required support. In this way we are directed back to anthropology and to the question of the purpose of human existence.

At the root of the malaise which accompanies the new equilibriums in health services we encounter a conflict between anthropologies. This conflict, as long as it remains underlying in character and lacks a clear analytical exposition, can only make the confusion worse.

The position at the basis of the Christian humanist approach can be expressed with a number of assertions. However, this approach is not the exclusive prerogative of Christians and is naturally open to rational analysis.

Every human being is a person. The person has his roots in the transcendent. At a primary and fundamental level, all human beings are equal.

It is this transcendence which is at the basis of the rights of man and their inalienable nature.

These rights impose themselves, therefore, on those who wield authority and power within society. They have a normative value.

The human being by nature possesses a social dimension. In natural law an opposition does not exist between the individual and society. For this reason all the members of society are called upon to contribute to the achievements of the common good. But the common good of society is a good of persons; it is at the service of persons. A conception of the common good which does not recognise this ultimate subordination to the good of persons is thereby deprived of legitimacy.

The Biblical revelation of the *imago Dei*, the image of God, provides us with the reason for the transcendence of the person. It also illuminates the sense of destiny of persons – the destiny of eternity which is not confined to the limits and horizons of time and history. What does a man gain by it if he gains the whole world but loses his own soul?

The rooting of man in the transcendent has been lost from view, placed between parentheses more or less deliberately, or denied, and the recognition of the dignity of the person is mortally wounded. This pernicious anaemia may not immediately develop its effects, but there can be no doubt that we are on a dangerous downward slope. The banalisation of abortion and eu-

thanasia are worrying signs of a negating process where in the end man in his humanity is threatened.

The questions which concern us must be placed within this context.

Beginning with a process, I do not in the least intend to suggest that we are face to face with an inevitability. It is important to supply to man the meaning of his dignity and his greatness. This is perhaps our first task, namely to help in the discovery or the rediscovery of the beauty of the human calling within a civilisation which, by exalting and exciting selfish appetites and the spirit of competition, nourishes a subtle feeling of the insignificance of human existence. This work will be first and foremost a work of education, and will take a long time.

In order to begin this work in an aware fashion, we should bear in mind the intellectual bases of an increasingly invasive mentality.

The negation or the condemnation to oblivion of the transcendent can lead to the bitter experience of the emptiness and the vanity of everything. But in most cases this negation and this oblivion are the fruit of man's claims to self-sufficiency. The negation of the transcendent accompanies, in other words, the affirmation of the immanent.

But at the moment in which man wishes to see himself as the absolute centre of everything, as a logical result his sense of his humanity changes radically. This takes place not only in the sense that he no longer recognises his condition as a created being, but because the human subject is no longer the same. This subject is no longer the individual but humanity as a collective being. Feuerbach, one of the fathers of modern atheism, asserted that "man is the god of man" and immediately went on to say that he was not referring to the ephemeral human individual but to mankind in general. In this way the individual is no longer recognised as a person – the subject of humanity is the collectivity. Each of the great totalitarian ideologies in its own way defined this collective being – a race, a class, the state. It is significant here that the totalitarian concept of the state endowed it with the attributes of a person. It will be observed that the materialist vision of man bears upon these ideologies because its thinking concentrates on the species, and thus sees the individual solely in terms of being the member of a species.

It is true that specifically totalitarian ideologies are dead or in irreversible decline. But the materialist approach still has many followers, and at a broader level the idea that man is simply a member of society is gaining widespread ground and support. In this point of view the human being is to be judged in terms of his total services. That is to say in relation to his "usefulness".

Although the idea of the person is a part of our cultural inheritance, its definition is changing. For example, it is identified with consciousness in such a way that those people whose consciousness is still to develop, or is turned off or seems to be turned off, as in the case of the embryo, the mentally handicapped, or the person suffering from Alzheimer's disease, are not recognised as persons. Some people define consciousness as the ability to feel and in particular to suffer, and in this way the status of the person is conferred upon the primates but is not given to the human embryo. In truth, this remelting of the concept of the person does not have the capacity to deceive us – it would be equivalent to negation.

Collectivism in its various forms is a primary consequence of the anthropological nature of immanentism. A second consequence, which is no less serious, is the utilitarian approach to questions and issues. Indeed, we increasingly see utilitarian ethics lying behind decisions. This can also be observed in the field of health.

If the human individual no longer has a transcendental horizon and reference point, he will inevitably be defined in terms of his environment, in which society occupies a preponderant position. He finds himself in a relationship as a part of everything: from that moment the human individual is in that which makes him in essential terms a part of a given everything in the immanence of history. Such a relationship to society is necessarily a functional relationship.

What function does such an individual perform in the great social machine? It is by beginning with this question that those judgements are made which I have defined as utilitarian, and where persons are valued in relation to their effectiveness.

The weak, some categories of sick people, the handicapped, and the elderly are those who as a result will be more or less directly sacrificed. The metaphor of health applied to a society or an economy thereby runs the risk of becoming a real transformation of meaning – health defines the subject (which is society) before defining the individual. A similar transfert is carried into operation from the individual to the species, and the temptation of eugenism is not so far off.

With these final observations I have wanted to demonstrate the logic of an immanentistic anthropology, given the trends of our culture. This logic is not always perceived in the national consciousness, given that the pragmatism of many people is accompanied by a refusal to face up to fundamental questions and issues. But it was necessary to expound this anthropology in its internal coherence in order to address it with a rigorous philosophical and theological reflection. This is one of the primary tasks of Christian thinkers, and of humanist thinkers as well. Allow me in conclusion to quote once again a thought which we remember well: "contemporary man listens more willingly to those who bear witness than to teachers, or if he listens to these latter it is because they are witnesses" (Paul VI, *Evangelii Nuntiandi*, n. 41).

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Notes

[1] See G.FILIBECK, *I Diritti dell'Uomo nell'Insegnamento della Chiesa: da Giovanni XXIII a Giovanni Paolo II* (Vatican City, 1992, Libreria Editrice Vaticana), p. 524. The subsequent quotations are to this valuable work.

[2] *Op. cit.*, B 40, p. 79.

[3] *Ibid.*, A 191, p. 274.

[4] *Ibid.*, B 194, p. 278.

ELIZABETH MORAN

Other Religions and Economy and Health: Reflections from Conciliar Protestantism

Introduction

Greetings to the members of this Conference from the Team on Mission and Evangelism in the World Council of Churches in Geneva. It is a privilege to share in this setting some fruits of ecumenical reflection, discernment and prayerful willingness to work together in the Christian service of health. I come to participate in these Conference days, from the "conciliar Protestantism" of the churches of the World Council. I speak out of the experience of the role of Roman Catholic Consultant, based in the staff team responsible for Mission and Evangelism, Health and Healing, and Community and Justice. The Team works with issues and themes which are of particular concern to the more than 330 member Churches of the World Council of Churches. The fundamental purposes of the Council are stated thus: "To pray for and pursue the visible unity of the church, in one faith and in one eucharistic fellowship, expressed in worship and common life in Christ, through witness and service to the world" (WCC Brochure 1999).

It is not surprising that the hopes and aims, the setbacks and struggles recognizable in the WCC experience have run parallel in many ways to those experienced in Catholic communities. In many areas of the world, in local situations, these hopes and aims, setbacks and struggles, have been shared, in an ecumenical movement for healing which has emerged in many instances because of the basic needs of people in the crisis of struggle for survival.

Health and healing as mission

In the present restructuring of the WCC, the Team working with the understanding of Mission deals with the concerns of the Churches in the area of health and healing. This means that the networks to which the staff relate directly, involve the Mission personnel and leadership in the Churches. In the same way, the Advisory Body of people who work with the WCC staff will be mainly people in the work of Mission in the Churches and other bodies. There is also a considerable network of Christian Health Associations of many kinds. We should note that, because of changing relationships, these networks often include Catholic persons and groups. The "next door neighbours" in the work of the staff are the WCC Teams on Justice, Peace and the Integrity of Creation, Education and Ecumenical Formation, and Faith and Order. None of the concerns which are priorities for these teams can be separated from the concerns of Mission and the immediate concerns of Health, Healing and Wholeness. However, the endeavour to bring health, healing and wholeness, while it is inseparable from the building of justice and peace, is seen as a counterpart of the growth towards wholeness within the Churches themselves, in wisdom, compassion, forgiveness and strength.

Present concerns

The Mission Team inherits the convictions and the insights developed over thirty years in the working of the Christian Medical Commission (CMC) which came together in 1968, under the auspices of the WCC. Inevitably, the Commission inherited a concern for the underdeveloped nations, since much of the missionary work of the Churches there had been directed towards a pastoral formation and care that included medical and educational work. As this century progressed, the Commission also inherited some of the difficulties and problems of a changeover from colonial methods and structures to *management and ownership* by local groupings

and personnel. These difficulties have included until now the problems of sustainability of services, maintenance of property and equipment, and continuation of standards of performance and expertise in medical and community work. The availability of finance from Churches and donor agencies can no longer be taken for granted. In Churches in the developed world, and in coordinated donor associations, the demands and the methods of proper accounting, and the structures of monetary systems, present a new set of requirements. In the language of Christianity, the word *stewardship* is used more frequently as a basis from which decisions are taken. The relationship with donor agencies has become more and more an integral part of the work of the Churches.

The Christian Medical Commission was originally asked to:

a) enable and support the Churches in their search for a Christian understanding of health and healing.

b) identify and find funding for innovative programmes.

c) encourage collaboration. Among the obvious services it could offer was that of putting people in touch with others doing similar work, in order to make possible a widespread sharing of information and resources.

Predominant tasks

Two particular emphases emerged as this service took shape. These remain as two predominant tasks of the WCC Churches in the work of health and healing today.

1) An orientation of Christian medical work for health care which would start *in the community*, focussing as much on prevention as on the treatment of disease.

2) Stimulation and empowerment of *structures of co-ordination*, on a national level, for Christian medical work.

In African countries and in India this has been very quickly effective, especially where there had already been productive collaboration among church-related health professionals. Collaboration and systematic coordination has meant not only genuine support for increase in quality and availability of medical care, without competition. It has also allowed co-operative work for local training and education for health. It has helped collaboration in bringing to bear a needed influence or pressure in negotiation to ease financial pressures where voluntary organization are concerned. Cooperative buying has made it possible to reduce the cost of medical and pharmaceutical supplies. Such ecumenical activities have involved Churches in work together on global issues affecting poor people, and in the effort to influence the international and multinational systems. Planned collaboration which continues today can be seen in the Pharmaceutical Programme and in the campaign for a code of conduct relating to the marketing of breast feeding substitutes for babies. Such collaboration requires leadership which ensures technical assistance, training and information exchange, and research and evaluation. It also requires a certain courage, as those who participate in such programmes and campaigns will often be required to present alternatives to the procedures, plans, and agreements which governments and business coordinates formulate. The financial arguments, and the objectives proposed at the level of government or business discussions are frequently experienced as coming from a world other than the one inhabited by the people to whom we are sent.

Development and deprivation

It has been a strange experience to be preparing this short paper in Geneva, in the week during which the city has played host to the world-wide Conference on Telecommunications. The amount of money and of goods circulating, the sophistication of technology, and the availability of luxury accommodation, food, and medical service, as the thousands of visitors pass by, present such a sharp contrast to situations elsewhere in the same world at the same time, that it is difficult to hold the two realities in the one mind-space. One can only conclude that the world we live in is certainly in need of health, healing and wholeness, and that it is imperative to preserve the ability to recognise the entirety of the combined effects of economic development and economic deprivation for humanity as a whole.

Activity and attitude

The ability and capacity to bring people together, to enable a sharing of purpose, of questions and resources, and to support and evaluate programmes is until now one of the strengths of the WCC. However, in the work of the health and healing mission of the Council, as in all other areas, there are always two interests – one concern, we may say, is for what is to be done; the needs or aims, the organisation, the activity. The other concern is for the attitude, the spirituality from which decisions are made and activities pursued. There is need for continuing search for insight into the connections between the life-experience of people, healing, the Word of God in Scripture, and the Mission of the Church.

Such a reflection is appropriate

today among those who belong to groupings or organisations working hard for the improvement of facilities, coordination and resources in medical work. It is possible to be very busy with much work for people, and quite unaware of the work of God in which the labourer is graciously invited to take part. Still more, perhaps, it is possible to be unaware of the healing work of God that is available in the lives of members of a church community always in need of evangelisation.

The WCC continues to try to help people to change their attitude to health. This is so difficult as to be impossible without a corresponding change in attitudes to today's world realities – political, sociological, cultural, religious. Changing attitudes can influence the whole situation in which persons live. Values will change, behaviour will change. A sense of personal and community responsibility for health can lead to genuine movements to reform society.

Primary health care

Important changes in attitudes and values have come about through the promotion of Primary Health Care. This directs Christian medical work towards health care that starts with the community, and pays attention to the need for health education, action and care in the community and home settings. Common preventable illnesses can be comprehended, and to a large extent prevented, by the people themselves. Scarce resources of personnel and equipment based in clinics and hospitals can then be used for more critical needs and extended more widely in order to initiate and support the training of village health workers, competent in areas of simple practice and providing a reliable network for communication. Primary Health Care can become an enabling and empowering process.

Communication

To be effective not only locally but globally, such a development needs a system and an instrument for information which connects people and offers the service of formation and sustaining of linkages. Successful efforts to improve knowledge and services in health and healing must be made known, internationally if possible. The publication "CONTACT", started in 1970 to further communication and interchange, continues to be an extremely valuable vehicle and a powerful instrument for sharing on an international level (and in translation into several languages) information and expertise on community based health. The magazine offers information on developments in health care, and on critical situations, in a language and format acceptable to ordinary health care workers and to communities in many countries. It raises levels of awareness and enables cooperation. Recent issues have presented topics of major interest, such as: *Globalization* – What does it mean for Health? *Networking* – Linking People for Change; *Ethics* – Taking Sides in Health Care; *Environment and Health* – Making the connections; *Spirituality and Health* – Can our Faith Help to Heal us? *Trade or Health?*

The publication is a tool for community education, a key to resources, and a channel of communication. While it is now available on the worldwide web, the fact is that it is a valuable source of information and encouragement for communities who do not have access to means of communication now taken for granted in affluent countries.

A liberating force

The combined effect of the promotion of PHC and the availability, in a readily acceptable magazine, of information and explanation, has been a powerful liberating and enabling force in small communities. Recognized as important by the World Health Organization in the 1970s, it must be credited with having an influence on the reassessment of WHO priorities in health care and the WHO move to promote the use of PHC methodology and principles. Allow me to recall some of the principles formulated by the WHO:

– Primary health care should be shaped around the life patterns of the population it should serve.

– A local population should be actively involved in the formulation of health care activities so that health care can be brought into line with local needs and priorities.

– Primary health care should be an integrated approach of preventive, curative and primitive services.

– Health interventions should be undertaken at the most peripheral practicable level of the health services by the worker most simply trained for this activity.

However, the attempt on the part of the WHO to make PHC universal, through government programmes in many countries, has produced its own difficulties. Such problems are sufficiently familiar to most Church-based health personnel today.

I quote from one overview: *"The original vision of PHC had been as a force for liberation and empowerment through the promotion of health care. Once it had been watered down to methodology acceptable to governments, it could no longer address key issues such as corruption and op-*

pressive systems. Governments interpreted placing 'maximum reliance on available community resources' as a means of saving costs. Gradually PHC came to be a top-down government approach rather than bottom-up peoples' initiative".

In the developing countries, the reality of community-based activity, which can identify problems, analyse structures and mobilise energies and opinion, has meant that PHC has been seen as linked with movements for justice and processes of "conscientisation". Health workers, as community workers, are often at risk in the political confrontations of our times.

In the more affluent nations, in North America, Europe and Australasia the health of poor people has not been improving. Finance is required for the maintenance of large, viable, well resourced hospitals and clinics, the quality of whose service can not be questioned. On the other hand, finance is required for the support of energising, community-based health care, with the accompanying need for training and communication. The two requirements present a tension which has continued. This is a matter for reflection and discussion not only by the WCC health team but also by all those truly concerned with the promotion of health. It touches the industrialised world as well as the developing world. Questions arise as to the priorities in the distribution of resources, including available money, and questions arise as to the method of making influential decisions which affect peoples lives.

"This is still a live debate. There is even more expensive technology around today than there was in past years and there are now more people in the North and the South who can afford to pay for high-tech medical care. The problems of poverty are no less pressing than they were. It is now generally accepted that the two sectors (hospitals and Primary Health Care) are both here to stay, that they need each other, and that they have to find ways of relating, so that justice and equity are achieved without the sacrifice of excellence and scientific creativity." (CONTACT, The CMC Story, 1999, p. 21).

Empowerment and the systems

In this Conference of November 1999, we are, no doubt, still pondering on the challenge of working genuinely for the liberation and empowerment of people, according to the Gospel call, within the systems of today's world. Many of our questions regarding the economy and health start in this area of thinking . The Health and Healing staff of WCC see it as very important to maintain a presence and to contribute where possible from the Churches to the continuing discussions arising from this challenge, in organisations such as the WHO, and in collaboration with aspects of the work of UN Health personnel. A recent training activity, supported jointly by WCC and UNAIDS, brought together Christian health workers from Zimbabwe and from India for a time of study and planning. This group prepared together strategies and operational plans for leadership formation and supervision, including a time frame and budget, and returned to start the process, as planned, in the two countries.

Certainly they would meet the challenges of working for the liberation and empowerment of people within the systems of today's world. The messages received since then from those who accepted this local leadership are enough to ensure that such collaborative ventures will continue. For example, from Zimbabwe: "We have managed to carry out five Workshops (which we prepared) on "The Churches response to AIDS". People are so grateful for this approach. We are looking at the new document by UNAIDS on 'Communications Framework for AIDS: A NEW DIRECTION'. We can see that there is such a thirst for the spiritual on this continent that we MUST try to respond on an international level. We have just shared in a Round Table meeting on the UN document..."

The Mission and Evangelism Team are prepared to invest the needed time and money, from the resources of the Churches, in this kind of collaborative leadership effort, and in the production of suitable training materials. At the same time, the Team looks for opportunities for dialogue with international organisations.

Theological implications

In response to the above-noted challenge, there must be exploration of the theological implications of work for health and healing. This is an exploration to be shared with international organisations as the collaboration and the dialogue continue. In Christian understanding, health is more than medicine. Healing is more than a cure for pain or disease. Wholeness cannot be a reality unless each person accepts an appropriate level of responsibility for divisions and oppressions that are acted out in such dreadful ways, even as we watch. The meaning of Christian healing and health care may be forgotten in the urgency of immediate needs for practical functional structural change. This realisation has been vital in the continuing reflection on, and refocussing, of the Churches'commitment and work.

We may appreciate the challenge given by Professor Charles Elliot as he called for a new level of understanding and involvement.

"For a Christian organisation to ignore the importance of the spiritual dimension of health is for it to ignore the really crucial impact it has to make on the debate about the nature of healing. It is to do with the way you live and the way you are, the quality of life and the quality of death. The ultimate answer lies in a way of life – a life of surrender and obedience that leads to wholeness".

The Church as a healing community

The establishment and maintenance of institutions to care for the sick has been a feature of Christian living in the development of the Church through the ages. Medical work was an important part of missionary work in Africa, Asia, and Latin America. It seemed though that this work of the Churches became separated from the ordinary life of Christian communities. Christians, members of congregations and parishes, raised money to support health work "on the missions", and particular people were sent on mission. Mission was at a distance. The understanding that *the whole Church is missionary*, that the mission of the Church in enabling health, healing, and wholeness, belongs within each local community, requires a renewal of the sense of Church as a healing community, in its own life and relationships, and in the service it offers.

Those involved in Christian service of healing through the caring professions need to know that the concerns they carry are recognised and integrated into the concern of the whole Church. They are greatly helped by church communities making clear their recognition of a theology of healing that takes seriously the relationship between the structures of health care and the Kingdom of God. In the member Churches of the WCC, the invitation and encouragement to explore further and to renew the understanding of the Church as a healing community, has been followed. Profound and moving assertions have been offered in the outcome.

The Church of Scotland document "Health and Healing" (1998) views the restoration of right relationships as part of the promotion of health. *Salvation*, in the Gospel understanding, has a particular sense of healing, and the Gospel presentation to us of *reconciliation* as a major theme indicates that health is to be found most fully in the restoration of relationships. This reflection goes on to identify and comment on the lack of health coming from disorder in the physical environment, the social environment and the unity and coherence of personal life. It names emotional and nervous breakdown, the results of anxiety, fear, and guilt, as the signs not only of a sick person but also of a sick society. In a thoughtful summary, it offers on the Church's behalf an expression of the scope of Christian healing, concluding by saying that the Church becomes involved in the healing ministry *because the Church has a contribution to health and healing that no other agency can provide, namely the gospel of redemption and forgiveness through the grace of God without which we cannot be made truly whole. (Romans 5:10).*

Networking

In the planning now being undertaken in the WCC, following the recent Assembly of the World council in Harare in 1998, and the meetings of the Central Committee in September 1999, the priorities for forwarding the aims of the Churches in the area of Health and Healing include, in every case, the resourcing and encouragement of a network. The Health Team mean a great deal more by this than simply communication and co-operation among people with a shared purpose. The CONTACT magazine published in 1994 an issue on this subject, with the sub-title "Linking People for Change". The issue included a listing of names and addresses of useful networks operating at international and regional levels. It also included the following comment: "When networks are truly "grass roots" or people's organisations, they have a life and momentum of their own. Some have a particular focus on a topic or problem where the potential of a collaborative network can enable an alternative voice to emerge and policy decisions to be changed. Where the poor are involved, it is not a job or a task to be fulfilled, it is quite often literally a matter of life or death. The commitment is phenomenal, overcoming illiteracy, poverty, class and caste distinctions, gender differences and so on in order to build solidarity through ever enlarging networks. Experience has shown that people realise that the larger the network, the stronger they become, and the more possibility there is of bringing about meaningful change".

From the developing networks come voices like that of the convener of the consultation of Christian Health Coordination Agencies in Moshi in Tanzania in 1995: "The health sector everywhere is now engaged in reform and search for new vision, for new mission and for new ways of caring. Unfortunately in many countries the search is guided by institutionalisation and the conferring of respectability on injustice, selfishness, live-and let-die,

greed, and so on... We have no way out but to be part of this reform... But our search and our reform need not be guided by the same principles. Church-related health care reforms ought to be different and must be rooted in our Christian values, theology, and the tradition of service of preferential option for the poor in a resources starved world... how we accomplish this is our challenge."

Strengthening such networking is a primary task for the WCC Mission and Evangelism Team in promoting the work of the Churches for health and healing. This is carried forward through meetings organised to enable people in leadership to come together for information, reflection, analysis, and decision-making. It is also supported through the promotion of a sense of membership and involvement for individuals, small groups, and congregations struggling with their own faith, vision and ideals. This is a globalisation that gives back to individuals and communities something of their own identity, resource, power to heal, dignity to decide and to participate, a voice to take part in decision-making. For many of the members of the Churches whom the WCC serve, the globalisation of trade has not so much eroded as bulldozed that capacity. The Harare Assembly of Churches in 1998 asked for a focus on Africa, where the reality of HIV/AIDS predominates in the existence of so many. It is essential to continue, there and in other regions, to promote ecumenical awareness of the seriousness of the epidemic, and to assist Churches with suitable formation for Christian action. In this, as in the face of the increasing threat of other major diseases, and the accompanying tragedies, the World Council will support the local Churches in the effort to sustain and encourage the community of faith.

Healing for eternal life

Yet we have to recognise, as the speaker on a recent programme from the BBC World Service suggested, that the greatest tragedy may be found in the realisation that, for Africa, the concern and financial support from the West for those whose lives are torn apart by the HIV/AIDS epidemic diminishes as the richer countries develop a drug that can hold the development of AIDS at bay. The poor, and the poor nations, cannot pay for that remedy, even in times when the countryside is at peace. There are other realisations that confront us with the same sense of shock, leading us, if we will follow, into a discussion of health and the economy that uses an unfamiliar language, a more basic language, perhaps, of manipulation and responsibility, of violence and peace, of deprivation and resource, of hatred and love. The healing we hope to promote is, eventually, a healing for eternal life.

A final reflective word comes from the collection "The Violence of Love" taken from the prayers and meditations of Archbishop Oscar Romero. I invite you to listen:

"The Church's task in each country
is to make of each country's individual history
a history of salvation.
One cannot be a true follower of the Gospel
if one does not draw from the Gospel
all the conclusions it contains for this earth,
that one cannot live a Gospel that is too angelical,
a Gospel of compliance,
a Gospel that is not dynamic peace,
a Gospel that is not of demanding dimensions
in regard to temporal matters also."

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ABRAMO ALBERTO PIATTELLI

The Jewish View of the Economy and Health

The rapid advance of medicine and medical technology which has taken place in recent years has brought about a situation in which to the lack of suitable medical structures, supplies of medicine, and equipment for treatment has been added the serious reality of increasingly limited economic resources. This means that no government in the world today has the ability to provide to each and every citizen those suitable services which he or she needs from a medical and health care point of view. Thus it is that every political system is forced to lower the level of the health care services it provides, to establish new priorities both in terms of consumption and of what is actually offered, and to advise, in the majority of cases, resort to alternative economic coverage, in the form, for example, of private insurance companies.

What has been affirmed so far makes clear that the question in hand is not merely that of rationalising the economic resources which are available to us. It also involves ethical and moral considerations which bear upon issues of fairness and equity.

In the past the guiding idea was that the condition of the patient alone had to be assessed and evaluated with a view to preserving his or her life and reducing his or her pain. Unfortunately today we also have an assessment or evaluation of an economic character which arises because of the costs of admission to hospital, of the tests which are carried out, and of the medical care and treatment. To this should be added the costs of scientific research and any preventive medicine which may be engaged in.

In this way, modern society finds itself in a situation where it has to operate at two levels. On the one hand it must establish priorities – for example it must decide whether to engage in dialysis in the case of Alzahimer's disease or if transplants should come before research into AIDS. On the other hand, it must decide whether to engage in an increasing policy of limiting the public health service.

A subject to which the Jewish tradition pays a great deal of attention, and which can be of a certain value and utility in relation to the theme of our international conference, is that of society – the community of individuals in which we live. The issue is the following: should the community, that is to say society in general, be seen as an entity in itself which has its own characteristics and interests or should it be seen as the sum of the individuals that compose it.

If the latter is the case, this means that there must be concern for every individual because the individual is the primary element in society. Holy Scripture, when referring to the individual, expresses itself in the following way: "you must not be responsible for the death of your brother". From this we can deduce that the individual is of pre-eminent importance, that he or she is the highest value there is, and that each and every resource must be sacrificed to his or her needs above and beyond those of society as a whole.

If, on the other hand, society is a reality in itself, then it has the duty to provide other public services as well, such as roads, water, schools etc., and it follows from this that actions to the advantage of each individual must necessarily be limited as a result.

The Jewish tradition establishes on this point that society is not merely the sum of a large number of individuals but is an autonomous entity in itself.

If we want to go back to the sources in order to find a reference to what has been affirmed above, that is to say that in a situation of limited economic resources these should be directed towards public provision, we can find it in the Talmud. In the tract by Ghittin we encounter the rule that it is forbidden to pay a ransom for a kidnapped person which is above its real value, and this "*for the sound working of society*". Two explanations are offered for this affirmation. On the one hand, that the idea is to avoid a situation where the kidnappers blackmail society and are encouraged to take other prisoners and demand a higher price. On the other, that the intention is to prevent the impoverishment of society itself and thus the possibility that resources are not directed towards other social goals and objectives.

However, there are certain basic needs of individuals which cannot be ignored by society as a whole. Here we are dealing with fundamental needs which can even involve the actual survival of the individual. All economic resources should be directed towards such needs with full priority. In the same way, in the case of an overall and general health care programme it is essential not to end services which have been guaranteed previously and which are indispensable to the health of man. The person who is really in need turns to such services and indeed desires them in a very strong way.

The criterion of distributive justice must be at the basis of the distribution of economic resources in favour of public health. This is not a matter of adopting principles of equality which are them applied amongst all users, but of establishing criteria as to priorities in relation to helping one sick person rather than another and in relation to the decisions concerning the allocation of

economic resources – especially when such resources are limited in nature – to one sick person rather than another.

In establishing criteria in relation to priorities, one can base oneself upon different considerations, such as the medical data (the success or otherwise of the treatment, the likelihood of the patient surviving); the economic data (the costs of hospitalisation, of the treatment, economic benefits in terms of costs and expenditure); and the personal data of the sick person (his or her age, social status, etc.). In my opinion we should always bear in mind that we have before us the dignity of man, and that we are also faced with the Jewish dictum: "*he who saves a life saves the whole world*". A Talmudic maxim affirms: "*Rofe chinnam, shavé chinnam*". That is to say that a medical doctor who does not receive payment for his work is worthless. In the Jewish tradition the physician must take care of a sick person, and for this reason he should rightly be rewarded for his training and his labour. If we adhere to the view that the medical doctor who is not paid for his work is worthless, then the same is equally true for health care which indeed becomes worthless when suitable economic resources and suitable provision are not available.

In Judaism a cardinal principle is to be found in the belief that human life is of inestimable value. The duty to preserve the life of a man takes precedence over all the other religious duties required by the Tora precisely because the value of life is infinite and supreme. An elderly person, whether a man or a woman, a mentally retarded person, a deformed baby, or a terminally ill patient – all these figures have the same right to life. From this there derives the principle that it is forbidden to do something which could shorten the life of a person even to a small extent. This is because every moment of human life is of infinite value.

Another fundamental principle of the Jewish tradition is that one human life cannot be sacrificed to save another. Maimonides, a medical doctor and a theologian, explicitly emphasised this when he wrote: "*logic requires that one cannot sacrifice the life of an individual to save the life of another or to free someone who is threatened by violence. The destruction of one life to save another is not allowed*". The reason for this is summarised in the maxim: "*who says that the blood of that individual is redder than another?*".

The infinite value of the life of man, an axiom of Judaism which has been described above, is often compromised by the conditions brought about by the fact that economic resources are limited. Many times we are faced with a situation where we only have one dialysis machine and there are two patients with kidney malfunctions but the same needs and requirements. To whom should the medical doctor give precedence? How can he or she reach a decision? And when he or she takes a decision does he or she not perhaps condemn one patient to death by providing the other with the treatment which is needed? I would like to pose the following question: why should a medical doctor find himself or herself in a situation where a decision has to be made regarding which patient should be saved and which left to die? Why does society not make available a larger number of kidney machines and establish new operating theatres rather than opening new museums or laying out heavy expenditure on sophisticated weaponry and armaments?

Society must be involved in these problems, and made more sensitive towards them, through projects and programmes which seek to preserve the life of man and see such life as having a sacred value, thereby ensuring that the idea of the dignity and immense value of the life of man is trasmitted down the generations.

This is our responsibility towards the generations to come. In the Talmud there is a story about the pious man Choni who was walking down the street and saw a man who was planting a carob tree. He asked him: "how long will it take before this tree bears the fruit you hope for?". The man answered: "seventy years". Choni then asked him: "do you really think you will live another seventy years?". And the man answered: "I have found carob trees in the world, and just as my ancestors planted those trees for me so will I plant this tree for my descendants".

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The Economy and Health in the Light of Islamic Principles

This research does not tackle the details of economic theory in Islam, nor the imperatives of public health, nor does it compare them to other theories and systems. In fact, these are broad subjects that we leave for specialists to examine. Nevertheless, this paper underlines the general principles that define the point of view of Islam concerning man, his dignity and his legitimate rights for a decent life. It also deals with wealth and its goals so that it will be at the service of Mankind in a way that would enable it to set the bases for a healthy, clean society, before it becomes a means for corruption and luxury among individuals, and an instrument for oppression and tyranny among governments and states.

1. Human Dignity

Islam defines the primary message of Mankind on this planet as believing in God and worshipping Him. In obedience to God man was encouraged to explore earth, and exploit its resources. These two, being linked together, set bounds for man's activity, control his defiant tendencies for possession, and resist excessive materialism over human feelings.

The Koran as well as the Sunna "traditions" of the Prophet stress the dignity of Mankind regardless of religion, sex, color or country. The story of creation in God's book reflects how God honored mankind. In fact, God created Adam with his own hands and blew his soul into him. He also gave him beautiful features which distinguished him from other creatures, and granted him reason and the power of expression. He even called him His "viceregent" on this earth, which he provided with air, water, innumerable kinds of metals, trees and fruits. He guided him on paths open to development, discovery and invention. One of the most important theses of the Koran rotates around reminding Mankind of this beginning, keeping up its fundamental features so that Mankind will not break with its origins or revolt against its message. All heavenly messages come from God to bring man back to these principles every time corruption or perversion prevails, or whenever man is obsessed by a false feeling of power and independence from God's will, as clearly stated in the Koran:

"Nay, verily, man becomes grossly overweening. Whenever he believes himself to be self-sufficient, for, behold, unto thy sustainer all must return" 96/6.

The Sharia (Law of Islam) builds upon these general elements and quotes from its spirit detailed principles that protect the dignity of man and his rights to life, to liberty, to forming a family, to possessing... etc.

When we talk about the one origin of Man and the dignity which surrounds this beginning, we should not forget the fact that these rights are guaranteed in Islam for both men and women, each according to his/her physical characteristics and social duties. Non-Moslems are also offered these guarantees; Islam does not consider itself a new separate religion but a continuity of the divine revelation which started with Adam, the Father of Mankind, and reached man through a long series of prophets and messengers. Since Islam recognizes all divine books and respects the prophets of God, it follows that it recognizes all nations and peoples, the followers of these religions, and considers them members of the one family of Mankind whom God has honored and taken care of.

These fundamental principles are found in the Koran in different versions such as: *"It is He Who has Made the earth manageable for you, so traverse Ye through its tracts And enjoy of the sustenance which He furnishes: but – remember – Unto Him is the Resurrection"* (67/15). In his commentary on this verse, Mohamad Assad, previously "Leopold Vays", said: Who has made the earth submissive to you. Be yielding to the intelligence with which he has endowed man."

This verse points to the balanced comprehensive principle of Islam;

exploiting earth and investing its resources to the maximum without disregarding the fact that Man will be held responsible on judgment day for all his efforts and whether they were in harmony with the will of God.

2. Warning Against Corruption

Most stories mentioned in the Koran on previous civilizations remind us of faith in God, its obligations and duties and how it should be a motivation, companion and a supervisor in all domains of life. The result is almost the same: when anything goes wrong in this formula, and development makes its way in isolation from faith, and power becomes a means for corruption and exploitation, this deviation will invetably lead to the deterioration of the civilization and its ultimate extinction. The Koran ends this warning by saying:

"There upon an earthquake (Rajfah) over took them: and then they lay lifeless, in their very homes, on the ground" (7/78).

Though the expression "Rajfah" means earthquake in the first instance, yet it has other meanings in Arabic such as violent commotion, according to Mohamad Assad in his translation of the Koranic meanings. It could also mean the destruction of societies and their implosion from within as a result of disobedience and revolt against God's commands. He, in fact, confirmed this in his explanation of verses 47, 48, 49 of Ya-sin (36)

"And when they are told,"Spend ye of (the bounties) with which God has provided you", the unbelievers say to those who believe: "Shall we then feed those whom, if God had so willed, he would have fed, (Himself)? Ye are in nothing but manifest error. Further, they say, "When will this promise (come to pass), if what ye say is true?" They will not (have to) wait for aught but a single Blast: It will seize them while they are yet disputing among themselves!"

It is worth noting that arguments and disputes are immediately followed by destruction when it comes to the right of the poor in national wealth. This means that the "Rajfah" or the commotion may take the form of an armed revolt led by hungry people, or a coup d'état led by adventurers in the name of the poor.

Prophet Mohammed urged people to till the earth. In fact, he said: "He who restores a barren land has the right to own it". Restoring earth is not limited to planting it and exploiting its resources, but also involves recovering precious minerals that could be used in different industries.

3. Islam and Research

According to Koranic logic, investing in the earth is part of a more comprehensive frame; it is dealing with nature since it represents one of God's greatest creations. In fact, if a believer ponders the open book of God, he finds God's most incredible Divine achievements, as the Koran says:

"No fault wilt thou see in the creation of the most gracious, and turn thy vision (upon it) once more: canst thou see any flaw?" (67/3).

In most cases when the Koran refers to nature, its resources and its secrets, it usually ends up by urging man to study, meditate and understand its different aspects. Not only for the purpose of strengthening his faith, but also to see how he could make use of it in his life. Besides, when the Koran talks about stars and their connection to navigation, to defining positions, seasons and navigational routes by land and sea, it actually sets the base to what Man has achieved today in geography, natural sciences and astrology. In this, the Koran says:

"And He it is who has set up for you the stars so that you might be guided by them in the midst of the deep darkness of land and sea: clearly indeed have we spelled out these messages unto people of (innate) knowledge" (6/97).

Professor Roger Garaudy, in his valuable book on Islam in the West, entitled "Cordoba, the Capital of the Spirit", says:

"The Koran contains 57 verses, all encourage believers to study and conduct research in the same way as the Koran treats astrology, physics, biology and mathematics. In addition to that, verses tackling the study of societies, their development and their deterioration are also found when God addresses Man".[1]

In this connection, we take a look at what Islam can offer to the modern world; high among these contributions is the emphasis on the indissoluble bond between science and faith. The latter should not be isolated or withdrawn in performing its role in developing human life, neither should science be separated from faith and ethics so that it becomes an evil power that destroys families and societies or sets the strong against the weak to seize their liberty and wealth as is the case today.

4. Wealth Belongs to God

One of the settled matters in the Sharia is that wealth belongs to God. He passed it on to Man to make use of it. In fact, there are clear signs in the Koran and the Prophetic traditions that stress this meaning and describe wealth as being the wealth of God:

"Believe in God and his apostle, and spend on others out of that of which he has made you trustees: for those of you who have attained to faith, and who spend freely in God's cause have a great reward" (57/7).

If faith takes control over Man's soul, the way Islam wants it to be, and if man commits himself to the duties which this faith imposes on him, then money would become a means to spread goodness and mercy among people, and help in devel-

oping the human community in all its aspects. Hence, monopoly, usury and extravagancy were prohibited, as well as depriving the poor and the needy of their rights to the wealth of the nation.

The Koran and the Sunna "tradition" of the Prophet include many passages treating all these cases. It is needless to say that Islam, though it gives priority to stirring up the power of faith in individuals so as to incite them to doing good deeds in order to win God's satisfaction and merit, and though the Sharia contains provisions that guarantee the setting up of a human community where mercy and solidarity reign, yet it also presents guarantees to the liberty of possession and private wealth as long as it is earned in a legal way and within the regulations of the Sharia.

5. Zakat and Charity

Islam is considered unique in that it made Zakat (due purification) one of its basic elements and religious duties in relation to which a believer could be punished or given credit. At the dawn of Islam, the first Khalifah Abu Baker Al-Sedeek had to launch a preventive war against a group of Moslems who committed itself to all the duties of Islam except that of Zakat. The Khalifah, the Prophet's disciple, considered that this rebellion constituted a violation of the rights of the poor which Islam guaranteed.

"Zakat" means literally cleaning and due purifying, as if cleaning money meant it would be used and spent and invested in a right way. Without this purification, money would be considered as stained and rotten thus bringing bad luck to its owner in his life in this world, and the hereafter. In one of the Prophetic traditions, He warned those who have gold and silver and do not carry out the religious duties related to them. This warning is derived from a famous Koranic verse *"And there are those Who hoard gold and silver And spend it not in the Way of Allah: announce unto them A most grievous Chastisment" (9/34)*

The value of Zakat is not restricted to the materialistic benefit it brings to society, but is also a way of purifying the human soul. If God is always present in Man's conscious and if man counts for God's right in his money, then he would have reached a high degree of perfection and social responsibility. While Zakat is considered a synonym for the term "sadaka" in the Koran, which is derived from honesty and belief, the Sunna of the Prophet on the other hand distinguishes between the imposed Zakat and the voluntary charity for which man is given credit. The Sunna of the Prophet specifies the amounts of Zakat and its conditions, which fall outside of the scope of this study. In addition to that, the Sharia granted Moslem leaders the right to collect charities from rich people to spend them on the poor as well as on the social public welfare specified in the Sharia.

6. Charity in Previous Books

Charity – the Zakat included – is mentioned 29 times in the Koran, and to stress the spiritual value of Zakat, we see it being mentioned in the Koran always in association with prayer "Pray and carry out Zakat". As Islam came to complement previous religions, it actually describes previous prophets as being committed to prayer and to Zakat. For example, this is what it says about Abraham and his children:

"We made them leaders who would guide (others) in accordance with our behest: for we inspired them (with a will) to do good works, and to be constant in prayer and to dispense Zakat, and "alone" did they worship me." (21/73).

The same description with different wording was given to Moses, Christ and the prophets of the Old Testament and how they used to pray and carry out Zakat. In fact, the Holy Bible urges, on several occasions to give away charities, as in the following words in Luke:

"Sell your possessions and give in charity. Provide for yourselves purses that do not wear out, and never-failing treasure in heaven, where no thief can get near it, no moth destroy it, for where your treasure is, there will be also your heart" (Luke 12:33-34).

As a matter of fact all the virtues mentioned in the Bible and the Koran came to underline and to clarify. Then He passed to form them into legislation so that they would be implemented. This confirms the unity of God's religion and the link between all prophets and messengers from the first to the last, as is said in the Koran:

"Step by step has He bestowed upon thee from on high this divine writ, setting forth the truth which confirms whatever there will remains (of earlier revelation) for it is He who has bestowed from on high the Torah and the Gospel, aforetime, as a guidance unto mankind, and it is He who has bestowed (upon man) the standard by which to discern the true from the false" (3/3-4).

7. Islam and Work

Before we end this part on Zakat and charity, we must underline two matters: first, Zakat is not the only right of the poor to rich people's money and the responsibility of any Moslem leader lies in collecting the amount necessary to achieving social justice and guaranteeing the prosperity and the stability of the society. Second, though the benefit of Zakat proves to be useful in certain cases, yet it should not be used to fund a class of unemployed beggars who live aside from social life. The mission of both Moslem leaders and the people is to create jobs in agriculture, industry and trade in order to absorb all capabilities and man power. In this way, unemploy-

ment – the source of all kinds of social diseases – will not expand. Dr. Irfan Al-Hak, the expert in economics and a professor in American universities said in his book entitled: "Economic Doctrines in Islam":

"Zakat, it should be understood, is largely a temporary relief measure. It is not meant to support, and thereby create, a permanent class of welfare recipients. It's first purpose is to meet the immediate needs; however, its second purpose is to help people stand on their own feet, to move out of the poverty line, and to be socially and economically productive. The Prophet has made it quite clear that charity is unacceptable for healthy adults unless they are in severe distress, and only to the extent of satisfying their pressing needs, and that they should make all attempts to be self-supporting through self-employment and remunerative work".

The Koran and the Prophet's traditions urge man to earn his living so he could be accounted a good citizen and would perform his role entirely in society, as the Koran puts it:

"That they may enjoy the fruits of this (artistry): it was not their hands that made this: Will they not then give thanks?" (36/35). Besides, faith is mentioned in association with conducting good work on several occasions in the Koran as we mentioned earlier. In addition to that, the Holy Book does not distinguish between types of work whether devotional, benevolent or secular because every type of work that emerges from the faith in God and aims at forming a family or serving the welfare of the society is considered good. In this, the Koran says:

"As to those who believe And work righteousness, Verily We shall not fail to requite any who persevere in doing good." (18/30)

The Prophet Mohammed refers to the traditions of previous prophets to set an example for the generations who have believed in them and followed them. He said: "Everyone should eat from what his hands have achieved, God's Prophet, Daoud (David) has done the same" (Bukari). He also said "There are sins that can only be forgiven by working hard and earning one's living, and not by praying or giving away charities or going to the pilgrimage" (Tabarani).

When a Moslem leader organizes the collection of charities and Zakat and spends them in a legitimate way, he is, in reality, protecting society and resisting destructive epidemics. It is said, in one of the Prophet's traditions, that the Prophet praised a man who offered a thief and a whore charity:

"May the thief request a pardon for his stealing, and the whore desist from adultery".[2]

The objectives of the Islamic method in developing and helping society to thrive at all levels have been clarified through what has been mentioned earlier: to fight against poverty and unemployment, to strengthen the bond that connects good work together with faith, fear of God, wanting to gain his gratification, and making use of the worldly achievements to win salvation according to God's command. The Koran has said:

"Seek, by all means of what has granted thee (the good of) the life to come, without forgetting, withal, thine own (rightful) share in this world; and do good (unto others) as God has done good unto thee: and seek not to spread corruption on earth: for verily God does not love the spreaders of corruption" 28/77.

8. For High Morality

It is clear from what we have mentioned earlier that faith is the base of social construction. It is the light that settles down in our hearts, and is reflected through the actions, the behaviour, and the words of man. Though its effect on formulating a stable society is quite obvious, yet its psychological influence on the individual cannot be neglected either. This dimension is described in many verses of the Koran as "the straight path" or "the patent light" which relieves hearts and appeases souls. Without it, man becomes as rootless as a feather blown in the wind, a creature with a disturbed, disoriented soul that knows no goal in this life. The Koran gave an eloquent description of this meaning:

"But then, is he that goes along with his face close to the ground, better guided than he that walks upright on a straight way" (67/22).

The objective of Islam is to form a healthy society, composed of healthy individuals. Accordingly, it has underlined the importance of the family, being the core of society and the first cell, which should be built on faith, love, confidence and mutual responsibility, so man and woman could lead a decent life within the prescribed bounds, and feed the children of today and the men of tomorrow from these noble human feelings, so that they will spread them in society and transfer them to every field they deal with. To achieve this goal, Islam has adopted a fair way as it always does when it comes to matters related to man. It placed women somewhere between complete seclusion that would hinder their skills and qualities on the one hand, and restrain them from being mere instruments for amusement and seductiveness, and spreaders of destructive powers that ruin the society around them on the other. At the same time, Islam has imposed many duties on the woman so she would participate in public life whether it be the academic, economical and political levels without having to lose her first responsibility which is that of taking care of the home and raising up healthy children psychologically and culturally. The Sharia contains many clauses that rule these duties in all domains. Besides, the Islamic concept regarding the role of the family, the duties of parents, specially that of the wife, represents

one of the basic theories that Islam can offer today to a modern society losing its balance and moving from one extremism to another, giving desires and whims fake masks in the name of individual liberty. All this will consequently lead to the destruction of families, to the fragmentation of the bonds of society, and to the deprivation of parents of the responsibility of raising up children and looking after them. It would be useful to study the Islamic method in an objective and fair manner away from any biased campaigns unleashed for trivial political purposes.

The whole community should join the Moslem family in fighting against social epidemics that are about to destroy modern society. What make things worse is a weak structure of the family, and the common tendency of the media towards encouraging perversities and violence, glorifying crimes and presenting their perpetrators as models and heroes to be followed.

Islam is launching a legitimate war against corruption, which society is suffering from such as adultery, homosexuality, crime, alcoholism and drugs. In that campaign, it relies as we mentioned on two methods: first, awakening the psychological deterrent and self-abstention by all means, then passing laws and promulgating legislation to resist the drift towards total degeneration.

The method of Islam lies in purifying the corrupted environment where the germs of crime and desires find a suitable atmosphere to grow. Thus, it is not enough to fight against adultery when it takes place, but to shut down every path that leads to it, from excessive mingling, to extravagant finery or disgraceful habits. The Koran forbids adultery in this way:

"And do not come "near" adultery for – behold, it is an abomination and an evil way" (17/32). As for crimes and atrocities it also says:

"And do not commit any shameful deeds, be they open or secret" (6/151).

In addition to that, the Prophet said regarding the same subject:

"So whoever saves himself from these suspicious things saves his religion and his honor. And whoever indulges in these suspicious things is like a shepherd who grazes his animals near the HIMA "private pasture" of someone else, and at any moment he is liable to get into it "O, people everything has a HIMA and the HIMA of God on earth is His "Forbidden things".[3]

As far as alcohol is concerned The Prophet said " If anything taken excessively leads to drunkenness then taking it in small doses is forbidden" (Tirmithi and Aboudwood). This saying applies to all drugs or any substance that harms a man's health or makes him lose his balance.

9. Public Health

It is clear from these dimensions that the Islamic economic system, including the capabilities of the state, is directed to achieving the dignity of the individual in the first place, and to satisfying his physical and spiritual needs, as well as securing a decent life for him and his children within a free, safe and stable society.

We have been through some of the methods adopted by Islam in reaching these goals. We also believe that we have talked about economic security and spiritual stability within the limited space of this paper.

Islam confirms the conclusion reached by modern theories which says: "A sane mind in a sound body" or as Jean Jacques Rousseau puts it in his book "Emile": "a weak body is only half the mind".

The Koran points out to the same conclusion when it talks about a brave king:

"Behold, God has exalted him above you, and endowed him abundantly with knowledge, and bodily perfection"2/247.

Prophet Mohammed said " a strong believer is better than a weak one." He even sets the base for a modern theory, forbidding marriage between relatives for it is the cause of having weak and unhealthy children:

"Marry from outside your relatives, otherwise you will produce weak children".[4]

The Sharia contains many passages relating to marriage, family, divorce, bringing up children, breast feeding them throughout the different age stages. They all rotate around the rights of the child, taking care of him, and his health under all circumstances. The Sharia does not ignore the duties and the responsibility of both the state and the society in this matter. All this comes under the large heading which the Koran imposed in:

"God urges you to take care of your children" (4/11) before he speaks in detail about the different shares of inheritance.

In the same way, the Koran entrusted children with their parents so the circle of mercy and probity would be completed, and would reign among the one family to grant both parents and children warmth and stability.

As for the right of children to breast-feeding even in the case of divorce, we see the Koran saying:

"And the "divorced" mothers may nurse their children for two whole years if they wish to complete the period of nursing, and it is incumbent upon him who has begotten the child to provide in a fair manner for their sustenance and clothing" (2/233)

Islam accompanies the individual from his early childhood, and insists on taking care of his health. Even when he reaches youth and becomes a working member in society, Islam and the Sunna still urge him to look after his health. Physical cleanliness is part of worshipping and is manifested in ritual ablution before prayer. In addition

to that, the Prophetic traditions talk in minute details about cutting one's hair and nails, brushing one's teeth, economizing in food, fasting, practicing sports, sleeping early, keeping away from alcohol, drugs, smoking and everything else modern society is suffering from nowadays. The Koran combines spiritual and physical cleanliness in one verse:

"Ye who believe! When ye prepare for prayer, wash your faces, and your hands (and arms) to the elbows; rub your heads (with water); and (wash) your feet to the ankles. If ye are in a state of ceremonial impurity, bathe your whole body." The Koran ends the verse in saying "*God doth not wish to place you in a difficulty, but to make you clean, and to complete his favour to you that ye may be grateful" (5/6).*

The Prophet said: "Purification is half the faith" (Moslem). In cleaning one's teeth, he said "I don't want to make it any harder on my community – or on the people – otherwise I would have asked them to brush their teeth with every prayer" (Bukari). We also find many traditions that stress collective responsibility in fighting against poverty as the Prophet – God bless him and grant him salvation – said: " He who sleeps with a full stomach while his neighbor is hungry does not believe in me" and "If a man living amongst rich people dies of hunger then they will be acquitted from God's custody"[1] He also warn against gluttony and its bad effects in saying "No man can fill a more ill-fated receptacle than his stomach."

To follow this general principle of making cleanness a manifestation of the faith, Koran and the Prophet recommend a wide range of measures that deal with cleanliness as – for example – mentioned in this Koranic verse "*O, Children of Adam, Beautify yourselves for every act of worship, and eat and drink, but do not waste, verily, He does not love that wastefull"* (7/31)

From this verse we can see clearly that the Koran advises man to have moderation in food habits, in order to keep his fitness and prevent burdening the body with excess of weight and fatness, in addition to the econimisation of wealth for using it in the development of the family and the society. The linking of the embellishment to the mosque is not without special significance, bearing in mind that the function of the mosque in Islam is not restricted to the ritual service, but to serving as a training ground and formation on social and civic healthy habits. The concept of embellishment entails the wearing of clean clothes, the avoidance of dirty appearance, or bad smell.

To stress this point the Prophet said "God likes to see the traces of his grace on His servants", referring to certain foods, He said: "who that eat onion and garlic should not frequent our mosques" When enumerating some niceties of the world He loves better, He included the "musk" the prevailing fragrance of the day. It is obvious that a Muslim can not meet all these required necessities unless he is cleanness-oriented and economically self-sufficient. At this juncture we see once again the close relation between the financial conditions of the individual and the sanctity of his mental and bodily health.

10. Living with Nature

Nature is one of God's greatest creations as we mentioned earlier. The Koran encourages man to live with nature, observe it and discover its secrets. Harmony between man and nature was useful from the very beginning. Earth is the mother of mankind, it embraces him in the beginning and in the end*: "out of this 'earth' We have created you, and into it shall we return you, and out of it shall we bring you forth once again" (20/55)*, according to the Koran. Trees, flowers, plants and fruits are the products of this tender mother where the sun, the moon, the planets, the clouds and the wind are the screen which surrounds man, and which he should know about and make use of. Living with nature, enjoying its views are the closest methods to revive the soul and feelings. The Koran says *"And thou canst see the earth dry and lifless – and (suddenly) when We send down waters upon it, it stirs and swelps and put forth every kind of lovely plants." (22/5).*

Coleridge said in the "Nightingale": "In nature, there is nothing melancholy".

No religion more than Islam shows respect for nature, and uses its beauties and secrets to revive the body and the soul. The Koran says:

"And he it is who has caused water to come down from the sky; and by this means have We brought forth all living growth, and out of this have We brought forth verdure. Out of this do We bring forth close – growing grain; and out of the spathe of the palm tree, dates in thick cluster, and gardens of vines, and the olive tree, and the pomegranate. All so alike; and yet, so different. When it comes to fruition and ripens! Verily, in all this there are massages indeed for people who will believe" (6/99).

This continuous urging to love nature makes it necessary to look after it, value it and protect the environment around it from extravagancy, destruction or pollution. Extravagancy is objectionable in the Koran: *"Eat and drink in moderation for God does not like extravagancy". (7/31)*

The Prophetic traditions also call on us to protect nature from corruption and transgression, saying : "If someone was holding a seedling on judgment day, let him plant it". The obligation of economizing in using water is also mentioned: "A disciple of the Prophet was accompanying him and recalls having passed with the Prophet by one of his followers as he was performing the ritual ablution before prayer and so he told him: "Why all this waste?" He

said: "Is any waste considering performing the ritual ablution before prayer?" He answered: "Yes, waste of water is inadmissible even if you were taking from a running river" (Ahmed).

11. Protection of Society

The Islamic method tends to protect the society from epidemics and diseases and to provide the necessary treatment for people. In fact, it is strictly forbidden for sick people to move freely without medical care as a means to prevent diseases from spreading, to encourage people to be treated as quickly as possible and not to neglect any symptoms. The Prophet had lots of sayings on prevention, such as "Do not allow a sick person to frequent a healthy one" (Bukari). This recommendation was applied rigorously later on; it is reported that when the second Khalife Omar Ibn Al-Khatab made his trip to accept the keys of Jerusalem from Patriarch Sophronius, He declined to visit certain effected regions because of the spread of the epidemic in those regions, Abu Obeida the general commanding the Muslim armies in Syria protested against this attitude in saying: prince of the faithful "would you escape the divine decree of God? Omar retorted angrily "If anyone else has said that I would have punished him, because I escape from the divine decree to the divine decree", and he mentioned the Prophet saying: "If you hear that plague had stricken one of the lands, do not enter it, but if you were already there, don't get out of it" (Bukkhari). Though the prophetic traditions treat this subject extensively, yet they are only general principles which have been thoroughly examined by jurists and theologians covering all aspects of life. Responsibility in the first place falls upon the individual with the aim of observing the rules of cleanness and prevention to take care of his health and that of his children. The objective is to bring up a responsible mature citizen for this constitutes a personal responsibility that the state cannot assume. It is enough for the government to bear the duty of creating jobs, fighting against unemployment, providing prevention methods from diseases and treatment when epidemics break out. The Prophet – P.B.U.H – said: "God gave a cure to every disease He brought down on Man" (Bukari and Musslim).

The Sharia underlines the responsibility of the family along with the state in protecting the society and its members from all social and physical epidemics. If they fail to assume this responsibility then they are the main cause behind stirring up riots and chaos, which would destroy the political and social structure of the society. This is called "Fitnah" or internal strife, which the Koran terms "Worse than the crime of killing." There is no doubt that taking care of public health, setting up hospitals, training skilful doctors, providing the necessary equipment and medication are part of this responsibility.

The greatest guarantee for the ruler to carry out this mission is the principle of "consultation" in the Islamic system. The latter may take different forms from one era to another, and from one environment to another, yet the essence and the spirit remain the same, being the importance of making the citizens take part in choosing the suitable way of defining the general policy of the state, and achieving public welfare. If this participation takes the form of representatives who speak on behalf of the citizens, then this is the best way to achieve public welfare. People know their needs best and what is useful or not useful to them. The ruler has to respect their will. This meaning is quite obvious when describing the society of believers: *"Those who respond To their Lord, and establish Regular prayers; who (conduct) Their affairs by mutual consultation; Who spend out of what We bestow on them for Sustenance." (42/38*)

So also the injunction of the Prophet "*Consult them in public affairs" (3 /159).*

One might say that the present situation of Moslems is far from the bright picture given here. Though we admit this fact, yet it is clear that Moslems have been through different circumstances that have imposed on them weird ideas which take them away from the spirit of Islam, especially during the foreign occupation that lasted for centuries. It is a pity that this picture is still present in the West... the proof is the unfair campaigns organized to distort the image of Islam and discourage Moslems from following the Islamic pattern. Despite that, Moslems still tend to resume the Islamic way of life though this tendency might in certain cases deviate from the positive path. The majority hopes to build a modern Moslem society founded on these grounds and looks forward to holding a dialogue with others, living with them, sharing their rich human experience and cooperating with them in building a new world where peace, justice, respect for the dignity of man and his legitimate rights, help him to live in peace and security.

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Notes

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[2] Bukari 1/247.
[3] Bukari (Faith).
[4] Lissan Al-Arab.
[5] Compilation of Izuldin Bulaik "Method of the Pious".

THIMAPPA HEGDE

The Economy and Health: the Hindu Perspective

I feel very honoured to have the opportunity of giving this lecture at this extraordinarily important conference. I will be speaking on the subject of "The Economy and Health from a Hindu perspective". I would like to dwell briefly on religion and health and about *Ayurveda* which is the Hindu concept of medicine.

Hinduism

The term "Hindu" itself originated as a geographical one for those who lived beyond the river Sindhu (Indus). Another origin for the term "Hindu" comes from an abbreviation of the expression in Sanskrit. "*Heenam Nashayate – iti Hindu*" which means that a Hindu is one who destroys or wins over that which keeps him low.

Hinduism does not originate in any single teacher as Christianity, Islam or Buddhism does, but comes from many teachers, most of whom are not named. Nothing, in fact, is known about those teachers, except that they must have been very extraordinary persons judging from the nature of their thoughts and experiences. They taught only that which they themselves had experienced in a super-conscious state.

The Central message: Hindu concepts of God

Although many people associate Hinduism with a multiplicity of Gods, the universal understanding is that there is only one Supreme God. The term used is Brahman, and everything, whether living or not, comes from, goes to and is made of the stuff called Brahman. All things can be regarded as sacred in essence.

Although symbolically there are thousands of Hindu Gods, Hinduism accepts a triad – Brahma – the Creator, Vishnu – the Sustainer and Shiva – Destroyer. Other important Gods are Ganesha and the consorts of Brahma, Vishnu and Shiva that is Saraswathi, Lakshmi and Parvathi. The Goddess Saraswathi symbolises knowledge; Lakshmi is symbolic of wealth; and Parvathi stands for strength.

Social and Moral Teaching

The affirmative attitude of Hinduism towards life has been emphasised by its recognition of four legitimate and basic desires – *purusharthas* – the first three Dharma (righteousness), *Artha* (wealth), *Kama* (sense pleasure) are secular in the realm of worldly welfare, and fourthly *Moksha* (liberation from bondage or communion with God) which is perfection.

Though Dharma or righteousness is the basis, both *artha* or wealth and *kama* (sense pleasures) are legitimate. The acquisition and possession of wealth are indispensable in the world. Money must be earned and all efforts should follow Dharma. The *kama* – enjoyment of sense-pleasure – covers a vast area, including conjugal love, appreciation of art, music poetry, beauty etc. Life becomes drab and grey unless one cultivates aesthetic sensitivity. But sense pleasures, if not pursued according to Dharma, degenerate into sensuality.

Purusharthas underscore the importance that health and wealth be acquired in a righteous way. It calls on one to follow one's own duty and not to give up obligatory functions, to keep motives high. Personal vagaries are checked while personal desires are restrained. The above injunctions make a person lead a high quality of life.

Hinduism and Health

– To attain the *Purusharthas*, that is the goal of life according to the Hindus – is to attain the following: *Artha* or wealth, *Kama* or fulfilment of desires including sexual desires and *moksha* or enlightenment

– Good health is a basic pre-requisite to the attainment of life's objectives.

– Health care in ancient India was a branch of religion. The Hindu system of medicine is said to have originated from Lord Bramha, the fountain head of all learning.

The Relation with Dharma. Disease according to Hindu tradition

According to the spiritual tradition of India, diseases have two causes. First, they can arise from physical or biological causes, the imbalance of the biological humors, the elements and prime energies of the physical body. Treatment involves mainly physical or medical methods with a naturalistic basis including herbs, diet, body work and yogic postures (*asanas*). In more extreme cases

mineral and drug medicines or surgery may be required.

Second, diseases can arise from karmic causes from the effects of wrong actions we have done in life meaning from psychological or spiritual causes. They may be wrong occupation, problems in relationships or emotional difficulties, and treatment may require changes in life style and attitude. Such causes include not living up to our inner purpose or spiritual will in life, What is called in Sanskrit our 'Dharma'. Diseases can arise from wrong actions in a previous life, primarily those which brought harm to other beings.

Such karmic diseases may require some form of atonement or sacrifice, an 'inner rectification' to re-establish our well being in life. For this *Ayurveda* uses *Yoga* and a system of divine or spiritual therapy which includes the use of gems, mantras, prayers, rituals and medications. These are not Medieval superstition but reflect profound understanding of the deeper levels of the mind and the means of healing the subtler aspects of our being.

Healing and Religion: the Hindu perspective

The essence of healing is integration, faith and love. These create the grace and flow of the cosmic life-force necessary for healing to occur.

From its hallowed ancient perspective medicine and religion are the two faces of the same coin. But Ayurveda doesn't impose its religion, its background on anyone. Along with the regular tools and methods of natural healing, it provides yogic methods which can be adopted to whatever form our religious or spiritual life may take.

The Disease Origins

Ayurveda emphasises the role of the mind in the causation of diseases. Psychological stresses are considered important in the etiology of disease. We are today increasingly becoming aware of the importance of psychic influences on the somatic response of the body. We also know today that this psychic influence is measurable in terms of neuroendocrine and even immune responses.

Health is our natural state. The WHO has defined it as something more than the absence of disease – health is a state of perfect physical, social and mental hygiene. To this may be added spiritual wellbeing, a state in which a person feels at every moment of living a joy and zest for life, a sense of fulfilment and an awareness of harmony with the universe around him.

High blood pressure is a very common disorder and affects a large proportion of the population. Hypertension is harmful because it can damage vital organs including the hearts, the kidneys and the brain. Stress has been shown to play a major role in the genesis of hypertension. Long term studies have proved that yoga and meditation if regularly kept up effectively reduce high blood pressure.

Coronary artery disease is the number one killer in most parts of the world. The most common risk factors associated with that are obesity, high blood pressure, stress, smoking and lack of physical exercise.

It is estimated that one out of four people will develop some sort of cancer during his or her life time. The ultimate answer to the problem of cancer lies in finding out ways to promote the body's own inner resistance to cancer causing agents.

If cigarettes, alcohol and "recreational drugs" were eliminated from society, we would have nearly empty hospitals.

Smoking, drinking and drug abuse exist because they satisfy a natural need that has become a craving. To solve this problem, we must find mental techniques that are far more enjoyable and life enhancing to practice which can give a much greater 'high' than smoking, alcohol or drugs. Meditation is one such technique.

Obesity is the most common metabolic disorder in affluent societies. Obesity is not merely unattractive, it is in itself unhealthy and predisposes a person to a number of illnesses such as high blood pressure, heart diseases, joint deterioration, gall stones, diabetes and cancer.

Obese people may be suffering the consequences of a faulty body image.

There is a psycho-physiological connection in the development of obesity.

Generalised weakness, depleted energy, lack of zeal (fatigue of all sorts mental and physical) is one of the commonest symptoms that bring a patient to a doctor's office.

Fatigue appears more usually among people who have no definite purpose in life, those who have too much time, who are bored in the monotony of daily routine. Fatigue may very well belong to the category of attitude problems.

Disorders of the stomach and intestines are very common and sensitively connected to every day situations. Many digestive problems are psycho-somatic in character.

Sexual dysfunctions can be broadly divided into two categories:

1) Changes of sexual drive.

2) Changes in the ability to perform and gain satisfaction.

Almost every study of this problem has concluded that anxiety about performance contributes to sexual inadequacy. In both sexes the decrease in the drive for sex or loss of libido usually has an underlying psychological cause which includes depression, fear, insecurity and guilt.

Sexual activity is good only when its enemies are absent and they are fear, frustration and repression.

Sleep is entirely natural, absolutely necessary and yet mostly still a mystery. Sleep deprivation quickly leads to a loss of wellbeing. When we cannot sleep well, it is our thoughts, worry and anxiety that keep us awake. Good health in general is indicated by a restful sleep. Happy contendet, loving people seldom suffer from insomnia. People ridden with guilt, anxiety and unhappiness suffer it routinely.

Sleep disorders are practically unknown among children. Children can sleep well because they are innocent – Christ said "Unless you are the like little children, you cannot enter into my kingdom of heaven."

Stress is indeed a major cause of

disease and even death. It is implicated now in almost every disease from heart disorders and hypertension to cancer and diabetes. A striking recent discovery about stress is that it depletes the immune system of the body. We may have found the link that connects stress and the development of disorders like pneumonia and cancer. According to Maharishi Mahesh Yogi an authority on consciousness from the eastern perspective "Stress is that which blocks the full expression of creative intelligence".

Depression affects millions of people. During an attack of depression a person feels sad and drained, and lacks the ability to enjoy life. No one clearly understands why such attacks occur.

People who suffer from depression or other psychological maladies are victims of shattered wholeness. The wholeness must be restored from within.

We have seen the common but serious problems such as high blood pressure, heart diseases, cancer, over weight, chronic fatigue, depression, stress and psychiatric illness, we have found that the mind has a crucial role to play in the genesis of all these disorders.

Accidents happen most often to people who are habitually prone to them, who have a characteristic absent mindedness that attracts mishaps.

There is more and more evidence to show that diseases result from disruption in the mind.

Healthy people are happier than unhealthy people and the reverse is also true – happy people are healthier then unhappy people. The physiology effects the psychology and the psychology effects the physiology. In all these above mentioned conditions it is obvious how important the mind is in the causation or alleviation of diseases.

A "Placebo" is a pill made of nothing but sugar and some inert colouring to make it look like an authentic drug. Patients are given it with the information that it is in fact an authentic and powerful medicine.

Now we know that placebos induce the body's own healing mechanism. Placebos may be the best medicine of all. It is as though the mind gave permission so that healing can take place. Norman Cousins writes "The placebo is the doctor who resides within". A belief that a pill can cure can bring about that very result.

Aging is the progressive deterioration of physical and mental functioning that occurs with time, ending with the cessation of all function which is death.

Religious Practices which Promote Health

In experimental animals it has been found that periodic fasting increases their life span. Fasting has traditionally been a part of many cultures and figures in most cultures.

Healthy habits are great forces for health. They can achieve astonishing results that medicines cannot rival. Clean air and water, nutritious food, moderation in all activities, regular physical exercise and a good night's sleep can all be healthy habits.

"Food is Brahman" – according to the Rig Veda

Eating indiscriminately or eating unconsciously, eating on the run, habitually over eating or not eating at all – these are all violations of the natural law.

Innumerable disorders are linked to diet and eating habits. Our bodies know what is good for us. Good eating habits include:

– Paying attention to eating.

– Pausing before eating and sitting in silence.

– Eating only when you are hungry.

– Do not sit down to eat if you are upset.

– Take time to chew food well and slowly.

– Eat in congenial surroundings.

Vegetarian diet
(A diet without meat).

The truth is that the human physiology sustains health best when the intake of meat, fat and proteins is small or non-existent. A diet which is high in meat and animal fat has been linked to coronary artery disease, cancer and obesity.

Benefits of Meditation.

1. Improved health, including reductions of hypertension and the levels of cholesterol in the blood.

2. Reduction in the use of alcohol, cigarettes and recreational drugs.

3. Reversal or slowing down of the aging process.

Hindu systems of medicine, Ayurveda – Yoga, Naturopathy.

Ayurveda means the 'Science of life'. This system traces its origin to Rig Vedic times over 3000 years ago. It deals elaborately with measures to combat illness. It is still widely practised in India and caters to the needs of 75% of the population.

Ayurveda is a supplement of the *Attarvaveda* (One of the 4 vedas). In the post vedic period many treatises were written by sages. They include the *Charaka Samhita* and *Susruta Samhita*.

Ayurveda is a holistic science and lays emphasis on preserving and promoting the fitness of healthy individuals, besides giving methods for the treatment of diseases.

The objective of "preserving and promoting health" in *Ayurveda* is achieved through different modalities, based on principles within its own conceptual framework. It is not a science dealing only with drugs. It is more a 'way of life' and describes methods for the promotion, prolongation and maintenance of positive health. It emphasizes the importance of a specific daily routine and seasonal regimen along with diet, drugs, physical exercise and good personal hygiene to achieve physical and mental health.

Ancient Ayurvedic physicians describe diseases as a disequilibria

of these functional units. The objective of any therapeutic measure is therefore primarily to reachieve a state of equilibrium.

Unique features of Ayurveda

Ayurveda treats a disease in an individual as a whole (body, mind and spirit). Ayurvedic drugs are inexpensive, do not need foreign currency and are free from toxicity. *Ayurveda* emphasises preventive medicine and promotion of health.

Yoga

Yoga is one of the six orthodox systems of Indian philosophy aiming at liberating the soul through perfection. Yoga strives for the full and integrated development of an individual. It can be utilized as a safe and effective method for good health, through mastery of the mind. Along with *Ayurveda*, it dates back to the rigvedic times.

Naturopathy

Naturopathy is based on the art of living according to the principles of nature. Disease is considered as the body's effort to cleanse itself of impurities brought about by faulty living. This nature cure utilizes air, water, earth and sunrays abundantly available in nature for a cure. It stresses the prevention of disease and a proper diet, exercise and rest to maintain health.

Hindu texts on the economy

The Hindu texts which deal exhaustively with the economy are the Manu *Dharmashastra* and Kautilya *Arthashastra*.

They emphasise the importance of creating wealth and describe ways and means of achieving them according to religious principles.

However wealth is not an end in itself. It is useful as a means to achieve the objectives of life.

To live a full life, a life of freedom to live long and to live well. The ultimate objective is to become so purified that one becomes united with God.

The economy and health

There are two Hindu concepts which have been wrongly interpreted as being responsible for the poor state of the Indian economy. The first concept is the value of a simple and modest life style as a means for God realization. Any religious Hindu often has a conflict regarding the value of creating wealth versus his value for God realization. The second is the theory of *Karma* which is wrongly interpreted as the idea that irrespective of my efforts whatever is destined for me will happen. So why should I put in so much effort?

There is this often quoted story in the Sanskrit scripture, the *Brihadaranyaka Upanishad* dating to the 8th century B.C. Maitreyee and her husband Yajnavalkya are discussing the subject of earning money and ways of becoming more wealthy. How far would wealth go to help them get what they want? Maitreyee wonders whether it could be the case that if "the whole earth, full of wealth' were to belong just to her, she could achieve immortality through it. "No responds Yajnavalkya like the life of rich people will be your life But there is no hope of immortality by wealth." Maitreyee remarks, "What should I do with that by which I do not become immortal?"

While there is a connection between opulence, on the one hand, and our health, the linkage may or may not be very strong in all circumstances. Wealth quite often offers freedom from avoidable illhealth and escapable mortality. This is very glaring in the underdeveloped countries where poverty is often the contributory factor in so many diseases. Despite this, it has been shown by Amartya Sen, the Nobel Laureate in Economics, that even though the income per capita of an African American in the United States of America is very many times higher than that of the people of the Indian state of Kerala, the survival prospects of an African American are decidedly lower than the poorer Indians in Kerala. The Hindu system of medicine which is widely practised in the state of Kerala might significantly contribute to this observation.

While there is no doubt that economic development is associated with better health and longevity, it has been shown that poorer communities who are under the influence of religion and traditional holistic systems of medicine can have a good quality of life and life expectancy.

In most of the maladies affecting humanity today it is seen that the human mind has a major role to play. The integration of religion into life and the use of holistic systems of medicine have much to offer towards better health care in the future.

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AFTERNOON SESSION

PASCUAL PILES FERRANDO

The Practice of the Diaconate and Mission in Health Care

1. Introduction

I extend a cordial greeting to H.E.Mons. Javier Lozano, President of the Pontifical Council for Pastoral Assistance to Health Care Workers, to the presidential group, and to all the participants at this assembly. A special greeting to Mons. Julian Harranz, President of the Pontifical Council for the Interpretation of Legislative Texts, who is here present as chairman.

I would like to express my gratitude for the invitation I received to give a paper, which I have prepared with great care, in my capacity as General Prior of a Hospital Order, on my pastoral ministry of fostering and promoting activity within the Order. I am not a researcher. I consider myself a pastor who formulates his concepts beginning with reality, trying to make them suitable to that reality. My thought and observations must be linked to practice, taking as its starting point pastoral experience, which during my thirty-five years of religious life, I believe, in humble fashion, to possess, and which gives me the confidence to be able to discuss the subject which is here under consideration.

The title of my paper – "the practice of the diaconate and mission in health care" – limits our field to two concrete areas: that of the diaconate and mission, and that of health care. I will try to discuss them in a rapid way from a historical point of view. I will then offer certain observations regarding what the presence of the Church as diaconate, and thus as a bearer of health, fundamentally means, something which also signifies presence within health care. This will be done taking into account that the subject of this XIV international conference is "the economy and health".

2. Terminological Clarifications

The term "diaconate" comes from the Greek word *"diakon"* which means service. We can commence this reflection on our subject beginning with the service that I believe the Church has rendered to sick people through sound and valuable health care. In this approach we will interpret and dwell upon the term "mission", which comes from the Latin *"missio"*, and refers to the message received from the Lord to bear witness to the Good News in the world of health and health care.

When speaking about health care we enter to the full in the meaning which today concern for the health of people actually involves. We have made great steps forward in this concept and in developing the social conscience of peoples. Today in many countries we have reasonably adequate services, although in others these such services lacking. We have passed from a concept which sought to cure the illness to one which places health at the centre of things. This is certainly not everything but it is a step forward because it places the accent not only on the illness but also on health. Health and illness refer not only to the physical aspect but also to the totality of the person. For Christians, which we are, there should be added the factor of the salvation brought to us by Christ.

3. The Mandate of the Lord

We will refer here to what the New Testament tells us about the subject of health, about the concepts of hospitality, illness and treatment.

At the beginning of his public life Jesus of Nazareth was aware of his own mission. In chapter 4 of his Gospel St.Luke captures this awareness with clarity: "The Spirit of the Lord is upon me; he has anointed me, and sent me out to preach the gospel to the poor, to restore the broken-hearted; to bid the prisoners go free, and the blind have sight; to set the oppressed at liberty, to proclaim a year when men may find acceptance with the Lord, a day of retribution. Thus he shut the book, and gave it back to the attendant, and sat down. All those who were in the synagogue fixed their eyes on him, and thus he began speaking to them, This scripture which I have read in your hearing is today fulfilled" (Lk 4:17-21).

Jesus presented himself to men as a physician: "It is not those who are in health who are in need of the physician, it is those who are sick. Go home and find out what the words mean, It is mercy that wins favour with me, not sacrifice" (Mt 9:12-13). The mission of Jesus is identified with the figure of the medical doctor who seeks out the person who is sick in body and spirit, and provides care and salvation.

The Gospels are full of tales of healing. Jesus himself sums up his work: "Go and tell John what your own eyes and ears have witnessed; how the blind see, and the lame walk, and the lepers are made clean, and the deaf hear; how the dead are raised to life, and the poor have the gospel preached to them" (Lk 7:22). Jesus himself defines the work carried out during his public ministry, himself giving us an example which should be followed by going, teaching, and healing.

The Gospels also inform us about the mandate which was given by the Lord to the apostles: "And he called the twelve apostles to him, and gave them power and authority over all the devils, and to cure diseases,

sending them out to proclaim the kingdom of God, and to heal the sick" (Lk 9:1-2). "So he called his twelve disciples to him, and gave them authority to cast out unclean spirits, and to heal every kind of disease and infirmity" (Mt 10: 1).

Accepting and acting on the mandate given to them by the Lord, the apostles thus began their work: "So they set out and passed through the villages, preaching the gospel and healing the sick wherever they went" (Lk 9:6). "So they went out and preached, bidding men repent; they cast out many devils, and many who were sick they anointed with oil, and healed them" (Mk 6:12-13).

4. The Response of the Apostolic Church

In addition to what is related in the Gospels we find a number of examples of healing in the Acts of the Apostles. The action of the Apostolic Church was growing. Its faith was accompanied by signs of healing: "but they used to bring sick folk into the streets and lay them down there on beds and pallets, in the hope that even the shadow of Peter as he passed by, might fall upon one of them here and there, and so they would be healed of their infirmities. From neighbouring cities, too, the common people flocked to Jerusalem, bringing with them the sick and those who were troubled by unclean spirits; and all of them were cured" (Acts 5:15-16).

St. Paul observed that amongst the charisms to be found within the community of that time was that of the gift of healing: "The revelation of the Spirit is imparted to each, to make the best advantage of it. One learns to speak with wisdom, by the power of the Spirit, another to speak with knowledge, with the same Spirit for his rule; one, through the same Spirit, is given faith; another, through the same Spirit, powers of healing" (1 Cor 12:7-9).

The Letter of James refers to the ministry of healing through the action of the presbyters and the prayer of the community: "Is one of you sick? Let him send for the presbyters of the church, and let them pray over him, anointing him with oil in the Lord's name. Prayer offered in faith will restore the sick man, and the Lord will give him relief; if he is guilty of sins, he will be pardoned" (James 5:14-15).

During the time of the Apostolic Church we can already encounter the need to distribute tasks. Some members dedicated themselves to the ministry of the word and others devoted themselves to the needs of the community: "Come, then, brethren, you must find among you seven men who are well spoken of, full of the Holy Spirit and of wisdom, for us to put in charge of this business" (Acts 6:3).

The practice of the diaconate within the mission of the Church subsequently began to take form. Later on, in his work *Didascalia Apostolorum*, St Polycarp of Smyrna addressed deacons and exhorted them to base themselves upon Christ and be merciful, diligent, and the servants of everybody (III, 13:2-4). *Lumen Gentium* carried on the same criterion and outlined what the diaconate involved, being: "dedicated to the offices of charity and care" (LG 29).

5. The Historic Response of the Church

From the historical data and information that we have available, we can affirm that the Church was responsible for the organisation of different kinds of hospital activity, ranging from hospitals to care centres. These were institutions which catered to the needs of pilgrims, the sick, and orphans. There were then held the great Councils and Synods: of Carthage, of Nicea (325), of Tours (567), and from these encounters arose the obligation to create buildings offering accomodation next to churches and to take care of those who were in need, the sick, and widows.

Roundabout 370, St. Basil, the Bishop of Cesarea and Cappadocia, created a structure called "Basiliad", and this institution can be seen as the first authentic hospital establishment: it was a small accomodation building, a shelter, a hospital, and a lepers' colony.

In the cities there appeared different kinds of hospital structures: the xenodoquiums to take care of pilgrims; the noxocomiums for the sick; the procotrofiums for the poor; the gerontocomiums for the elderly; and the orfantrofiums for abandoned and orphaned children. This took place both in the East and in the West.

Monastacism was present in this field with the construction of health care centres next to monasteries where the monks acted as medical doctors, nurses, and herbalists and provided service to sick people as well.

With the passing of time the development and growth of the charitable project of the Church acquired greater size and increased in organisation. Members of religious orders and the lay faithful both took part. Roundabout the year 1000 various Orders came into being, some of which were secular in character and had the purpose of taking care of the poor, the sick, and abandoned children.

An important phenomenon of this period was the coming into existence of the confraternities – associations of men and women who took care of new needs and cared for the sick and those who were in need.

The poor person is an image of the suffering Christ and for this reason in the various statutes of these confraternities we can encounter statements such as: "our sick lords, our poor lords".

In the ecclesial context which followed the Council of Trent there appeared the figures of John of God and Camillus of Lellis, reformers of the world of health care who through their example gave rise to two great religious Orders. I think I can safely say that in that period there took place a change which led to a secular concept of reality which left behind it the primarily religious approach.

Thereafter, in recent centuries, a progressive process of care has taken place. Technical methods have imposed themselves but this is something which has brought with it a loss of those humanising elements which should accompany the provision of care and treatment.

We can state that during this progressive process, when governments were scarcely present in the welfare field, the Church, aware of her mission to envagelise by healing, ensured that there was a constant service – the diaconate – which was offered by members of the lay faithful and members of religious orders through institutions created for the sick and for those in need.

The Gospel of charity, in all

epochs, has written pages of holiness and devotion to others. Many saints have dedicated themselves to their neighbour, bearing witness through their love to the Gospel, building the Kingdom, and making the world more human.

6. The Present-Day Situation

I have given this introduction in order to call attention to the presence of the Church of Jesus Christ from the beginnings of her existence to the present day. Today, Christian health care workers are called upon to be the living image of Christ and his Church in their love for the sick and for those who suffer. "It is necessary that this most precious heritage, which the Church has received from Jesus Christ, "Physician of the body and the spirit", must never diminish but always must come to be more valued and enriched through renewal and decisive initiatives of pastoral activity for and with the sick and suffering" (*Christifideles Laici*, 54)

In her diaconate of health the Church sees the centrality of the sick person as an inescapable priority.

In *Salvificis Doloris* John Paul II confirms this when he declares: "the Church is called upon to search for the encounter with man in a particular on the way of his suffering. In this encounter man becomes the way of the Church, and this is one of her most important ways" (*SD*, 3).

This is confirmed by the bishops in the final message of the Synod on the vocation and the mission of the laity in the world. Addressing themselves to the sick, they declared: "we will do everything possible so that you find the position which is due to you in society and in the Church" (*CL*, 53). The sick person cannot be seen merely in terms of his passivity, as solely a person with a need which must be met. He is the active and responsible subject of the work of evangelisation and salvation (*CL*, 54).

All this has political, social and economic implications which are very precise and specific, and which we cannot continue to ignore. To place the sick person at the centre of things means placing resources at the service of values which find their synthesis in love. And all this in order to favour the quality of life.

Our mentality is heavily conditioned by efficiency and effectiveness. At times cost-benefit ratios and economic constraints make us lose sight of the duty to take care of the needs of the patient. The problem of existing resources, of their use and distribution, is the most difficult problem we have to face; it is the question which provokes the greatest discussion and the most heated controversies. A harsh struggle to reduce the costs of health is now underway. All these issues have been addressed over recent days. Today we can practice our diaconate in the world of health and health care by knowing about them and by seeking to throw light upon them.

The Holy Father Pope John Paul II in his Encyclical *Centesimus Annus* reminds us that the logic of the market, when left to itself, cannot be reconciled with justice, first and foremost because it does not take responsibility for, or cater to, the fundamental human needs of the weakest among us: "there are many human needs which find no place in the market. It is a strict duty of justice and truth not to allow fundamental needs to remain unsatisfied, and not to allow those burdened by such needs to perish" (*CA*, 34)

The centrality of the sick person requires that we struggle to meet and respond to the needs of those who, in so many instances, are the last. We must promote a style of implementation that perceives the spiritual needs of man, and which places in mutual harmony the needs of the health of man and the need for his salvation.

7. Directions and Policies to Follow in our Diaconate and Mission in the World of Health Care

7.1. Our Diaconate as Witness to the Church of Charity

The Gospel of Christ is clear. He came to proclaim the Good News and he proposed to us the Gospel of love. Two things are fundamental: to love God and to love our neighbour (Lk 10:22). Our faith is summarised in this central tenet. James tells us that faith cannot exist without works (James 2:17). And St.Paul, for his part, declares that without love we are nothing (1 Cor 13:2).

In *Dives Misericordia, Salvificis Doloris* and *Evangelium Vitae,* His Holiness Pope John Paul II has more than once repeated that we must act, that we are called to create a civilisation of love.

In today's world, hospitals, which are places of suffering, are actually more frequented by people than our parishes. In these places of suffering men ask themselves fundamental questions about the meaning of their existence: Why does suffering exist? Why has this happened to me? Why has this happened to my family? These are questions which very often do not receive an answer; they are questions which are addressed to God, even though at times the speaker is not a religious believer.

To a God who is Love and who is remonstrated with for being without love. To a God who is presence and who is rebuked for being absent. Our God, the Father, always loves us. Our God is never absent in our reality, although at times He is silent, because for Him it is normal to act without changing the laws of history; it is normal for Him to accompany the paths of people beginning with their own reality.

This God who is not always listened to is always Love, and being Love, He suffered in Jesus Christ the powerlessness of the experience of his own Passion and Death, the Son who accepts the will of the Father.

Health care workers have the good fortune to be called to evange-

lise within the Church through these actions of charity. We must use the word and prepare ourselves to know how to use it, but above all else we must use silence, actions, senstivity, and we must perceive and sense the needs of the sick person and his family relatives. We know that an approach of nearness creates very many personal bonds. We are linked to very many people for whom our actions have been liberating, have been the carriers of life, even though the sick person may be dead and his family has suffered because of his passing. We are the Church of charity and we must continue to commit ourselves to the construction of the civilisation of love.

We can never ignore the real meaning of the mission of our vocation. We must carry out our action with technical prowess and professional skill, but at the same time we must have approaches which express nearness, presence, listening, dialogue, sharing, and concrete help (*CL,* 54).

7.2. We are the Bearers of the Good News to the Poor and to the Sick, thereby Defending them

As was observed at the beginning of this paper, Jesus of Nazareth defined himself as the anointed of the Holy Spirit who had been sent in order to bring the Good News to the poor and to heal the sick.

The Church, which continues his mission in the world, must do likewise.

The brief historical outline which has been given shows how the Church has been sensitive to the needs of mankind. She has been near to the poor and the sick. When she has drawn away from them she has needed charasmatic people who have made her turn back to her real mission, that mission which she received from her founder.

Dwelling upon the role that she should play in the world of health care, we can say that today the Church defends the health care rights of all people. The sick person, because he is a person who finds himself in the most visible conditions of vulnerability, is poor. If, in addition, he is not defended, not because of his own means but because of a lack of social means, then he is doubly poor.

We must be the defenders of a health for everybody. In many places the Church continues to play in the present, as in the past, a role of substitution because the social structures are inexistent or inadequate. There is a great deal of space for action. Even when it seems that the best conditions exist for health care, some aspects of the lives of sick people lie beyond social care and concern and the Church has the task of supporting and being near those who suffer to ensure that they are cared for in a holistic way.

The parable of the Good Samaritan describes very well the sensitivity and sensibility which every health care worker should possess. John Paul II captures this point in *Salvificis Doloris* (28-30). The Good Samaritan stops and does not pass by, he takes up the cause of the person he has encountered, he feels compassion towards him, he is ready to provide what is needed, and he helps him.

Our task is to care for, and treat, the sick person, to be sensitive to, and concerned about, his needs, to provide him with a voice when he cannot be heard, to make up for his vulnerability with our readiness to help so that the rights he possesses can be respected.

7.3. We are the Promoters of Health Care for the Person

We are now entering the third millennium. The century that is now coming to a close has witnessed

levels of progress in our technology and technical methods which have never been previously achieved in our history. This is an unstoppable process. Day after day we are surprised by new discoveries, by new tools and instruments, which enormously facilitate the task of transforming the earth. And the earth was entrusted to our keeping by God our Father.

In the field of medicine this is very evident. The diagnosis of illnesses is facilitated by new instruments available to us in laboratories, in the field of radiology, in the areas of surgical, chemiotherapeutic, and radiotherapeutic analysis, in pain-killing methods, in forms of intensive care, through dialysis, and so forth.

Everything should be at the service of the person. Our important role should be to ensure that technical and technological culture is placed at the service of the wellbeing of mankind. We cannot make a bad impression on people by using ridiculous concepts, which are far from what science itself does, in order to help others. Some projects which we have proposed and which we implement seem to be more linked to a justification of our ignorance than to the service which we are called upon to provide.

At the same time we have the great task of promoting the humanisation of care, of ensuring that the sick person is treated with quality and warmth, with the brain and with the heart, bearing in mind all his biological, social, psychological and spiritual needs.

A great human quality is asked of the health care workers we are: that of humanising ourselves in order to humanise. This is a slogan that we have used in our institution, which in essential terms requires a whole programme of implementation at the level of individuals and structures. The people of the Church, whether male and female members of the laity, male and female members of religious orders, or priests and bishops, all have a major role to play. We run the risk of offering people the very best at a technical level but of neglecting what they need at a human level.

In my institution I have repeated this concept very often wherever I am within it. This is one of the fundamental principles of our foundation and must be a categorical im-

perative for us. John of God was treated as a madman in the Royal Hospital of Grenada in Spain during the first half of the sixteenth century. His first biographer informs us how, because he had been treated with so little humanity and also seen how his companions were also badly treated, he became convinced of the need to found a hospital where sick people would be treated as he himself wanted.

This is our challenge. The challenge which faces our Order and the challenge which faces the Church. We must promote humanised medicine and car. We must promote humanised health care.

A chronic illness, a long illness, and death, cause fractures and a great deal of suffering. We have to know how to act within this situation of conflict in an excellent way. Adequate information, the right treatment, the due sensitivity, all these elements ensure that people deal with their difficulties in another spirit.

A diaconate that we are called to carry out, that is to say the mission that the Church must fulfill today in the world of health care, is that of fighting for the practice of holistic medicine and care. The Church must do this with words and defend it with her own voice. She must do this with a profoundly humanised devotion to her professional workers, who, at both an individual and and institutional level, can ensure that health care is centred upon the person, on everything that he, in his illness, needs.

7.4. We Must Fight for a Suitable Distribution of Resources

We who are directly concerned with care are responsible for our service. But we cannot neglect the role which has been performed in history and which we are called to continue in the present day.

It is not up to us to organise our societies in a political sense but to fight for a just distribution of resources in favour of people.

Because of the service which I am now called to render through the Order, I have personal knowledge of the many and great differences which exist in our world.

The Church is called to be a social conscience, to constantly insist in every circumstance.

At a universal level there exist great differences between the North and the South of the planet. Although this situation is well known there is still no path that will lead to its solution. The voice of the Pope, of the bishops, our voice, in the same way as the representatives of institutions, must be the voice of those who have no voice.

Although we know that we will not be listened to, we must nonetheless be constant and not halt until the world has been made a juster place.

The initiative taken by the Holy Father, who on the occasion of the Jubilee of the year 2000 asked for public debts to be remitted, brings out the force of his word which, together with others, is mobilising – albeit slowly – the necessary process of justice and fairness.

The Pope declared: “the Jubilee should be a suitable time for thinking, amongst other things, about a substantial reduction, if not the total remittance, of the international debt which burdens the destiny of many countries” (*TMA*, 51).

In the countries where we live we must be a force which fights for fairness in the distribution of resources in favour of health care. There are political circumstances which mean that social resources are allocated in line with one policy or another, according to precise interests. Subjects such as defence, electoral propaganda, economic support, etc. are at times favoured over services which we are called to promote in order to meet the needs of citizens.

In our countries we must be a force which opens the conscience of our politicians, which stimulates them to support developing countries. We must also be a conscience in favour of a distribution of the resources which a state has available in support of people who need a great deal of help because of their vulnerability. Every category of sick people, the elderly, social problems etc, although they are not remunerative, must be supported by us because they represent those who are most in need.

The Church, in addition, is responsible for many institutions which, in order to carry out their mission, must be able to draw upon public resources. In equal circumstances we do not always receive the same treatment. We must fight to be seen in relation to the levels of quality care that we offer, elements that are integrated into the spaces of services which our community of citizens needs.

I believe that we should reflect upon what both historically and at the present time has been and is offered by us to the population, and to what extent certain institutions can be defended in terms of providing a good spirit of service and diaconate on the part of the Church.

7.5. We are the Managers of Public and Private Resources

As a Church, the professional workers of the health care field have a diaconate to fulfil in relation to the actual administration of health care. We must provide levels of salaries which are in line with the social doctrine of the Church and the status systems of the society to which we belong. We must, in addition, work to ensure that the resources which are available to us are well employed to the benefit of society and the sick people that we care for.

We must look after the structures which are available to us, have a normal approach to the saving of energy, take care of our equipment, and not engage in what would be an unsuitable use of resources. In essential terms, this is something which works to the benefit of everybody.

Some of us probably direct public institutions. For the good of society, and for the good of the patients, the systems of management must be

sound in order to use adequate resources for the service for which we bear responsibility. We must also engage in an evangelical style of management of the institution that we represent.

Some of us are the heads of our institutions and work to ensure that they are recognised by the public sector and work for the private sector. We are also called to carry out management in an evangelical way.

At times management is the bugbear of institutions. Good management is a service of diaconate. Budgets, analytical accounting, the participation of the staff and personnel, the fair distribution of resources in the various services of the hospital centres, the satisfaction of the staff and personnel, shared management – all these are elements which must not be forgotten about.

Although many people do not feel so called, we should not as a result criticise in a facile way the heads of this section which is necessary to our health care. We want to be prophets. If at times we are not prophets because we do not talk, at times we are not even prophets in what we do say. As a result we do not engage in a sound diaconate.

We must be witnesses to correct management which is carried out with clarity and fairness and based upon the principles of the social doctrine of the Church, without profit-making goals and in an evangelical way.

In addition to the use of public resources or that income that we receive as payment for the services that we provide, there continue to be people who trust us and provide us with their financial support so that we can continue with our work of charity towards poor people who are sick, those patients of our countries who do not possess financial means. It is up to us to distribute such resources in favour of those most in need according to the needs of the various institutions for which we are responsible.

7.6. We Must Promote a Spirituality of Service: the Kenosis-Diaconate Relationship

Christians, whether health care workers, priests, members of religious orders or members of the laity, have their own spirituality, that of service, which takes as its own starting point their own identity, their own profession.

In our Hospital Order we have defined what St.John of God was in terms of a process of kenosis-diaconate, the same process as took place in Christ: “he dispossesed himself, and took the nature of a slave” (Phil. 2:7). In this way he took on great opportunities for service – that of offering us the Good News of salvation, of liberation, and of healing.

The generous service of health care workers presupposes this same process; it presupposes professional and human training and grounding. Those who have the vocation to health must be people who are sensitive to, and concerned with, the needs of others, people who have striven to eliminate their own self-interest, selfishness, and kenosis, in order to direct themselves to the diaconate. This is a process which we are all called upon to engage in.

In doing this we are helped by sharing in the suffering of other people. We are helped by contemplating the reality of conflict and suffering which surrounds us.

Christ took on this same reality. He is the man of pain. He identifies with the sick in Mt 25:36. In contemplating and accompanying the reality of each and every sick person we find the source of our spirituality, our way of acting as health care workers.

We must prepare ourselves to offer the service which sick people need with professional quality. We must prepare ourselves in human terms in order to live the strength which hosptality has inside it in the experience of service. We define charism as the gift that God grants us and which enables us to carry out our mission. This mission is the source of the enrichment of the gifts of the charism and the spirituality that the charism itself generates.

At times we feel that our activity drains us of the contents of our spirituality and that we need spaces of prayer with which to fill our spirit. I am a strong defender of our spirituality, that of the Christian health care workers, that of the priest, that of the female member of a religious order, and that of the male member of a religious order, people who are dedicated to those who suffer, who read through their faith the reality of the world of illness, of the processes of the very many sick people that we have accompanied, who greatly enrich our spirit. Our action is a great richness, and I see it as a grace. Those who work with the suffering, and open themselves to God and other people in accompanying suffering, enrich their being, their spirit, and find in such action a great source for their own spirituality.

With time they deepen the essence of hospitality and increasingly become real “hospital” people.

With this observation I do not want to eliminate prayer from our lives, but rather to strengthen the absolute necessity for it. I believe that prayer constitutes the framework within which we can bring our feelings and the needs that we find when we come into contact with sick people. In prayer we must tell the Lord what we feel in our relationship with the suffering because He has invited us to engage in mission. He is with us when we are with the sick.

I believe that this kind of idea leads us to focus our being, and this is something which breaks the dichotomy of action and contemplation. I believe that our action is a major source for our spirituality, our ability to grow, an origin of life in the Spirit.

7.7. Our Sprituality has a Social, Cultural and Political Implication

Our lifestyle, the substance of our

spirit, of our being, has a dimension of presence in our world.

We are people dedicated to politics, but we should not as a result forget the "polis" within which we live, and we must pay attention – for our good and for the good of the people we take care of and treat – to the things that take place within the polis. Our diaconate has a political aspect; our spirituality has a political aspect.

We must know the principles that are put into practice by those that govern us, along what lines such people determine the character of laws, the values that they promote, how they distribute resources, and this so that it is really the human person, and not other interests, who is the centre of their services, thereby ensuring that the sick person is at the centre of all our action of care.

At times, because of false pietisms, we want a diaconate which is detached from these concepts – we think that it is a value to be distant from public life, to be far away from certain commitments which in essential terms have beneficial results for everybody.

When I am asked about this subject I remember the section on Jesus and his priestly prayer which is related by St.John. Jesus in this section calls upon the Father to act on behalf of his disciples whom he had sent out on their mission and who are engaged in a diaconate: "I am not asking that thou shouldst take them out of the world, but that thou shouldst keep them clear of what is evil"(Jn 17:15).

I answer in the same way when I am posed this question by my brothers, and I make this concept our own today in order to have a spirituality which helps us to be within our health care polis, to have a social conscience, and to put into practice the cultural concept which care now requires: "Lord, I ask you to make us know how to be at our posts, to ensure that nothing escapes us that is required by our mission, that is called for by our diaconate, our service in the world of health care. I ask you to give me the capacity to do this as a real service to the Kingdom".

7.8. Our Diaconate Requires Constant Up-dating

If science follows a path of constant progress, if we cannot achieve health care without the use – to the extent that this is possible – of what technical capacities make available to us, then suitable service to the sick person requires our own constant up-dating.

This is required at a human level. We must have the human quality that our mission requires. Our lives must lead us to achieve constant growth in the values that define it and which ensure that our profession is always at the service of other people.

This is required by the psychological approach to the needs of the sick person. To be a sick person today is not the same as it was fifty years ago. We have created a society of wellbeing and prosperity and given rise to new needs which cannot be forgotten during illness. Although we have technically specialised institutions to treat the culminating moments of a process, all of us must also know how to meet the psychological needs of our patients.

This is also required by the social concept of illness. We know that the illness of a child places the whole family in a state of uncertainty. We know that the illness of the father or the mother of a family provokes upsets in the habits of the family. We know that the illness of an elderly person shakes a series of families, according to the case in hand, who enjoy independence and have different obligations. All this requires study, and the possibility of treatment, by technicians who deal with these social aspects of illness, but it also requires the health care professionals to become the path to, and the instruments of, this treatment.

This is required by the ethical concept of care. Bioethics is a science of our times. Enlightened by the Word of God and by the Magisterium of the Church we want to engage in an ethical approach to the different situations which present themselves at the moment of birth, during life, during illness, and at the moment of death, all of which require of us adequate training and treatment in our institutions, so that such institutions can take the right decisions in their day-to-day and exceptional actions and initiatives.

This is required, too, by the spiritual approach, which each person has according to his own identity. If we are dealing with agnostics we must be present with human actions which make them perceive the value of a life dedicated to other people, and which helps them in the already difficult process of illness. We must do this with sensitivity and sensibility, with our loving care, and with our cordiality. If they are believers belonging to other Christian denominations or to other faiths we must act in a way which respects their identity and with a readiness to provide them with the services which are required by their creed. If they are Catholics we must help them to see life as an opportunity to obtain salvation in Christ, even during illness, suffering, and death.

In this sense there exists today a great promotion of the pastoral services provided by public and private institutions. In our centres we must foster the promotion of a suitable implementation of such care so that during periods of illness, admittance to hospital, and death itself there is an opportunity to understand life in the deep and eschatological meaning of faith.

All this means that our vocation requires a constant training which must be promoted in relation to everybody. Its denial would involve not understanding the needs and requirements of our diaconate and our mission as a Church in the contemporary world of health and health care.

7.9. We are Witnesses of the Fact that Faith is a Source of Health

We do not want to adopt ideas

about miracles in dealing with care and treatment. When He sees fit God acts directly or through intermediaries in a way that surprises us. His works are elements which help to strengthen the faith of our believers, our own faith, and touches the feelings of the most indifferent and the most agnostic.

Our diaconate, our mission as a Church in the world of health care, leads us to be witnesses to our faith. A faith lived out in the Father in all circumstances, a faith lived out with an eschatological dimension, committed to the building up of the Kingdom, in the here and now, but for which we feel called one day to eternal life in Christ.

Our faith has been subjected to questioning. It has been said that it is the outcome of our own projection, and that God does not exist. It has been said that it is a neurotic experience of reality which we have used as an instrument by which to silence the consciences of people, to promote a fatalistic conformism in relation to destiny, and so forth.

From my own personal experience I can say that nothing could be further from the truth. We can be mistaken incarnations of our faith, but through service to health, through our diaconate and mission in the world of health care, we are called to proclaim that the opposite is true. Our faith has a unifying and healing function in relation to people.

Christ came to save, to heal, to treat and to free. He wanted people to live out their lives with meaning, taking on each reality which our limited being has within it – the joys and the sadnesses, health and illness.

God is a source of health for the person. His presence amongst us fosters and aids brightness and interior oneness. Our faith, if well lived out, is a factor which works for the maturity of the person.

Hence the fact that in the world of health care we live out the diaconate of faith as a source of health, with an adult and mature approach. We do this when we help the sick – while at the same time respecting their feelings – to know the presence of God in the lives of everybody (and God always loves them), even though illness may have appeared in their lives as an expression of their limited natures. To believe in God, to believe in Jesus Christ, makes possible a healing action with respect to the sick person's being which unifies his reality and strengthens within his inner being those vital energies which are of help in the process of care and treatment or which help him to accept the very harsh reality of leaving this world to enter into a life which is without end.

8. Conclusion

The Church must be a healing factor within society. She must help its citizens to understand the meaning of health, and aid them in learning how gain health and how to keep it. She must help people to discover the meaning of illness, how to live out the process of care and treatment, and how to accept what cannot be cured.

We health care operators are called upon to continue within history the role which the Church has always performed through the exercise of her diaconate and her mission in the world of health and health care.

I would like to finish with an exhortation: that we place all our trust in this task. In essential terms, when speaking about the economy and health, we are dealing with a productive concept. Christ has been for us a great witness. In her history the Church has had very many witnesses. Next Sunday, the twenty-first of December, one of our brothers will be canonised, the General of the Order, the founder of the Hospital Sisters of the Sacred Heart, the restorer of the Order in Spain, Portugal and Mexico, who knew amongst other things how to fulfil his own diaconate by placing the economy at the service of overall health. Let us imitate him.

Fra PASCUAL PILES FERRANDO,
General Prior of the Hospital Order of St. John of God.

CARLOS TALAVERA RAMIREZ

The Christian Communication of Goods: What Should be Done?

To the lame man who asked for alms outside the Beautiful Gate of the temple, Peter said: "Silver and gold are not mine to give, I give thee what I can. In the name of Jesus Christ of Nazareth, rise up and walk" (Acts 3:6). These words well illuminate the subject which has been entrusted to me for the paper I will deliver here today. A very large part of mankind does not receive the basic health care that it requires and needs. The problem of relative costs – which taken together would not endanger the economy of the world's nations – cannot be solved because those who could provide a solution to this problem do not have the right mentality, understanding and commitment when it comes to the question in hand. The Church, for her part, like Peter in the New Testament account of the above-mentioned event, because she has in her possession something which is not thought to be a practicable solution, can and must give "what she has", that is to say what she has received and continues to receive freely and endlessly – namely, the charity and the power of the risen Jesus Christ. These elements are always necessary in providing a solution to this problem and to all the problems which face mankind.

1. The Christian Communication of Goods is an Experience of Faith

Material goods can be communicated for a variety of motives and in a whole host of ways. In particular, however, the Christian communication of goods is the outcome of faith in Jesus Christ. He makes us see him in all human beings, and especially in the poorest of our brethren, and provides us with trust in his power to heal all forms of illness and pain, whether they are psychological or spiritual in character. This springs from the Christian virtue of charity, a gift of God placed in the heart of man which grows in relation to how much faith is practised. The Christian communication of goods is carried out in relation to how much we live out our faith in Jesus Christ. Thus it was that Peter and John, when asked about the miracle which had been performed, asserted in a strong way and full of faith in Jesus Christ: "God has raised him up again from the dead... Here is a man you all know by sight, who has put his faith in that name, and that name has brought him strength; it is the faith which comes through Jesus that has restored him to full health in the sight of you all" (Acts 3:15-16).

As a result of his personal encounter with Jesus, Zacchaeus was able to say: "I give half of what I have to the poor" (Lk 19:8). And in the first Christian community: "all the faithful held together, and shared all they had, selling their possessions and their means of livelihood, so as to distribute to all, as each had need" (Acts 2:44-46). Thanks to this personal encounter with Christ, they attributed less value to material goods than they did to the people of their community. Today as well, the Christian communication of goods comes from a personal encounter with the living Jesus Christ. In the post-synodal exhortation "Ecclesia in America", the Pope observes that solidarity amongst men comes from the Encounter with Jesus Christ through conversion and communion.

The giving of alms is a good thing; charitable works have always worked to bring individuals and peoples closer together; and social assistance is necessary. But the Christian communication of goods has deep roots and comes from the interpretation of human life generated by the encounter with the living Jesus Christ. The abundance and effectiveness of gifts cannot take the place of this vision and its roots. However, we must not forget that the concrete actions by which we help those in need often become the path which leads to faith.

The encounter which Saul has with Jesus changes his approach towards Christians, whom prior to that moment he did not understand: "why do you persecute me?... I am

Jesus whom Saul persecutes" (Acts 9:4). The Christian communication of goods cannot be reduced to the individual giving of alms – it is the ecclesial action of those who believe in Jesus Christ. After his encounter with Jesus, Paul said: "the reality is found in Christ" (Col 2:17), and not in isolated believers. These last, united to Jesus, make up his Body, a living organism whose *life* is the Lord Jesus and whose unity is life. The Church, a living body, is healthy when there is intercommunication between all its parts and when there is suitable organisation. This unity of life leads everybody and each individual to say with Paul: "does anyone feel a scruple? I share it; is anyone's conscience hurt? I am ablaze with indignation" (2 Cor 11-28). The life of Jesus flows abundantly amongst us and fills the Church with health when "we are in communion with the Father and the Son Jesus Christ", thereby establishing communion between all our brothers and sisters, the parts of the Church.

Solidarity is the virtue which corresponds to awareness of the interdependence of all people and of all the peoples and nations of the world "as a determing system of the relationships of the present-day world".[1] "It is a firm and persevering determination to commitment to the common good; that is to say, to the good of all people and every person, so that all people are responsible for all people".[2]

The Christian makes God present amongst men and this divine presence is made real through the act of solidarity which is "collaboration".[3] Every human being needs the collaboration of other men to achieve his fulfilment. The Christian collaborates in the construction of men by helping them to become subjects of their own development, so that by their own actions they can obtain human health and fulfilment.

To the extent that we develop the physical, psychological and spiritual capacities which God has given to us, we will be capable of performing, in a responsible fashion, that role which is ours in the divine work of the construction and perfecting of man, both in relation to his own person and that of other people. We build men by collaborating in the development of their capacities, by encouraging them to shoulder their responsibilities and to take full advantage of all the opportunities which have been given to them by God. Following the example given by Peter and John in the presence of the lame man, the members of the Church of today's world are called upon to say to those who so need it: *"in the name of Jesus Christ of Nazareth, rise up and walk"*.

The deepest reality of the Christian communication of goods is not to be found in the giving of alms, it is not a matter of welfare. It is the charity which builds man implemented through the application in real terms of the creative imagination. It is helping man "to collaborate" in the divine work of making him achieve fulfilment. Nobody, not even God, can provide man with fulfilment if man does not do what he should do.

The earth was given to us so that we could steward it "with holiness and justice" (Wis 9:3). In the earth we find what we need to achieve the good of every man and of all men, including the fundamental good of health. Through our work these goods become useable and we become better men. For this reason, through the earth and work we must achieve the common good of mankind. A merely economic vision of work deprives it of its deepest meaning, which is the fulfilment of man, both in relation to the person who performs it and with regard to those who benefit from it.

The goods of the earth and the fruits of work are the fundamental wealth of mankind. They exist for the good of all men. The Christian communication of goods brings about and renders effective the distribution of goods. It is an instrument by which goods reach their universal destination through the work of all. The stewardship of these goods must be practised in a correct fashion, and here we find the basis of the value of ecology.

The Christian communication of goods requires the exercise of freedom and freedom strengthened and guided by the action of the Holy Spirit. It gives an impulse to economic effectiveness, to social justice and to the constant creation of new ties of unity between men.

Health is a "harmonious process of physical, mental, social and spiritual wellbeing which enables man to carry out the mission for which he is destined by God, according to the stage of life in which he finds himself". To be real and to be a good of every person, it needs the Christian communication of goods. The health of mankind, even more than the economy, needs the spirit of faith which lies behind the joy of seeing every man grow and develop.

2. The "Civilisation of Love", Work of the Christian Communication of Goods

"The wisdom of fraternal love, which has characterised by virtue and by works – which rightly define Christians – the historical journey of the Church", proclaimed Paul VI in prophetic fashion, "will explode with new fecundity, with victorious happiness, with regenerating social force... The civilisation of love will prevail over the trials of implacable social struggles and will give to the world the dreamed for transfiguration of a finally Christian mankind".[4] And for their part the bishops of Latin America, gathered together in Puebla, made an appeal for the Church to become "the place of communion with God

and all men, in order to build the 'civilisation' of love".[5]

In the Christian tradition, the goods which Christians should share are material and spiritual in nature. Not everything can be exchanged through the instrument of money. Those things which are the most important do not have an economic value. The Servant of God Mother Teresa of Calcutta addressed the following words to us at an international meeting of Caritas (my version is only approximate): "I hope that you, professionals of charity, will not forget charity. In order to explain to you what I mean I will tell you about something that happened to me. As I did every night I went out of the convent to go into the streets and help poor people. One of them asked me for charity; he was sitting on the pavement. I drew near to him and he was hoping that I would give him a coin. But I, too, did not have any money with me. He put his hands in mine. He raised his eyes towards me and said: how warm your hand is! It's a long time since someone gave me their hand". The giving of alms has often been an obstacle to, and a caricature of, charity.

Much of the health of people is to be found in their relationship with God, with men and with nature. The re-establishment of good relations with these three areas is a solid base for health. Paul VI declared in *Populorum Progressio:* "sincere dialogue indeed creates brotherhood. The work of development will draw nations together in the attainment of goals pursued with a common effort if all, from governments and their representatives to the last expert, and inspired by brotherly love and moved by the sincere desire to build a civilisation founded on world solidarity. A dialogic based on man, and not on commodities or technical skills, will then begin. It will be fruitful if it brings to the peoples who benefit from it the means of self-betterment and spiritual growth, if the technicians act as educators, and if the instruction imparted is characterised by so lofty a spiritual and moral tone that it guarantees not merely economic, but human development. When aid programmes have terminated, the relationships thus established will endure. Who does not see of what importance they will be for the peace of the world"?[6]

A. The Christian Communication of Knowledge

In 1980 John Paul said to the United Nations: "there is an urgent necessity to share the resources of intelligence and of the spirit, of scientific knowledge and cultural and artistic expression. This sharing is not a one-way sharing – it is reciprocal and multilateral. It requires that the cultural, ethical and religious values of populations are always respected by the parties involved. It requires mutual openness to learn from each other and to share with each other. In this sharing, technological advance and economic growth clearly brings with it a change in the socio-cultural models of a people. Up to a certain point this is inevitable and must be taken into consideration in a realistic way for the good of the growth and development of a people. But, if we are honest with ourselves, when we say that man is not simply a *'homo oeconomicus'* we must be careful to ensure that a harmful change, where positive values are sacrificed, is kept to a minimum in order to give precedence to ethical-moral, cultural and religious values over indices of merely economic growth".[7]

As a result, the first place in the Christian communication of material goods is given to the free and generous communication of the good of knowledge. This is the first thing which must be distributed in the undertaking of spreading health and contributing to the building of human beings. The communication of knowledge is a direct help for the innermost part of man which remains with him in facing up to new situations and enables him to receive yet more and greater knowledge. It is the fundamental task of the Christian communication of goods to give life to a culture which takes care of and fosters health through the knowledge which is available to us. Through such knowledge men will learn that health is not in essential terms a matter of feeling good, but of real wellbeing, and they will become responsible with regard to its protection and the causes of illness. In the same way, we must all come to know that health is not an end in itself but an important means by which to bring about what God has in mind for each one of us.

Many inherent problems of a unhealthy life and illness are characteristic of cultures which do not appreciate health to the full and which ignore the fundamental norms of environmental and food hygiene. Furthermore, some illnesses from which advanced populations suffer are due to lack of knowledge, to a lack of information, or to a contempt for the moral values which support the harmonious process of the physical, psychological, social and spiritual wellbeing of man. The spread of knowledge about these subjects is certainly one of the most important "works of compassion" of the members of the Church.

This task falls both to the members of the Church who have such knowledge and to those peoples which do not have such knowledge. The spread of health in the world is the specific task of love between men, that is to say it is a task bound up with the creation of the spiritual health of the social body made up of all the men of the world.

The ground-level ecclesial communities, in the words of John Paul II, are "a solid point of vaid departure for a new society based upon the 'civilisation of love'".[8] Through

these communities it is possible to build a new culture, promote the wellbeing of the members of these communities, and through acquired health allow new progress in the humanisation of the peoples of the world. I think that it is very important that such communities have a constant desire to achieve their own development and rely upon their own strengths in the promotion of health. The building of men means helping them to develop their most human part – their spiritual capacities.

B. The Communication of Material Goods

The communication of material goods must be carried out in an economically productive way and in a way which guarantees the building of human dignity and quality. At an economic level it must be operationally effective, well administered and efficient, and produce the overall development of man. It cannot be reduced to mere alms giving, except in cases where it is not possible to achieve the real development of self-reliance and independence, such as occurs at times of natural catastrophe and permanent need, or to cover up the negative effects of a national economy which is disordered in its goals, its production and in its distribution.

All the goods of the earth which man in some way or other possesses – personally, through the state, or through the community – must be administered in such a way that they reach their proper universal destination, perform their mission of satisfying authentically human needs, and develop all the capacities which exist within humanity, and all this so that every person reaches that fulfilment to which the Father has called us. In this way, therefore, the Christian communication of goods is the path by which to provide the goods that we possess on the earth with their universal destination. This undoubtedly means that there must be a new way of living the economy, of spreading and exchanging knowledge, and of entering into a relationship which will obtain the *globalisation of solidarity.* Here I would like to examine three points all of which require a serious commitment on the part of Christians to a future "civilisation of love" where the Christian communication of goods is a reality.

A Giant and Patient Intellectual Task of the Science of Economics

Today weak economies and economic crises directly affect the physical states conditioned by health, by diet and by work. We know that the science of economics must strive to find the right routes by which all men can have access to these goods. However, we still do not know how to meet these needs in an effective way. It would seem that the effectiveness of the fruits of this science has benefited only those who are moved by materialistic motives. It is important for Christians to respond to this call if a science which achieves the universal meeting of needs is not really possible.

I believe that care for the health of poor groups and nations requires, as I have already observed, a new look at, and a promotion of, the health of the whole social body of humanity. This task should correct the goals which men at a practical level search for in their economic activity. Mankind must free itself from the hyper-economic motivations which govern the world economy: economic activity must not strive first and foremost for the creation of wealth and its accumulation but, rather, for the satisfaction of the authentic human needs of all men. As a result, we should give pride of place to the distribution of the products which are made. Perhaps this new approach will come to propose new points of departure for the science of economics and the creation of new models.

An attempt to find the right routes to take for a new way of meeting needs and requirements in a human way is being made by the scholars of "the economics of solidarity". Their principles are as follows:

1. Solidarity, co-operation and real democracy, both in the productive process and in forms of life and of human living together in society.
2. The supremacy of the goal of service over the impulse to gain, and likewise the supremacy of the common good over individual gain.
3. The supremacy of labour over capital.
4. Associative work as the principal basis of the organisation of the firm, of production, and of the economy.
5. The social ownership of the means of production by workers.
6. Workers' management.
7. The integration of the units and the organisations of the solidarity-inspired economy.[9]

The size of this intellectual initiative and the hopeful experience of poor people organised into communities which work for this project, aspire to be the beginning of universal solidarity. This solidarity must come about through small steps which will shape the new society. These small steps, together with other small steps, are for the moment the only elements which promise a new way of living the economy, with new values, new goals, with a new humanistic meaning, and constructive of human dignity and fulfilment. These steps are the signs which the Church knows how to produce when following in the footsteps of her Master Jesus.

Signs are not the total solution to the problem, but they point out its path. Jesus did not solve the problem of the hunger of his time, but in giving food to the hungry he taught the route to be taken to solve it. This sign is the model which should be followed in present-day circumstances. Solidarity is not an

optional but corresponds to what it is to be a Christian. Yes indeed! It is Christian to be solidarity-inspired, with Jesus who made himself man and showed himself to us as such, the same as us in everything except sin.

The small communities which have become self-reliant in relation to the prevention and the treatment of their illnesses, in order to promote cultural transformations which help people to gain health and take care of it must foster personalisation, must make themselves able to serve within the community, and must strengthen the weak so as to make the body of Christ truly vigorous. The Church, which is the body, must strive to be such in an effective way by carrying out actions which accredit her as a Church, in the same way as Christ gained credit through his works.

The Christian communication of goods means the construction of relationships which generate health. For some people health is a correct relationship with the environment. A correct economic, educational, cultural and political relationship is a part of the health by which man becomes capable of full communication at the service of others. In this way he discovers the image of God within himself; becomes the master of himself; and walks towards the full development of his physical, psychological, spiritual and social dimension.

The Sharing, without Causing Damage to our Economies, of the Goods that God has Granted us

In the spirit which guides these experiences, and given that the moment has arrived when these thoughts and generous efforts should produce a "new economy" which will globalise solidarity and function effectively, the Church, faithful to following in the footsteps of her Master, is producing new ideas and proposals which should be examined in the conviction that at one and the same time they spring from an inspiration provided by God and must be implemented by means of fragile human thoughts which need to be ordered and purified. The actions which come from the implementation of these ideas can be clear signs of what is desired by God of man.

Ignacio Cantarell, a member of the laity who is full of practical charity, launched a project in Madrid taking as his inspiration the words pronounced with insistence by Paul VI in 1973: "we have still not yet arrived at the contribution (decided by the United Nations) of at least 1% which every country should make, according to its level of development, in order to help developing countries". Furthermore, the author referred to the repetition of this wish expressed by John Paul II: "my predecessor Paul VI called on the developed nations to contribute 1% of their gross domestic product (GDP) to development. The level which is presently allocated for this purpose seems to be very much below this 1%..The Holy See wants to repeat this appeal of Paul VI so that this percentage figure does not continue to be a utopian goal".[10]

In the opinion of the creator of this project, the levels which should urgently be reached in the sphere of health – something which Christians can do in a special way – are two in number. The first is the level of *"extreme need"*, described by FAO as being "intense loss of weight caused by serious malnutrition" and by the theologian Soto as "when one sees that one's brother runs the risk of falling into an incurable illness, or another grave evil from which men usually die". The other level is that of *"almost extreme need"*, defined by the World Bank as "moderate malnutrition" "because it does not generally involve the danger of dying, only anxiety, a great deal of pain, and lethargy caused by hunger, accompanied by the risk of falling into a state of serious malnutrition" and which in the words of Lugo "leads to the risk of falling into a state of extreme... although not fatal... need".[11]

We should pay great attention to these needs. Cantarell observes that "an analysis of the real possible contribution which can be made by Christians must be based upon support for combating malnutrition or absolute poverty as the first step in the universal destination of goods. This step is of primary importance and is urgent; it is the only step that Christians can address themselves to in an economic sense, and it forms a direct part of ecclesial practice".[12]

This project seeks to encourage all Christians, the followers of Christ, to allocate 1% of their income to answering the basic needs of the world. I believe that the Pontifical Council for Pastoral Assistance to Health Care Workers could ask Catholics to create and administer a special fund for health in the world sustained by the free donation of 1% of their incomes. This would be a important sign of the presence of Jesus Christ in the world; and, after all, the Lord came to heal the sick. The organisation of this project would help people to become aware of the precepts given to us by the Lord of love and solidarity and to understand them in the modern day terms of the need for all men to free themselves from what damages their health, and to provide care which was previously not considered necessary but which is now seen as being fundamental given the present state of knowledge in relation to health. In the same way, this sign would show that it is not a utopia but a real possibility, which involves the work of many people, the members of the body of Christ, who carry out the work of giving health to the sick.

The Roots of the Christian Communication of Goods Calls us to act in Conformity with what we are: the Body of Christ

In the work of faith the instruments to hand are always short on the ground and not sufficient for the purposes of the work which must be carried out. After Jesus had finished his preaching, his disciples said to him: "give them leave to go to the farms round about, and buy themselves food there; they have nothing to eat. But he answered them, It is for you to give them food to eat" (Mk 6:36-37). Because the disciples did not have the two hundred denari which were needed to buy the bread need, Jesus asked them what they had, and the answer was: "five loaves of bread and two fish". This is the problem which we are faced with every day in the world we live in, a world which enjoys undeniable progress and advance. By this episode Christ taught us to be concerned with the needs of the poor. We must *marshall all the means we have available* and this must be done voluntarily. Here we encounter the starting point of the Christian communication of goods-sharing. *Organisation* then follows, because the Lord wants us to be organised. The *work of apostles and of servants* is needed because, once broken, bread multiplies. Organisation and shared work are the bases upon which *Jesus effects multiplication.* In this way the *undertaking* becomes *effective* and the needs are effectively met – "they ate and were filled". What was left over was kept. All this was done by Jesus with *explicit reference to the faith* – he raised his eyes to heaven and blessed the bread and the fish, thereby stimulating faith in the people who were there.

Perhaps it is no accident that the moment has arrived when we Catholics should act as one body to work for a solution to the problems of mankind. John Paul II said to the United Nations: "For many of these problems it would be necessary to have merely a political will which goes beyond immediate personal interests... This will must be constantly guided by criteria which place the human and social, ethical and cultural, moral and spiritual side of things above what is purely economic and technological. This will must be developed not only amongst the leaders of the world, but amongst all men, at every stage of life. A large number of problems can be solved only at a global level".[13]

The body of Christ is living through the risen Jesus Christ and the union of all its parts is ensured by the continuous action of the Holy Spirit. The collaboration of the parts of the body must be manifested so that the community enables the power of the risen Lord to be present, and this so that the world comes to believe and transforms itself. "Christians should say through their concrete attitudes that one cannot be happy 'alone'".[14]

His Excellency Mons.
CARLOS TALAVERA RAMIREZ,
Archbishop of Coatzacoalcos, Mexico

Footnotes

[1] *SRS*, 38.
[2] *Ibid.*
[3] *SRS*, 39.
[4] PAUL VI, Homily at the end of the Holy Year of 1975.
[5] *DP*, 188.
[6] *DP*, 73.
[7] JOHN PAUL II, 'Speranza: Criterio Costruttivo nella Strategia dello Sviluppo', 22 August 1980, n. 7, in *Magistra.*
[8] *RMI*, 51.
[9] LUIS FRANCISCO VERANO PÀEZ AND ALEJANDRO BERNAL ESCOBAR, 'Elementos Ideologicos y Politicos del Modelo de Economia Solidaria', (typescript), p. 63.
[10] JOHN PAUL II, 'Speranza: Criterio Costruttivo nella Strategia dello Svilupo', 22 August 1980, n.8, in *Magistra.*
[11] IGNACIO CANTERELL, 'Un Compartir Eclesial en la Caridad', (typescript), p. 3.
[12] *Ibid.*, p. 5
[13] JOHN PAUL II, 'Speranza: Criterio Costruttivo nella Strategia dello Sviluppo', 22 August 1980, n.8, in *Magistra.*
[14] *DD*, 72.

PAUL RUZOKA

Assessing the North-South Difference in the Economy of Health

1. Some Facts and Figures

– The average income per head of the population is 254 US$ a year.[1] Child mortality is declining (in '91 of the children under 5 years old, 141 in every 1000 died before reaching the age of 5 years and in '96 it was 137 in 1000). This means that 1 in every 7 children dies before reaching the age of 5 years.

– On the other hand 71% of children of 24 months or less have received all recommended vaccinations (the rest partially).

– 46% of health services are provided by Government; 54% by voluntary or private services. There are 164 hospitals in Tanzania, 269 health centres, 3078 dispensaries.

With a population of 30 million people that means 1 doctor per 23.000 (in 1995 there were 1264 doctors of which 1007 were Tanzanians); 1 hospital per 190.000 people; 1 health centre per 110.000 people; and 1 dispensary per 10.000 people

– The population is structured as follows: 47% under 15 yrs, 49% between 15-64 yrs, 4% above 65 yrs.

	In urban areas	In rural areas
Electricity in the home:	36.1%	2.5%
Water in the home:	31.5%	2%
Pit latrines (traditional):	89%	82%

In rural areas 70% of the households are more than 15 minutes away from their water source.

Radio	65.4%	33.8%
Bicycles	25%	33%

– The population increase each year in Tanzania is about 600.000 persons (that would mean that we need 3 new hospitals, 6 new health centres and 60 dispensaries each year just to keep up existing ratios and proportions).

These are rather dry figures but they show clearly that the state of health service is far below the minimum required to provide a satisfactory standard of living. These are figures which present averages and do not express social differences and the unequal distribution of these services. E.g. the number of doctors in towns is high leaving a minority living in the rural areas where 75% of the population are still living. Rural health facilities lack other qualified personnel and drugs.

Looking at the actual situation in a country like Tanzania and comparing it to rich countries and middle income countries, we see how the differences in economic capacity have a big impact on the quality of life especially in the area of health care. The poverty of lacking factories or modern units of production may cause a country to have a low level of income. But to lack health facilities is a matter of life and death when illness strikes a person.

To lack health facilities is only part of the reality. We also lack basic health education for a good number of our people. Though awareness is growing among the people about health care and how to look after health, nevertheless it is a reality that many people are still ignorant and many people are still victims of this ignorance and will follow practices of a superstitious type and even of witchcraft and related social problems. Many people are still fatalistic, thinking that they cannot do anything about their problems and have a false notion of submission to God's will.

Within the context of economic and educational poverty concern for health care and providing services to people is not just an economic issue, it is a highly moral issue. And when we agree upon the dignity and sanctity of human life then we can not pretend that health services for people is an issue which each country must solve on its own. The question of health service should be the concern of all and should be treated at a global, worldwide level. To this point I will return later on.

1. We are in a Period of Transformation

When Tanzania became independent in 1961 the population and its leaders considered free health care as one of the fruits of independence. From the colonial powers Britain, people had learned that a National Health Service, providing free services, was a clear sign of political and social advancement. With independence, reaching political freedom, the people of Tanzania wanted to receive tangible profit for their daily lives.

These expectations of independence were justified, however the service had to be financed from the country's income or from gifts. With the years and with a growth in the needs and lack of sufficient economic growth and some adverse circumstances (e.g. the increase in oil prices, the war with Uganda) the Government began to

realize that they did not have the means any more to provide such free services. The donor community also did not want to continue lending money for payments of such services.

From this came the Structural Adjustment Programs and the general policy that people should participate in the costs for these services. The cost-sharing policy was introduced which is now being implemented.

The SAP programs called for reform in the health sector in the following ways:

– Charges for user fees in Government health facilities (in the private sector this was already the case).

– To organize health insurance systems or other risk coverage systems (i.e. organize the mobilization of resources from individuals).

– Use non-governmental resources more effectively.

– Decentralize the planning and budgeting and purchasing for government health services.

These reforms were indeed necessary. But the weakness of the policy has been that it was indiscriminate. That it did not study and plan the reforms with the differences of economic capacity in mind of the different social groups in society. The reforms have fallen upon the poor as a very negative experience. It has caused a lot of suffering and death among the poor – that is among the lower income group, which constitutes about 60% of the population. This experience of not being able to find the necessary resources in time of illness has been a painful reality for many and it is creating a sense of fatalistic harshness among the population and a morality of each one for oneself mentality.

A struggle for life attitude which has negative effects upon the social coherence of the nation. This will have a long lasting effect upon the basic moral attitudes of a nation. The reform may make some economic sense but it will create a lot of social-moral harm which we are noticing now in society and it is eating away at the moral fibre of the nation. It will cause social tensions in the years to come.

In Tanzania user fees were introduced in 1993. However the services at government rural health centers and dispensaries are still free of charge, except at district level where a fee is paid and where there is the community health fund.

At the same time private-not-for profit health services are highly encouraged – like mission involvement by the religious groups and institutions.

But these institutions experience the same difficulties of a lack of economic capacity. E.g. mission hospitals cannot be run on local payments only, subsidies are still necessary for many years to come if the Church is to maintain its hospitals in Tanzania. Dispensaries have more chance to become fully self-reliant if they are well run and cost-effectively organized. At that level the local Church capacity could make an efficient self-reliant contribution to the health service.

The basic policy by government to decentralize the administration of the health sector to the districts is now in implementation. Included in that policy is the aim to engage the local community directly in the management of our health services. This higher level of involvement by the local community will hopefully increase the sense of responsibility in the community. However, this will take time to become a reality. It cannot be altered in a few years.

Community involvement by itself will not solve all the problems. It is not only a question of lack of funds – it is also a question of reducing inefficiencies, to make the service more cost effective. But it is also a question of professional quality and moral dedication and service mentality, which does not depend solely on a financial rewards system. Moral and human quality in the Health Service is of paramount importance. It is an ethical issue which does not get the importance it deserves in political and civil service circles which are responsible for planning and administration. We are in fact noticing a lowering in ethical standards among the medical personnel.

It is with sadness that one has to say that there is a good deal of corruption in the medical service, people using their position as an occasion to obtain additional income by demanding a bribe before rendering a service. This phenomenon has been growing considerably in recent years and is noticed more in government institutions, though it is not absent in private institutions.

Although it is true that the official policy asks for small contributions in the form of fees to be paid by the patients, the reality very often is that such items as laboratory examinations or medicines are not available in the official way, e.g. medicines are not obtainable in a government hospital but can be bought next door in a private pharmacy. This reality adds to the burdens for the patients. The extended family system is still the basic support system for ordinary people. Yet this is limited to the economic capacity of the family. There is a great need for a larger base of support. Solidarity must be organized on a wider scale.

In this regard, the idea of health insurance schemes is slowly making its way. There is an interest in such proposals. Both government and Church institutions have started to plan and to experiment with health schemes. But the idea will take time before it enters into the culture and behavior of people. The insurance culture of foreseeing and budgeting for such unforeseen future expenses is not yet part of the culture and behavior patterns of the majority. Again this will take time but the awareness is growing.

Also, different situations and circumstances must be envisaged in planning insurance. The employed, the urban unemployed, the rural cash crop growers and rural subsistence producers, these social groups have to be approached in different ways.

There is a need also to educate the people on how to take care of their needs and to structuralise that sort of solidarity. One has also to plan such services well so that loss and theft by some unscrupulous people can be avoided. Without trust and a mutual help spirit such communal risk bearing systems can never succeed

Modern developments in our society have also given rise to new problems which we need to address. Growing urbanization has given rise to a diminishing of extended family responsibility and special types of needy people are

growing in number e.g. young people emigrating to towns leave the elderly alone at home; the AIDS problem is creating an orphans problem which elderly grandparents have to cater for; the number of widows and women left alone with the charge of children; even young children having to take care of other children, this is a growing social problem; the street children and other young people who venture out on their own are social realities.

In Tanzania we also have new problems which have been created by others and which are giving us many headaches, namely war and refugees. As Bishop of Kigoma, I have personal experience of neighboring countries experiencing war and ethnic tensions and clashes which create a lot of suffering for many ordinary people. Especially women and children. Many thousands have fled their country and live temporarily in Tanzania. The international institutions have made a big effort to help, but this still leaves many problems to the local people and additional burdens on existing services within the country.

One cannot say that economic poverty is the sole reason for a lack of resources in the health services. If there is more than three times the amount available for defense expenditure than there is available for the health service, then we must say that it is not only economic poverty that is the cause, but also political choices made by government in considering military needs more important than health needs. This means that there is a lack of political will, both at national and at international level, to take health needs as a global humanitarian problem.

As a Church we need to put social pressure on our societies to make this problem an international issue and help create the political will to deal with the needs of the poor on an international approach.

3. Which Way Forwards?

The title of the paper I was given was: assessing the North-South differences.

From the description I have given of my country Tanzania it is clear that there are many differences between the rich countries and the poor countries. Yet this general description – rich countries and poor countries – is no longer adequate in analyzing the social situations of the world. In fact, we have groups of poor and less well off people in rich countries and in poor countries. True: the number of the poor is greater in poor counties, but social provision for the needs of the poor will be needed in both situations. In both rich and poor counties one finds people who are well off and who can easily afford costs of health service. In Tanzania there is a percentage of rich people who can easily afford health care. There are also a percentage of people who are in a position to obtain the money to pay for health services, even going abroad, either form government funds or from a network of friends who can obtain the privilege for them. These are indeed privileged people and their number may not be so big, but they are part of the real life situation and are among the people who participate in policy making. I am not referring here to abuse or to corruption (which also exists). I am speaking about privileges which some people enjoy whereas the majority of the population have no access to such possibilities. Such privileges are available to some within the present system.

Another consideration which we must bear in mind is that in rich countries there exists a social policy which is the result of a long history of trying to cope with social problems. It has given birth to a certain system of provisions which allow people to cater for their social needs.

In Tanzania we are still at the early stage of re-organizing our social system after the socialist system of free medical care. People are now asked to participate directly to some extent in the cost of health services.

As I said earlier the economic reality is such that many people cannot cope and the central government is no longer able to help those people as such a big proportion of government expenditures goes to debt servicing (35%). But even if that were not the case the government would not be able to set up a welfare system for the economically weak because the people in that category are too large in number. We need another approach to this whole social issue.

a) We need:

– A local government, local community approach as our basis where local efforts must be made responsible for providing the first step by gathering local contributions in the form of local tax, or local cost sharing, paying a part of the salaries and cost of basic medicine.

– Certain expenditures must then be guaranteed by national economic budget from the national revenue.

– Certain expenditures must then be guaranteed by the international community to supplement what the poor economic capacity of poor countries cannot afford.

In Tanzania we have made a beginning with this approach in letting districts become more responsible for planning for the administration of the health service. But we have still a long way to go because many elements of the local government reform are still not in place and are not yet acceptable to many people.

The national government is not yet ready, or not yet in a position, to shift more of its responsibilities to the local level.

The international community also is not yet ready to accept this orientation of giving greater responsibilities to the local level for the administration of the policy and of the funds. The control system of the donor community is still highly centralized, in spite of their insisting in words on the need for locally based community approach in the projects they accept.

b) We need:

To acknowledge the growing reality of social classes – very similar to the social classes which existed during the industrial revolution in 19th century Europe and North America.

– The social class of the privileged and the wealthy are already globalising their interests as a common aim and they are influencing world economic activities to their

own advantage. These privileged people can be found both in the rich countries and in the poor countries and they are making bonds of interest.

– With the demise of the socialist economic systems we are now seeing a growing capitalistic development which serves the interests of those who are better off and who impose their interests on policy making in the poor countries especially in the areas of finance and trade.

– We need therefore to start a global movement of redressing this capitalistic development and balance it by defending the social interests of the majority of the people in the world who are economically weak. This requires a global approach – a movement which aims at increasing global solidarity.

– This is not an issue of "aid" giving, it is not an issue which will be solved by a charity approach or an NGO approach. This issue requires an ethical-political stand and strategy and it will need political structures and channels.

– It is important to remember that this issue is of such importance that it will affect world peace for good or for evil. We cannot afford to look after the health of our economical system at the expense of a larger section of the world population.

– It need not be emphasized that this is also an eminently religious issue, and for us Christians, simply the very essence of our Christian vocation.

c) Strategy

– Let different religious groups and denominations continue to put pressure on policy making structures at an international level and devise particular ways to organize such pressure like the Jubilee 2000 debt relief program has done

– Lobby for a global social policy whereby some basic human needs are treated on a world – dimension (e.g. basic health needs like essential drugs) by introducing forms of international taxation, create organs of international policy making and establish universally accepted criteria on how to use those resources. Such decision-making requires political structures which are worldwide in character and have power beyond national sovereignty and beyond financial power blocks.

– International organizations to become more unified and integrated, so that policy can be drawn up which follows a common line of priorities. International organizations tend to increase fragmentation of interests by a lack of coordination.

– At a national level the aid giving and aid receiving needs a complete overhaul. It should not be so that programs are worked out in a way that follows the availability of loans rather than the real priorities of the people. And this is often the case. Donors should not encourage the fragmentation of help by dictating their own priorities.

Government leaders must become true ambassadors of their own people and must not give in to selfish inclinations of looking after their own personal political and economic interests or that of their close interest groups.

– To support the development of civic groups. This is the only way to build up true democracy. The introduction of multiparty politics will not lead to true democracy unless there is healthy pressure coming from civil society.

– To strengthen local government and local societies as the guarantee to a sustainable approach to the problems of basic health care.

Social awareness at local level is often weak, and as a result people have little creativity to build up structures at local level to take care of their needs. At the moment there is little trust in any type of leadership. The simple people have been cheated too often. The moral credibility in leadership has been greatly eroded as a result. This is a reality we need to face. This is a cultural-ethical issue, which needs far more attention than it is getting.

– Primordial needs like health, food, drink, land, shelter, safety, education should not be dependent on the economic capacity of a poor nation, nor should it be dependent on financial institutions and banks. Regional Parliaments and the United Nations should become more powerful politically. But the voice of the poor should be represented directly in the said institutions. There is a great challenge here to create democracy at an international level starting from the local level.

Conclusion

The Catholic Church should not only be our inspiration, but also an example for this orientation. As a Church which calls itself Catholic (or global) we need to rethink also our international relationships between Churches. We need a social policy which works out in a better way its own social teaching.

We need to let the diverse cultural voices and the different social situations become a more active part of the social policy we have towards social problems we face.

Donor-Church communities should not be the ones that set the criteria alone for distribution of resources. Local Church leaders should not be the ones who alone determine the needs of their local Church. There is need for a local-Church dialogue to determine together the needs of the people.

This dialogue, at these various levels, needs to be structuralised in a more satisfactory way than the way we do now. Let us be an example for secular institutions. At the African Synod we, African Bishops, stressed the family aspect of the Church.

But how can we sit together at our table, as a family, when some get plenty of food at the table and others can only look on with hungry eyes. Let us reflect more deeply on the political and ethical dimension of the words "give us today our daily bread".

For the Church this is a vital evangelical challenge. If we do not heed this call, the Church in the Third World will lose a lot of credibility.

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JOSÉ MANUEL R. BECCARIA

Towards a Political-Legal Model of Medical-Social Science

It is with great pleasure that I take part in this fourteenth international conference organised by the Pontifical Council for Pastoral Assistance to Health Care Workers, a conference dedicated to the analysis of the relationship between the economy and health. I would like to thank the organisers for this opportunity which they have given me and which allows me to offer a number of reflections on the evolution and development of the Welfare State and the criteria which could inspire a model for the distribution of, and access to, such a valuable good as health.

1. Health Care and the "Welfare State"

Health is undoubtedly an objective which both the individual and society as a whole aim for, and where their interests converge.

In the same way, health care is without doubt the most beautiful of the tasks which can be carried out. This is because for man health is the pre-condition of every physical or speculative activity, and of every form of material or moral advance. For society as well, the health of its members is a necessary pre-requisite for every kind of political, social and economic development.

Ever since very remote times, political organisations and communities have demonstrated care and concern for the health of their respective populations. At the outset this was done in an intuitive and instinctive way, but in time such an approach came to be based upon knowledge about diseases and illnesses and upon those scientific advances which were achieved by man's forward progress.

However, the right to health, or more specifically the right to the protection of health, is a relatively new right which was born with the advance of society. In more specific terms, it arose through the conjunction at a given historical moment of the egalitarian claims of socialism, the goals of Christian humanism in relation to the human person, and the conviction that no democratic society can advance in social peace if economic liberalism is not accompanied by redistributive policies which are able to secure due social cohesion.

This is the basis of the "Welfare State", a term invented during the historical period of the inter-war economic depression but which has its specific origin in the social laws passed by Bismarck and its practical implementation in the Beveridge Report of 1942. It was within the framework of these doctrinal and political approaches and ways of thinking that the major European health care systems evolved in the years following the Second World War.

The "Welfare State" has clearly involved major social advance and progress. Its conquests in the fields of public education, health care,and pensions, accompanied by the introduction of unemployment pay, made a marked contribution to social cohesion. Fortunately enough, all these advances became a point of departure for any government which really sought to improve the welfare of its citizens.

The Crisis of the Welfare State

However, in recent years and from very different theological points of view, major criticisms have been levelled at the Welfare State.

On the one hand, it has been stressed that a Keynesian economic policy, together with a broad concept of the Welfare State as benefactor, has led to a disproportionate expansion in planning and bureaucracy. This bureaucracy, it is argued, has suffocated social initiative and helped to bring about economic stagnation, leading in extreme form, according to the analysis offered by Max Weber, even to our being locked into a "cage of serfdom".

On the other hand, it has been proposed that the crisis of the initial model of the Welfare State has not only been a matter of its negative consequences for economic growth and competitiveness – principles which are at the root of every form of redistributive policy – but is to be found at a very deep level in the profoundest wishes of man for independence, justice and freedom.

For this reason, during the 1980s we witnessed in the Western world a critical analysis not only of the phenomenon of "stagflation" – a situation of stagnant inflation which was typical of the 1970s – but also of the dependence politics of bureaucracy. Both these elements were linked to the workings of the Welfare State.

From another point of view, it has been pointed out that from the Beveridge Report onwards a purely negative vision of welfare was embraced which involved a stress on fighting against poverty, illness, lack of education, destitution and unemployment. This, it has been asserted, was a pre-eminently economic vision of welfare and of the policies which were necessary to achieve its realisation.

2. The Dangers Promoted by Globalisation

Over thirty years ago the phe-

nomenon of globalisation, with the triumph of values based upon ideas of flexibility, efficiency, productivity, competitiveness and utility, involved an evident danger for the social progress which had been achieved, and, in turn, implied the risk of a deterioration in public services – the most serious consequence of the triumph of these values.

This process of globalisation, which has arisen from the gradual disappearance of administrative and political frontiers, is bringing about important economic growth which should favour a correction of territorial imbalances and provide an answer to the problems of unemployment, poverty and acute poverty. However, it remains the case that at a global level millions of human beings lack food; poverty afflicts over a thousand million people; and a third of children on the planet are malnourished. Furthermore, in a situation where a world without frontiers brings with it a number of possible economic advantages, there also exists the danger of a cultural loss of roots and of ideological confusion. Hence the need to take advantage of this situation of economic interdependence and international synergy in the areas of political, economic and social activity in order to intensify the fight against poverty and marginalisation in a way which is compatible with respect for the cultures and traditions of the peoples of the world.

In the opinion of a number of analysts of this process, the acceptance of the fact that transnational companies are the principal actors of the global market, and a confirmation of the creative force of civil society, may even lead to the exclusion of national governments.

3. The Reform of the Welfare State

Given this state of affairs, which has been summarised in a general way in the above paragraphs, the reform of the Welfare State appears to be an evident necessity. The risks that such a reform run are also there for all to see. What form, therefore, should this reform take?

While we ask ourselves about the nature of this reform and the risks it might bring with it, we should not forget the nature of our objectives – prosperity for everyone. This means that we are ready to accept the needs imposed by the competitiveness of global markets. In the same way, we want to live in a civil society which can achieve unity and build the bases for an active and civilised life for all its citizens. Lastly, we want a state based upon the rule of law and political institutions which allow not only change but also criticism and the exploration of new horizons. To put the point in essential terms: we want economic wellbeing and at the same time social cohesion and political freedom. How can these objectives be achieved?

It is certainly not easy to make these objectives compatible. In recent times Giddens has asserted that he has found a way by which to square this circle, and more specifically through the so-called "third way" which seeks to overcome the approaches of the neoliberal and socialist positions.

One characteristic of Popper's approach to problems is to urge avoidance of any sole overall approach. For this reason, it is asserted, the person who thinks that he has found the answer to every problem in reality has found the solution to none at all. Total solutions, far from improving the way things are, actually make them worse. The demolition by Karl Popper of Plato's Republic is based upon this belief and this kind of approach. Whoever tries to implement and put into practice utopian programmes must first of all clean the canvass on which the real world is painted. And this in reality is a brutal process of destruction. Having thrown overboard these utopian theories with their globalising tendencies, we can see how we can face up to certain fundamental questions which are covered by the subject which is discussed in this paper.

I believe that we can find more effective inspiration in the intellectual tradition represented by Popper but also in the lineage represented by Max Weber, Raymond Aron, Isaiah Berlin, Dahrendorf, and perhaps also by Norberto Bobbio and Keynes. All these authorities are strong defenders and proponents of the open society of freedom, social justice and equality, and are at the same time also committed reformers.

Taking the theories of these thinkers as our starting point, we can attempt to provide an answer to the following set of questions.

What should be the role of the state after the crisis of the Welfare State on the Beveridge model? What should this role be within the context of the globalised world? Is it right and helpful to exclude national governments along the lines which have been indicated above? Which model could allow a more just form of access to the fundamental right of the protection of health?

The social market economy certainly does not assume the presence of greater intervention on the part of the state in economic and social life. But at the same time it does not require the public powers to abstain from intervening in society or the economy. It is clear that the state cannot withdraw, nor should it extend itself, in an unlimited way. It should simply reform itself and its role.

The reform of the Welfare State cannot be the task of a rampant liberalism, as indeed some people have wanted us to believe. "To reform" does not mean to disappear, nor does it mean to abandon essential responsibilities. If the benefactor state has grown to such a point that it is on the verge of collapse then it is right that we should make it clear that the transformation of the state should not have negative repercussions on social goals which could, indeed, actually become extended as a result of a revision of the very concept of "welfare".

In similar fashion we could not agree with the idea, advanced by some liberal theoreticians, that governments are merely the umpires of the way the game should be played. In minimal terms, governments should decide the direction of the economy and of society in a general sense.

In the same way, we can agree with Giddens and his critique of the merely negative vision of welfare. The abandonment of this theory now seems to be more than evident. Economic services and advantages are almost never sufficient to produce welfare. What we need to do is to achieve positive welfare; not only to combat illness but to prevent its presence by promoting active health; not only to uproot ignorance but to act positively in the sphere of education; we should not only mitigate acute poverty but promote prosperity; and lastly we should not

only seek to remove indolence but reward initiative.

To this I would like to add another idea which in my opinion is of fundamental and essential importance – governments have a special responsibility in the public sphere. By definition it is their task to finance and organise public services. Sometimes certain countries of the OCDE have employed in extreme form the ideal model of public service to such an extent as to strike at its very quality. But as a reaction to this experience the introduction of pseudo-economic motives and terms into the public sphere can deprive that sphere of its essential quality and break up the service which it is intended to offer and work against the readiness of people to dedicate their activity to such services. We need to find a new balance. National health services, state education for everybody, and a guaranteed minimum wage, can become the victims of an uncontrolled "economism". In all probability, an area which could serve as an example to be followed for such an inquiry is that of medical care,given the importance that such care has for individuals and the costs which it involves.

In this context it is equally necessary to accept that cultural diversity should be a inherent part of the globalising order.

We could conclude in summarising fashion by agreeing with John Gray when he declares that "we need to look for ways to make our economic culture more favourable to the needs of people, which in the last analysis it should serve. We need to create institutions and policies which reduce the risks which people run and which reconcile in their lives the need for lasting relationships with the imperatives of economic survival. We need to make the distribution of specialised knowledge and opportunities more equitable. From this point of view we need to hope that our individualism becomes less possessive and more social".

4. The Reform of Public Health Care Services

In the health care field most countries have created systems which are rooted in, and shaped by, their respective histories, social realities and financial capacities. These systems have allowed important improvements in the field of health which have been reflected in a reduction in maternal and infant death rates and in an increase in life expectancy, and have been accompanied at the same time by improved water supply, systems of sewerage, and the improvement of the resources allocated to health. Major advances have been achieved in the fight against infectious and contagious diseases, and there is marked social sensitivity towards ecological questions and social imbalances and inequalities.

However, making full allowance for the special configurations characteristic of each national health system, all countries now face the shared problems created by changes in the models of illness and death, by the ageing of their populations, by the high costs of health care, and by the need to redirect welfare towards the authentic requirements and needs of the population. The answer to these challenges does not take only one form, but must be adapted to the peculiarities and the idiosyncrasies of each individual society in line with its present state of development and historical inheritance. Despite these circumstances, in all the processes of health care reform which are now underway there is a shared element, namely the search for greater efficiency and social return, which, in turn, must be expressed in improvements in the fairness of health care services.

The development and advance of the sciences of health and the new discoveries in the field of genetics have given rise to new forms of action and have opened up new possibilities in the prevention and effective treatment of a large number of illnesses linked to genetic defects. At the same time they have generated new conflicts which must be resolved taking as a starting point solid and sound ethical and juridical approaches from which must flow suitable rules and regulations, without, however, damaging or offending the cultural traditions and the beliefs of the countries concerned.

In the same way, technological progress is giving rise to spectacular results in the field of the transplanting of organs and tissues, the field of diagnostic techniques, or in the preparation of increasingly effective drugs and medicines which are, however, more expensive than was previously the case. It remains the case, despite such progress, that such illnesses of enormous importance as malaria or AIDS continue to exist, and these illnesses, together with smoking, take pride of place in the programmes for action of most of the countries in today's world. This complex and intricate survey necessarily leads us to address ourselves to the need to engage in a change of strategy – a change which, in this move from the old century to the new, must build a bridge between what is ending and what is emerging, and must also include the establishment of a new direction in health care structures which will provide answers to many new problems and well as providing responses to those which continue to exist.

This change should involve an increase in the strengthening and improvement of health care systems, and to this end their financial efficiency and organisational reform should be aimed for through providing health care centres with the right independence within a planned framework of regulated responsibility and allocation of tasks. These are elements which are essential if we want to obtain the stability of the health care system and the necessary motivation of its professional workers. This, moreover, will facilitate the redirection of the service towards the requirements and needs of citizens. A new model is now called for where the private health care sector can play a complementary role, as long, of course, as it has the necessary requirements of quality and suitable equipment and services.

This change should be based upon the modernisation and the up-dating of health care models in the sense of the incorporation of the innovations which science places at our disposal. As long, however, as this does not give rise to an increase in health care expenditure which operates at an unsustainable level. Renewal also means using the great advances which have taken place in the systems of information. Computer methods and informatics have become a necessary instrument of change and are transforming access to medical knowledge, research, and the management of health care services.

The challenge with which we are

presented today is complex and intricate, but it is nonetheless a challenge which can be met and overcome. We must create flexible models which are decentralised and not bureaucratic in nature. They must be sustainable in a financial sense and have the ability to adapt to an environment which is inevitably changing and shifting in character. In this way we will be able to guarantee the future functioning of those health care systems which ensure the access of the population to services according to its needs and preferences.

However, the reforms of the health care sector, as is the case in other economic areas, cannot take place in the form of an instantaneous and single change. We need to put them into practice gradually and, as indeed is logical, they must be never ending. The goal of satisfying all the aspirations of the citizens of a country will never be reached. We must understand the basic principle of fairness as consisting of giving more to those who are most in need, thereby overcoming the false egalitarianism of giving everything and the same thing to everybody.

On the other hand, we share the criterion which was has been discussed recently in such international forums as the World Health Organisation, according to which this change requires a new concept of the "universality of health care". This phrase is understood as meaning a commitment by the state to uphold and give practical expression to the right of citizens to health care of high quality and greater effectiveness which is as equitable as possible and which includes a set of services geared to health care needs and in conformity with the right values. Together with the criteria of efficiency, effectiveness and cost-benefit, there should also be the approach of ensuring that which is valuable in terms of social utility.

To this complex survey should also be added the subject of demographic change, and in particular those changes which are taking place in industrialised countries. These make absolutely necessary the implementation of programmes of health care which provide for a suitable health care and social response to the many physical problems of ageing. Thanks to health care and social advance, significant progress has been achieved in relation to the life expectancy of our populations. The objective for the future will be a longer life accompanied by better conditions of health, with the least number of impediments and limitations possible.

On the threshold of the twenty-first century the fight against infectious diseases and chronic non-transmissable illnesses will achieve its goals in large measure thanks to the exchange of, and co-operation in, knowledge and experience in the health care field at a worldwide level.

The benefits of scientific and technological progress and advance must be suitably distributed. These steps forward will help us to cross the threshold of the new millennium in a spirit of optimism.

5. Conclusion

During the last decades of this century, which is now drawing to a close, we have witnessed a process of political transition which has left behind it the counterposition of two blocs which was born after the Second World War and which has created a situation of dialogue and democratic progress – factors which work in favour of freedom, mutual respect, and economic and social development.

This situation has enabled us to consolidate the inalienable right of all people to the protection of their health, a right which is rooted in the recognition of the values and dignity of man.

The governments of all countries have adopted – within their respective historical, political, social and cultural co-ordinates – a commitment to make this right to the protection of health more effective through the development of active policies directed towards providing their populations with certain fair and high quality universal health care services. However, this commitment also includes that of persuading citizens of their responsibilities with regard to the maintanence of their own health.

Because of the growth in economic expenditure caused by the practically limitless demands and needs of the population, it is absolutely necessary that in order to follow a principle of social justice governments make suitable use of the resources which are available, but which, of course, will always be limited in nature. This situation obliges us to develop health care models which will ensure economic expenditure compatible with the supply of high quality services suitable to the needs of citizens, without, however, the appearance of limitations to the basic and fundamental rights of both individuals and of society as a whole.

New technological forms of progress will enable us to tackle illnesses and maladies which have devastated humanity for centuries. Despite this fact we are also now face to face with a context which may well turn out to be disturbing because the potential capacities of medical science are now leading us to almost unsuspected extremes. This reality obliges us to develop initiatives in a number of spheres which should include the regulation of the application and the uses of these various discoveries. Such a regulation should take as its starting point respect for the dignity of the human being, something which will allow an aware and conscientious use of such discoveries in the fight against illness and pain. At the same time, however, we should strengthen ethical and moral principles and the sense of individual responsibility within society with regard to what the possible implications of these scientific discoveries might involve.

We must be committed to continuing the correction of imbalances at a world level and to fight against want, acute poverty and illness. We need to strengthen co-operation between the least favoured nations and help them to develop all their potential. But this should not give rise to new situations of dependence, or to a system of interference in their historical or cultural models.

In this context, where, notwithstanding the difficulties which are present, there is much to be hoped for, it is absolutely necessary to encourage scientific meetings at which, as is the case with this international conference, an analysis is carried out of the various economic, social, political, cultural and religious elements and factors which belong to this whole area.

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ALBERTO J. MAZZA

The Promotion of Scientific Medical Research at the Service of Man from the Point of View of Cultural Effectiveness

One of the principal challenges which mankind now faces is that of the need to incorporate scientific and technological knowledge into the various economic, social and structural activities of contemporary countries.

The development of modern society is based upon knowledge. For this reason, we need research and development policies which are at the service of the members of society and which take practical form in explicit programmes. These programmes necessarily require a moral and ethical framework, in addition to the benefit of leadership on the part of the more highly placed institutions.

The construction of each and every society based upon knowledge requires the incorporation and the strengthening of scientific, technological and social research, in addition to suitable education activity which is able to provide those instruments which are necessary to the effective administration, diffusion and incorporation of the information which is available. This should take place so that the problems and difficulties which arise, and especially those which are present at historical moments of rapid technological change, can be solved in a creative way. When a society assimilates a form of scientific activity in a cultural sense, the process of the generation, transmission and incorporation of knowledge is facilitated, that is to say people "learn to learn". The great challenge which is before us revolves around these three elements, all of which must be followed and understood in an accurate way.

There can be no doubt that a society based upon knowledge is in a better position to achieve that sustainable growth which will allow its members to enjoy a higher level of health and a better quality of life.

In this *schema*, scientific and technological institutions have a fundamental mission with regard to the development of knowledge through research, the training of human resources, the administration of knowledge, and the supply of those investments which are needed for education and the on-going training of the workforce at all levels.

At the present time scientific research is one of the central pillars of the development of modern medicine and the effectiveness of health care. Such research must always be directed towards achieving the improvement and the maintenance of the level of life and the quality of life of all members of society.

In recent decades, medical science has achieved notable progress in many spheres of health and in particular in those bearing on life expectancy and the control of transmissible and non-transmissible diseases. Reference should also be made to our greater knowledge about health care realities and the factors which distort fairness and equity within health care systems and services.

It is clear that we have before us a historical moment permeated by extraordinary technological advance and development which in many cases interacts with, and complements, other sciences of knowledge.

Communications without frontiers, biotechnology and telematics are, so to speak, the trade tools of scientific and cultural change which are now helping to give rise to an extraordinary acceleration in the process of research, and which also allow a spontaneous generation of their own multi-centred development.

These changes in the field of health and health care, in addition to improving diagnostic and therapeutic capacities, create the conditions by which to modify and unify in a substantial way the models of consumption, forms of behaviour, ways of living and behaving in relation to health, and other values and concepts, which have all had a decisive impact on the health standards of the population.

In the opinion of the Panamerican Health Organisation: "the policies and priorities of research must have as their principal point of reference those people who receive the production of knowledge; they must identify their needs and strive to improve their levels of health".

It is equally necessary to emphasise the need to direct research in the field of health and health care – beginning with a multi-disciplinary approach which is required by the complexity now reigning in this field – with especial emphasis on the fact that research should always

be centred upon achieving the good of the human person. This latter endeavour should be achieved in a way which organises the biomedical, clinical, epidemiological and health care aspects of research within a framework of inescapable moral and ethical criteria.

It is for this reason that scientific medical research and technological development in the field of health and health care must always be seen as a means or a tool at the service of man and the family. These last are elements which are the fundamental pillar of each and every society based upon a just and fair social order.

From an ethical and moral point of view, this means that this type of research must be promoted in health care systems and services in a way which respects the religious principles, models and cultural values of the society concerned, and in even more fundamental terms, in a way which respects the dignity of the human person.

On 12 November 1987 His Holiness John Paul II addressed himself to scientists and health care operators and employed the following words: "the humanisation of medicine conforms to a duty of justice whose performance can never be entirely delegated to others but requires the commitment of everybody. The effective field is vast: it goes from health care education to the promotion of greater care and concern on the part of those responsible for the public domain; from commitment in one's own sphere of work to those forms of co-operation – whether local, national or international – which are made possible by the existence of so many bodies and associations whose statutory goals include the indirect or direct call to the need to make medicine ever more human" (*Teachings*, X/3).

The important observations which are constantly repeated by the Holy Father offer a suitable framework for the promotion of scientific medical research at the service of man in the sphere of cultural effectiveness which places especial emphasis on those areas of research and development where it is clearly necessary to guarantee and uphold respect for the dignity of the human person.

In this area, there must be repeated emphasis, whenever this is thought to be necessary, on the value and dignity of human procreation and the rejection of forms of genetic manipulation which alter the genome within the context of reproduction. In the same way there must be rigid ethical and moral controls in relation to the manipulation of physical cells for curative purposes, and this within a framework marked by a human and Christian approach.

When we come to survey and consider this subject, we should remember that the Pontifical Academy for Life has clearly established the position of the Catholic Church on this point and that the Congregation for the Doctrine of the Faith in its document "Donum Votae" has substantial observations to make in relation to the central aspects of the dignity of conjugal procreation.

On many occasions and in many contexts the Catholic Church has upheld the firm rejection of the cloning of human beings, something which the Church believes is a process which is contrary to morality.

This position was also adopted by the Plenary Session of the fifty-first World Assembly of Health when it approved its own "resolution WH51-10". This resolution maintains and asserts that "cloning as applied to the reproduction of individuals is ethically unacceptable and contrary to human dignity and human integrity".

Various countries in the world, including Argentina, have upheld this position in their legislation. Their swift response to the announcement of the first cloning to take place in the world allows us to face the future with optimism when we survey this particular area.

At the present time it is considered legitimate to modify animals genetically in order to improve the health and life conditions of man.

Scientific and technological research must be at the service of the integrity and the psycho-physical wellbeing and welfare of persons and of respect for life from its conception until natural death.

In our humanistic and Christian approach, as those who are responsible for, and guarantors of, the health of the members of society, we must pay attention to the promotion and the protection of being born well, of a good quality of life, and of death in dignified conditions, and this in a way which shows constant respect for the profound unity of the various dimensions of the human being.

In the same way we must remember that the Church is always favourable to scientific and technological development when that development is directed towards the improvement of the quality of the health and the lives of people.

As is demonstrated in the documents which give expression to its teachings, the Magisterium of the Church is not an obstacle to the advance of medicine when this latter is at the service of the community. It is, rather, a philosophical position which guides and sustains the researcher in his or her scientific activity, when he or she searches for truth, and when he or she contributes by his or her work to the progress and advance of science.

In the approach to research in the area of health and health care, research on human beings, given their characteristics as persons, must be clearly differentiated from research on animals. And in such research each specific area has its own ethical and moral framework.

Beginning with the aspect of actual procedure, research into health includes the development of initiatives and measures which help to:

a) improve knowledge about the biological and psychological processes of human beings;

b) increase knowledge about the links between the causes of illness, medical practice and social strutures;

c) deepen knowledge in the development of plans and programmes of prevention and control

based on evidence in relation to questions and issues of health and health care;

d) increase knowledge about, and control of, the damaging effects of the environment on the health of man;

e) carry out studies of new techniques and methods which can act to improve the provision of health care services to the community;

f) identify technological steps forward, appropriate forms of technology, and the making of new investments which are suitable to the field of health and health care.

For Frenck and others (OPS, 1988), who have as their starting point another approach based upon the individual, research can be classified in analytical terms into:

a) biomedical research, which is concerned with sub-individual elements;

b) clinical research, which studies individuals;

c) public health research, which is concerned with the population and its epidemiological trends, including research into services, resources, technological development, and the control of medicines and drugs, food, and medical technology.

In recent years we have witnessed a notable increase in the world's countries of the carrying out of biomedical research at both basic and applied levels. The same may be said of epidemiological research, research in the field of health care services and health resources, and research into new areas and biotechnological development, with special reference to the issues of quality and the non-harmfulness of drugs and medicines, the control of food and the development of new procedures, and the character of team work and other instruments in the area of applied medicine.

The principal objective of biomedical research is that of gaining knowledge about precise aspects of certain pathologies, the action of various etiopathogenic agents, the structural, chemical and physical changes in cells and organs, and the response of the human body to different kinds of treatment. Such activity has been largely carried out in well endowed and equipped laboratories of scientific medical research which are well organised, have highly qualified personnel, and are dedicated to this kind of research. The results of such research help in the prevention, diagnosis and treatment of illness and disease.

With regard to biomedical research in its clinical or experimental forms, what has been achieved in this specific field has contributed in a significant way to the advance of medical science throughout the world. Without doubt, given the progress that has been achieved in this sphere in recent years, there will be a further increase in the capacity of such research to obtain greater and improved results which work to the benefit of mankind.

Clinical research, which is seen by most authorities as the paradigm of the scientific method as applied to the sciences of health, is often used to assess the utility of medicines and drugs, techniques, and application procedures in human medicine which have not yet been sufficiently tested.

Much of this research, when it is carried out without the informed consensus of the patient and without respect for the dignity of the human person, must be adjudged to be cruel and ethically unacceptable.

This kind of research has been practised since ancient times and one can see that often there is a lack of respect for the autonomy and moral independence of the people who are subjected to it. Indeed they are subjected to it in general in an involuntary way.

In all this an important role is played by the drawing up of protocols which ensure the provision of suitable and complete information to patients on the procedures and risks of the techniques to be used in all forms of research. These protocols as a result guarantee that there is an authentic delaration of previous consent given by the patients involved to the director of such research.

At this point we should also note the need for a recognition of the full validity of the fundamental rights of man and of the principles of biomedical ethics. Such a recognition is a way of limiting the irresponsible action of those people who often bring about irreversible damage in their search for, and pursuit of, truth.

There can be no doubt that within this complex area it is of fundamental importance to establish ethical and moral limitations. This is especially the case in relation to the spectacular advances in medical science which – as for example is happens in the spheres of molecular biology and genetics – reach levels of power which go beyond suitable boundaries and thus require the presence of ethical and legal controls when clinical research is carried out.

The Nuremberg code was the first to set down that in order to take proceed with a clinical analysis it is first necessary to obtain the informed consensus of the person concerned. On the basis of this code, which has been universally accepted, a large number of national and international documents have come into being and have been developed during the second part of this century (which is now coming to a close). Amongst these documents special reference may be made to the Helsinki Declaration (1964), which was subsequently revised in Tokyo in 1975 and in Venice in 1983.

One should also bear in mind the Belmont Report on "the ethical principles and guidelines for the protection of people who are subject to experiments" (1982), the Hawai Declaration on ethical conduct in psychiatry (1977), when surveying the many existing rules and regulations in this area and which indeed are continually being subject to revision, re-elaboration, and change.

In the same way, we should also refer when considering this area to the "norms and rules regarding research on pregnant women and prisoners" which were drawn up in the United States of America in 1981.

This document acted as the point of departure for the document published a year later by the World Health Organisation and the Council of the International Organisations of Medical Science. This document bore the title "ethical directives on biomedical research on humans" and which was revised and up-dated in 1992.

Lastly, a brief comment should be made on other kinds of applied research in the field of health and health care which in some way take place and complement each other in the search for better conditions of life and of health of the members of society. Amongst these, brief reference should be made to advances in epidemiological research and to research into matters and questions connected with health care services and health care resources.

Epidemiological research allows us to obtain incisive knowledge about the health care status of the area subjected to study, of the risk factors and the factors which determine the principal causes of illness, death and informity within the population, and the variables and the trends of transmissible and non-transmissible illness and of endemic and epidemic disease. The results of this research are a valuable investment when it comes to taking decisions with a view to reducing the avoidable risks of illness and death through an intense action of health care supervision and control of illness, the promotion and protection of health, and the prevention of illness. This kind of research helps us to acquire the suitable and relevant knowledge which we need to be more familiar with the local and national health care situation, and the ways things are at a sub-regional and regional level.

Research into health care services gives us the opportunity to assess the way in which the services provided to the members of society are organised, administered and offered, their level of accessibility, the rational use of resources, the impact of programmes which are adopted, and the quality and the results of the procedures which are employed. The information which is provided by this kind of research enables the health care authorities to supply appropriate, suitable and effective responses to the demand for health which is advanced by the population.

It also provides valuable information by which we can construct knowledge about, and engage in the assessment of, the fairness and equity of the system, the degree to which the various parts of the population has access to the system, and the extent to which users are satisfied with the service that they receive.

It also allows the identification of educational and cultural factors which influence the health of the population so that strategies of communication can be developed for the improvement of lifestyles through the promotion of health-giving behaviour within the community.

The development of this kind of research is of fundamental importance in the definition of those priorities, strategies and alternative models which are designed to improve the effectiveness and the quality of the administrative-technical process involved in the management of the health care services provided to the population.

Research into health care resources offers us useful information by which to identify and develop a strategy for action designed to adapt the profile and the structure of human resources to the needs of the models of health care organisation and provision which prevail.

At the same time it is an indispensable instrument and method by which we can advance our knowledge of the factors that alter health care expenditure and the bear upon the cost of medical treatment, and give rise to an irrational use of technological resources.

Forming a part of this kind of research, we should also note the presence of research into instruments which allow us to establish mechanisms and procedures for the drawing up, control, fiscal organisation, and assessment of national and institutional programmes which guarantee the high quality of medical care and treatment.

Within the Panamerican Organisation of Health there has for some years existed a "Committee for Research into Health", which has been joined more recently by the "Regional Programme of Bioethics". These forums reflect a basic ethical concern about the need to ensure and uphold the protection of the rights and the wellbeing of people who are the subjects of research, and the people or vulnerable groups who could become the subjects of research. However, they do not extend to certain subjects and areas of research such as human genetics, embryos, foetuses or foetus tissues – issues which have come very much to the fore in recent times and in relation to which there are contrasting opinions of a certain importance. It is upon this aspect that we should place emphasis. We should point out in clear terms the position of the doctrine of the Church, and underline the importance of the defence of the dignity of the human person and respect for the models and cultural values of the community as a whole.

Stern perceives two great aspects in approaching the question of the factors behind the advance of medicine. The first refers to psychological and sociological factors which act to delay the spread of information. The second goes to the heart of what progress in medicine really means.

It is believed that no kind of "social pressure" as a psychological factor should be accepted and that such pressure cannot be based upon ignorance or incapacity in the determination of the relative merits of the results obtained by scientific research. And this is even more the case in relation to the economic interests which act to delay the incorporation of what is new. For this reason, all research must be suitably assessed from the point of view of ethical and moral principles and subordinated to service to man in its impact and role in the sphere of cultural effectiveness.

Notable steps forward have been taken in the conceptualisation of this inescapable criterion but we are still far from achieving major cultural change when it comes to the attiutudes of the scientific community in particular and society in general. The mere formulation of ethical models does not solve problems; nor does it guarantee an approach based upon respect. Yet there can be no doubt that such a formulation works to reduce the space for an acritical development of scientific medical research and at the same time encourages researchers and their financial backers to pay greater attention to the ethical and moral implications of the activities and initiatives that they engage in.

The challenge is therefore now before us. Every day it becomes clearer that the tendency to see research from a reductionist and molecular point of view is a moral provocation for humanity. This requires the creation of public spaces of debate which will allow a re-evaluation of the importance and the need for the development and application of new advances, not least because these latter have the potential to contribute to an improvement in the level and quality of life of the members of society.

From the 1980s onwards a number of countries in Europe and the United States of America have adopted legal rules and regulations in this area.

In the Republic of Argentina the government of the province of Buenos Aires promulgated in 1991 the "law on health research" which was concerned with ethical issues in relation to clinical research. In 1993 the Health Secretary of the Ministry of Health and Social Action created the "National Committee on Bioethics". And in 1997 the National Executive Authority established the "National Committee on Bioemedical Ethics".

It is important to see that biomedical ethics and justice have been complementary factors in protecting the rights of patients and the dignity of man in clinical research throughout the course of history.

We are convinced that the state, as indeed has been the case in Argentina, in its capacity as the guarantor of the health of the whole of the population, must provide those means which are necessary to both ensuring the high quality of services and making sure that they are accessible to all. We are also convinced that it should do this through the promotion of scientific and technological progress and research in all their many forms.

The health care authority must pay especial attention to the drawing up of national health care policies, to operational plans and programmes, to the rules and regulations of control, and to suitable tax regimes in the health care field, all of which should involve full respect for the full validity of the defence of the dignity of the human person, of the general interests of the society, and of the models and cultural values of the members of society, as well as of the principles of autonomy, safety and individual freedom of the person.

The National Committee on Biomedical Ethics has an interdisciplinary character and functions in conformity with the directions of the Ministry of which I am the head. It has drawn up a legislative proposal based on the documents cited above which is currently being examined and whose objective is to establish an ethical and legal framework which will uphold and promote the criteria previously referred to in this paper. This proposal will specify the advances which have been made in the various kinds of clinical research on the basis of the international models of the document issued by the World Health Organisation and the Council of the International Organisations of Medical Science.

At the end of the second millennium the world is undergoing a period of intense structural change and most countries of the world have engaged in reforms of the health and health care field. In general, the state has taken on a leadership role and is promoting mechanisms which strengthen, organise and complement what is done both within and outside this specific sector. A trend is underway which is growing ever greater and which revolves around the exchange and diffusion of scientific information.

In this context, and given the structural transformation of the health care sector and the profound changes in the programmes which are applied to this area, in addition to the new trends of science and technology at a worldwide and regional level, new actors and protagonists are appearing on the health and health care scene which give rise to the necessary forming of strategic alliances.

Another essential aspect is the need to define the indices of assessment of the quality of the results of scientific research in relation to the demand to which one seeks to respond. This aspect is more important than the indices of intrinsic quality, or rather the scientific-technological merit in relation to which the scientific community has developed and accepted certain standards.

This requirement arises from the evident fact that one of the criteria for the direction of activity in the field of scientific research and technological development in the sphere of health and health care is at the present time the response to social demand.

Equally, the incorporation of a system of mediation and assessment which allows a contrast and comparison between the resources of the system and its products on the one hand, and rigid compliance with ethical and moral norms on the other, would allow us to assess the actual effectiveness and efficiency of scientific research and technological development at the service of man.

We are convinced that the problems which present themselves day after day in the field of medical research can be solved given the increasingly obvious tendency towards dialogue and consensus in research, and that the existing differences are fundamentally based upon philosophical and moral positions envisaged in the various documents of the Church on this subject, and more recently in the encyclical "Fides et Ratio" with its observations on the relationship between faith and reason which are seen as "the two wings with which the human spirit raises itself towards the contemplation of truth".

In this important publication His Holiness John Paul II makes a "strong and insistent appeal...that faith and philosophy recover the profound unity which allows them to stand in harmony with their nature without compromising their mutual autonomy. The *parrhesia* of faith must be matched by the boldness of reason" (n.48).

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MARY HEALEY-SEDUTTO

The Pressing Need for an Analytical Approach to the Economic Management of Catholic Hospitals

Introduction

Our subject for consideration during this conference is not an easy one. Nevertheless, it is an extremely timely and important one for our Church and its healthcare ministry. The American Church, through the work of dedicated religious and laity, has accomplished extraordinary things within the context of its healthcare ministry, and has in approximately 150 years, developed one of the largest healthcare systems under a single affiliation in the United States. From the point of view of quality and access, we can be proud of the contribution to American Society that our Church has made, through the public dedication and witness of a largely immigrant Church. However, we cannot rest on our accomplishments, and we must candidly admit to ourselves that these very accomplishments are dangerously moving to the edge of a deadly precipice, and may be totally destroyed or lost unless we act in bold, thoughtful, and courageous fashion. Remembering our traditions, I remain confident that we can and that we will.

My experiences with the religious and laity of the Archdiocese of New York and with those committed to healthcare throughout the United States, give me the energy and confidence to address the very real and overwhelming challenge to those in the healthcare apostolate today. And while most, if not all, of our hospitals today have very sophisticated analytical tools and resources available to them, enabling them to tackle the economic crises that they face, especially the severe funding cuts that are being effected by the United States Federal Balance Budget Act of 1997 and the reductions in reimbursement resulting from the capitation payments of managed care contracts, unless there is a clear and concise strategy which those in governance and administrative leadership collectively embrace, the analytical tools and resources may not be sufficient. The trend in the United States of financing health care by means of managed care contracts, where a fixed sum is paid to the hospital and physician for each person covered by the contract (the financial risk shifts to the hospital and physician for giving the patient all appropriate services) has resulted in sharp declines in healthcare revenues. Resultantly, sophisticated economic analysis has become a necessity and a staple in the modern management in our hospitals. The pressing need, and therefore,

the challenge before trustees and managers and of those of us who are called to support them, is to integrate the relevant and sophisticated components of the ethical and social teachings of the Church into the equally sophisticated economic models of analysis that are being marketed to and adopted by Catholic hospitals.

In a time of economic constraints, it is very difficult to survive and reflect at the same time. It is also difficult to be proactive instead of reactive. It is harder still, to avoid the easy fixes that are marketed to our hospitals by too many consultants who lose sight of the fact that economic decisions, as pragmatic and number-driven as they may be, are nonetheless value-based decisions with social implications and consequences. There is a shared concern among those of us who operate healthcare institutions in the name of the Church, that the economic concerns which are necessarily central to management, may often, despite our best efforts, supersede the attention we can give to the behavioral and economic supports necessary for professional yet personal treatment of patients and quality pastoral care – the hallmarks of our ministry. This is not because compassionate treatment and care of patients and good pastoral care are no longer important or essential, but rather because they are assumed to be a "given" for Catholic healthcare providers. Because we are *believed* to excel in the areas of pastoral and compassionate care, we sometimes operate as if those dimensions of service which are so crucial to our ministry, exist out-

side the budgeting process and the productivity studies that necessarily drive the economic analysis. In short, they are "givens." In the stress of the day, we sometimes act as though our good will alone, and not the economic decisions we make, will carry the ministry forward.

In recent years we have begun to articulate in governing documents and in the mission statements of our healthcare corporations a goal to implement the social teachings of the Church. Sometimes, grappling with the content and application of those teachings as they apply the economic decisions and to the work place may be more difficult than adhering to the clinical ethical directives.

This is our challenge – the pressing need to reflect the social teaching of the Church in the adoption and use of the mainstream models of economic analyses. Often these business models may be based on unexamined assumptions expressing fundamentally different values about the nature of healthcare services in the economy; the value of the person; and the nature of the workplace. The reality is that economic decisions, which include the processes used and the factors considered and prioritized, in reaching the decisions, control the actual experience of people in our institutions, the relational value of the service exchanged between patient and provider, the credibility of our institutions as just work places in the community and the perception of our servant leadership. The economic decisions in a Catholic institution are often what really will make them distinguishable as Catholic. It is not that a Catholic hospital will not have to make the same hard decisions that its non-Church-related counterpart needs to make. The difference is in the analysis that leads to those hard decisions. Any analytical tool contains assumed value statements about the meaning of the individual, and the priority of rights to resources and the assignment of value to each one's work. What options are identified and which are chosen, depends often on the unarticulated values in the analytical tools and methods used.

The Church in the teachings of Vatican II, rooted in the incarnation, declares a fundamental principle of economic analysis:

"Human beings are the source, the center and the purpose of all socio-economic life... economic activity... detrimental to the worker is wrong and inhuman... workers should participate in running an enterprise... distribution of goods should be directed towards employment..."[1]

The Church calls healthcare an apostolate. The challenge of an economic model of analysis in a Catholic hospital is to deal with the business dimension as instrumental to the apostolate and not as an end in itself. An apostolate, with all that that term means theologically, in relation to its ultimate impact on individuals and the community, will not be a realized human experience if the tools of economic analysis from a business model are not consciously evaluated and modified in accord with the principles of the content of the Church's ethical and social teaching tradition.

While many have spoken about the essential characteristics of Catholic healthcare which distinguish it from all other healthcare delivery systems, perhaps no one has articulated it quite as eloquently as the late Joseph Cardinal Bernadin. In his address before the Harvard School of Business Club of Chicago,[2] he stated:

"...our healthcare delivery system is rapidly commercializing itself, and in the process is abandoning core values that should always be at the heart of healthcare... (despite the growing opinions of many) there is a fundamental difference between the provision of medical care and the production and distributions of commodities".

The assumption that the commercialization or distribution of healthcare as a commodity only happens in for-profit enterprises needs to be examined. A charitable corporation, using the same unexamined economic analyses as for-profits, may have the same effect in the community in terms of provider-patient relationships and stability in the community.

Harsh as it may sound, a Catholic hospital lacks integrity if it adheres to the prohibitions of the clinical ethical directives and never grapples with the affirmative implementation of the social teachings of the Church. The goal of the healthcare apostolate is not to simply conduct business enterprises which provide quality medical care and/or medical research, regardless of individual or societal implications. In his apostolic letter, *Dolentium Hominum*,[3] Pope John Paul II reminds us that the Church throughout the centuries has always recognized the fact that health care is an integral part of her mission, at the same time he calls our attention to the impact on our societies organizationally and the profound and pervasive ethical questions arising from rapid changes occurring within health care delivery. With great clarity the Holy Father reminds us that:

"The vast and complex sector (of social health care services) directly concerns the good of the human person and of society. Precisely for this reason it also poses delicate and inevitable questions which involve not only the social and organizational aspect, but the exquisitely ethical and religious one, since basic "human" events such as suffering, illness and death, are involved with the related questions about the role of medicine and the mission of the doctor with regard to the sick person. These new frontiers, then, opened by the progress of science and its possible technical and therapeutic

applications, touch the most delicate spheres of life at its very sources and in its most profound meaning".

Accordingly, we must never allow our focus to be diverted from these issues so basic to the Church's ministry. The practices and procedures of our Catholic institutions must never be at cross-purposes with the whole body of the Church's teachings, which Pope John Paul II has identified as normative for healthcare institutions and suggests the relationship of the institutions to the local Church.

"The teachings of the Magisterium are normative for Catholic health facilities and are constitutive of their identity. It is this truth which engages the mission and pastoral responsibility of the Church's Pastors in a very personal way. A Bishop will always have to delegate certain responsibilities with regard to the Catholic institutions operating within his Diocese. But this does not relieve him of the personal obligation to watch over the faith and Christian life of his people and, where necessary, call for proper teaching of the moral law."[4]

As we rapidly approach the third millennium, we as a Church see our essential healthcare ministries challenged by the proliferation of extraordinary clinical and technological advances, unprecedented deteriorations in healthcare financing, diminished governmental and societal support, and secularized organizational management attitudes.

However, changes in our healthcare system do not preclude us from following and even enhancing our mission imperatives. Results of a study undertaken in 1997, by the Association of Academic Health Centers in the United States, concluded that while the dramatic changes in our present day healthcare delivery system do pose significant challenges to its continued core values and viability, at the same time it affords us significant opportunities – in fact imperatives – to work towards a greater articulation and integration of our missions in our daily operations and strategic planning efforts.[5]

This message from the Association of Academic Health Centers (AAHC) parallels a similar message from the Second Vatican Council's Constitution of the Church in the Modern World.

...a change in attitudes and structures frequently calls accepted values into question (AAHC)

Traditional institutions, laws, and modes of thought and emotion do not always appear to be in harmony with today's world. This has given rise to a serious disruption of patterns and even norms of behavior (GS,7)

The work of Christ takes on the renewal of the whole temporal order (Vatican II,AA,5)

...the task of renewal engages the whole Church in the challenge to understand an manage changing structures and norms of behavior (AAHC).

The Church has always had the duty of scrutinizing the signs of the times and of interpreting them in the light of the Gospel ...We must therefore recognize and understand the world we live in, its expectations and its longings, and its often dramatic characteristics ... (GS4)

And further,

The people of God ... labor to decipher an authentic sign of God's presence and purpose in the happenings, needs and desires in which this people has a part along with other men of age. (GS4)

The 'signs of our times' in American healthcare call for our

study and our understanding in order to integrate our mission into not only daily operations and institutional strategic plans, but also to affect public policy decisions which promote access to healthcare as a human right. As Catholic hospitals struggle to meet budgets, we are asked to develop our economic and management strategies, which are based upon decisions about such issues as the following:

– Are employees cost centers or a resource?

– Is healthcare a social or private good?

– In the capitalistic economy, such as the United States, is one financial mechanism for access to capital morally better than another given the nature of the healthcare apostolate?

– What is the relationship of access to capital and stability in a community, especially a poorer community?

– What is the relationship of the legal structure of a healthcare organization and stability in a community, especially a poorer community?

– Should healthcare be distributed like any other commodity?

– Is it appropriate for both quality and access to be available unevenly?

– What is the relationship between a just wage, a legal wage, a competitive market wage, and what is the schedule of benefits that ought to form the basis of compensation in a hospital?

– What are the appropriate methods for both management and labor to use in a contested election for union representation if both parties claim the authority of Catholic social teaching and agree to work out an election procedure within the framework of the National Labor Relations Act?

These are only questions that underlie the analysis of funding for healthcare. How we answer them determines our approach when we face issues such as downsizing our hospitals' staffs, outsourcing jobs and pursuing mergers and joint ventures with new partners. The analysis of these questions necessarily requires management and consultants to examine the assumption of their analytical tools and to bring to that examination,

the content of the Church's teaching in regard to these questions. The integration of value questions such as these into our implementation of various economic models is the most pressing need facing the management, staff and trustees of our institutions.

Because it is so vital to Catholic healthcare administrators that we act in accordance with the Church's teachings when we implement specific economic strategies, it is important that we understand the Church's teachings. To be sure, the Church has a long history of social teachings that address the dignity of the worker and the very basic question of work itself, which as Pope John Paul II has stated is the center of the social question. In His encyclical, *On Human Work*, issues such as the positive and negative aspects of technology; the need to develop systems to reconcile the divisions between capital and labor; the relationship of the demands of work to family life, and the phenomenon of the new unemployment of intellectuals and professionals, are addressed. The discussion of the issues in the encyclical, are relevant to "the signs of the time" in American healthcare. The American Bishops have offered managers and their economic consultants fundamental criteria for evaluating the analytical tools acceptable in a Catholic hospital when implementing strategies in response to an economic crises. What does a given strategy do "for people" and "to people?" Who should participate in the development and selection of the options available to a Catholic hospital to solve its economic crises?[6]

In addition to these criteria, more recently, the American Bishops have addressed the growing numbers of unionization efforts of workers in Catholic hospitals. In September of 1999, the Domestic Policy Committee of the U.S. Catholic Conference issued a working paper entitled, *A Fair and Just Workplace: Principles and Practices for Catholic Health Care*. It is a collaborative effort on the part of the U.S. Catholic Conference Committee for Domestic Policy, Catholic Health Association, Leadership Conference of Women Religious, the AFL-CIO and the Service Employees International Union. The document is offered as a resource for reflection by all constituents.

Truly, these are challenging times for those of us in Catholic healthcare – not only in terms of our survival but also for truly making an impact. The mission of Catholic healthcare is carried out within a moral framework set by Church teaching and within an economic framework shaped by the market, public policy and available resources. Catholic Social Teaching has a long and proud tradition of thought rooted in scripture and the natural law. This tradition is found in papal encyclicals, the documents of the Second Vatican Council and Pastoral teachings of the American Bishops. Their content has been the source of dialogue and commentary among academicians. Now, American health care management is being asked to take that teaching out of the theoretical world of principles and norm and put them into practice – a formidable challenge!

Resources Within the Church that Support the Health Care Apostolate

In seeking to make the theoretical practical, we need to embark upon a three-step process that:

1) looks at the signs of our times;

2) analyzes the content and context of the Church's social justice teachings;

3) links these factors to the economic models we use.

A three-steps process; it is hardly as simple as it sounds. On the contrary, in his remarks to the Twelfth International Conference of this Pontifical Council for Pastoral Assistance to Health Care Workers, our Holy Father acknowledged "how complex health problems are, calling for joint, coordinated action, for effectively involving not only healthcare workers, but also those engaged in the field of education, the world of work, in protecting the environment and in the economic and political spheres."[7] Throughout his Pontificate, Pope John Paul II has repeatedly recognized the complexities and challenges of modern day healthcare, and has moved to establish organizational structures within the Holy See which provide essential assistance to those who work in and are served by the healthcare ministry; the Pontifical Council for Pastoral Assistance to Health Care Workers and the Pontifical Commission for the Apostolate of Health Care Workers being two such examples. Hopefully in the near future, we will see the materialization of yet a third opportunity for support and assistance, with the establishment of an international association of healthcare associations, supported in its activities by the Pontifical Council. Structures such as these provide the healthcare workers throughout the world with an opportunity for open and continuous dialogue among healthcare workers and Church leaders worldwide.

Within the United States we are fortunate to have a number of strong national and statewide associations to assist us. The Catholic Health Association has for a number of years provided us with excellent resources such as Social Accountability Budgeting, which is a tool for developing and tracking our affirmative efforts to serve the community. Accountable budgeting challenges our leadership to look at the short term and long term needs of the community, prioritizing those needs into the operational and capital budgets of the

hospital. This program has provided sponsors, administrators and trustees with invaluable tools and strategies, enabling them to be more responsive to the call of our ministry.

On a much more local level, dioceses such as my own, the Archdiocese of New York, and the sponsoring religious institutions through their healthcare systems are beginning to engage in collaborative dialogue and provide individual hospitals with resources affordable both in terms of money and the human intellectual capital to grapple with components of economic analysis, cost and economic indices. This supplemental assistance is focusing not only on realistic annual budgets but also on three to five year financial forecasts and, often, reviews of methodologies and assumptions and options in strategic financing and operational options. These programs will provide resources that attempt to address economic issues from multiple disciplines, which include the social teachings as discussed earlier.

Within the Catholic Health Care Network of the Archdiocese of New York, such a strategy has been employed and is now utilized at three of our hospitals. This approach has thus far been very positively received by our leadership, as it enables them to focus on daily issues while at the same time having highly skilled professionals look at future needs and opportunities.

The focus on technical assistance is not complete in itself. The goal is to be faithful to the apostolate. This brings us to the point of asking how can members of the Church help one another? I think the answer is that we can best help by being trusting and supportive. In fact, teacher, pastor and practitioner are all on a learning curve when it comes to the specific application of the social teaching to these very pressing economic situations in the incorporated apostolates in the American legal, political and socio-economic environments. We must be vigilant to be faithful without imposing unnecessary burdens on one another. The dialogue I referred to earlier is so important to our internal Church relationships. My own experience in the Archdiocese evidences that religious institutes and Bishops take very seriously the challenge of giving life to the vision of the Church, in the experiences of persons and communities served by our healthcare institutions, of making them apostolates, employing sound management and economic principles.

So far, I have concentrated on the situation of incorporated apostolates within the United States. A discussion of the pressing need for an economic analysis of Catholic hospitals would be incomplete if it focused only on national interests and left for a later time a sharing of resources if such becomes convenient. Doing justice is "a constitutive dimension of the preaching of the Gospel"[8] a "truly global vision is the hallmark of the Christian."[9]

The Catholic Church, Its Health Care Ministry And The Modern World

The Church views itself from both a local and universal perspective. One of the amazing things about our ministry is that we are part of a universal church, which views the whole as greater than the sum of its parts. I am impressed that this extends to the Church's healthcare ministry and that because we are truly a part of this ministry, the attention given to economic needs analysis is not solely limited to the hospitals within our diocese. Religious institutes and the Archdiocese of New York, who sponsor healthcare systems, are engaging management, employees and even their consultants to volunteer time to think of ways in which the resources of American healthcare can be shared with our brothers and sisters, internationally. We are exploring and designing, in the midst of our economic tensions, ways to reach out, to think globally, now. These efforts range from sharing human resources to developing capital financing mechanisms. Despite the current pressure on limited immediate resources, these efforts testify to real consciousness of the leadership of American hospitals to implement the teaching of Vatican II and read the signs of the times.

Thomas L. Friedman,[10] a modern day globalization specialist and multiple Pulitzer Prize winner, describes the immediate effect of events in one distant part of the world on other places. There is a more current expression found in the Second Vatican Council's *Gaudium et Spes*, a document written over thirty years ago, long before most of us ever conceived of the idea of globalization. *Gaudium et Spes*, prescient in content, admonishes us by reflecting that through the advances in technology we are all economically connected:

"One of the salient features of the modern world is the growing interdependence of men one on the other, a development promoted chiefly by the modern technical advances"[11] (GS, No.23).

The universality of the Church and the scope of its structures provide potentially effective forums to share both ideas and economic resources.

An example of such opportunity was the First Annual Pan-American Dialogue sponsored by the Pontifical Council for Pastoral Assistance to Health Care Workers and the Episcopal Conference of Latin America in March of 1999. With 12 different countries in attendance, dialogues and collaborative efforts were begun which within a single year resulted in significant and productive partner-

ships amongst and between the Church in America. A Catholic healthcare network has been established, and is now operational in Haiti; a community parish nursing program has begun in Honduras, a pediatric clinic is being staffed and supported in the Dominican Republic, a palliative cancer program and educational exchange has begun in Costa Rica and a primary healthcare center is now under construction in Tepepan, Mexico. None of this was even under consideration before the Pan-American Dialogue occurred. The Archdiocese of New York, like other dioceses and religious institutes, has committed staff to work with healthcare institutions to develop opportunities to share human and natural resources. Such is the power of international dialogue through our Church Universal.

Summary

Given the current day challenges facing Catholic healthcare, a comprehensive approach to financial analysis and strategic planning, that integrates our values as norms for economic analysis, is essential if we are to succeed in our efforts to sustain our ministry and remain viable participants in a highly competitive society that relates to its constituents globally.

We, together – pastors and practitioners – must continue to develop on both the national and international levels, the forums for cooperation such as the CHCN initiatives I have cited previously. These initiatives, each working in its appropriate sphere, will enable the institutions to focus both on the daily issues which burden them so critically, as well as the long term considerations of what can and should be done to sustain their future viability and identity.

As we rapidly approach the Eighth World Day of the Sick, which will be held in Rome on February 11, 2000, let us do as our Holy Father has asked, and contemplate the face of Christ in the sick.[12] Let us rejoice in all that we have and have done in the name and vision of Jesus yet remain ever cognizant of all that remains to be done in the name and vision of Jesus. Let us be open and willing to provide assistance whenever and wherever we can, at the same time as being open to accept the assistance from each other. As we prepare for our Jubilee Year, let us renew our spirits and commitments to serve, heal the sick and promote health in the name of our Lord. In this way, through compassionate service and tough but value-based economic analysis, we will as an incorporated apostolate be a Church where "faith does justice."

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Notes

[1] HENRIOT,PETER J., ET. AL, *Catholic Social Teaching: Our Best Kept Secret*, Orbis Books, Maryknoll, NY, 1996.

[2] JOSEPH CARDINAL BERNADIN, *Making the Case For Not-For-Profit Healthcare*, a speech before the Harvard School of Business Club of Chicago, January 12, 1995.

[3] POPE JOHN PAUL II, Apostolic Letter "Motu Propio", *Dolentium Hominum*, establishing the Pontifical Commission for the Apostolate of Health Care Workers, delivered at Rome at St. Peter's on February 11, 1985.

[4] POPE JOHN PAUL II, Letter from the Vatican, January 26, 1995, Greetings to His Borther Bishops on the Occasion of the Fourteenth Annual Workshop for Bishops, *The Splendor of Truth and Health Care*, Dallas, Texas.

[5] BULGER, ROGER J., OSTERWEIS, MARIAN, AND RUBIN, ELAINE R., *Mission Management; A New Synthesis*, Association of Academic Health Centers, 1999.

[6] *With Justice for All? The Ethics of Healthcare Rationing*, CHA,1991.

[7] Address by POPE JOHN PAUL II, *To Promote Health Development Based on Equity, Solidarity and Charity*, November 8, 1997, at Rome, The Vatican.

[8] 1971 Synod of Bishops, *Justice in the World*.

[9] HENRIOT, PETER, ET. AL, *Catholic Social Teaching: Our Best Kept Secret*, Orbis Books, Maryknoll, NY, 1996, p. 18

[10] FRIEDMAN, THOMAS L. *The Lexus and the Olive Tree; Understanding Globalization*, Farrar, Strauss, Ciroux, New York, 1999

[11] *Pastoral Constitution: On The Church In The Modern World – Gaudium et Spes*, Proclaimed by His Holiness Pope Paul VI on December 7, 1965.

[12] Address of Pope John Paul II, Message for the World Day of the Sick for the Year 2000, *Contemplate The Face Of Christ In The Sick*, Castel Gandolfo, 6 August 1999.