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TO HEALTH CARE WORKERS

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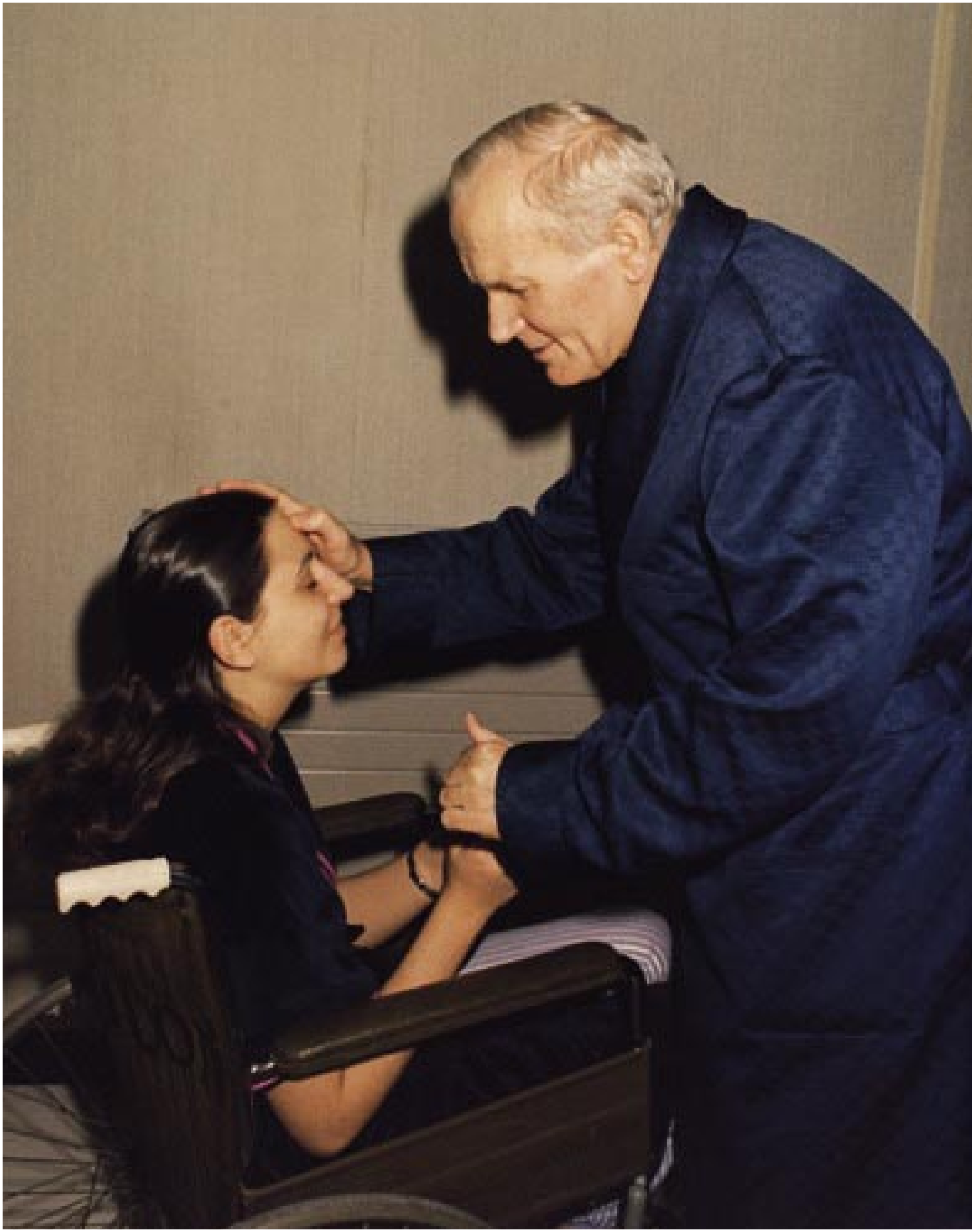
Summary

The illustrations in this edition are taken from the book:
Los Niños Jesús del Museo "Casa de los Pisa"
Granada



“As a mother comforts a child, so I shall comfort you”

(Is 66,13)

The Holy Father's Message for the World day of the Sick for the Year 2000 Rome, February 11th 2000

1. The Eighth World Day of the Sick will be held in Rome on 11 February 2000, the year of the Great Jubilee, and will find the Christian community dedicated to re-examining the reality of illness and suffering in the perspective of the mystery of the Incarnation of the Son of God, to draw from this extraordinary event new light to illumine these basic human experiences.

At the end of the second millennium of the Christian era, as the Church looks with admiration at humanity's progress in the treatment of suffering and improved health care, she is paying attention to the questions raised by the health-care sector, the better to define her presence in this context and to respond appropriately to the pressing challenges of the time.

Throughout history, people have made the most of their intellectual and emotional resources to overcome the limits inherent in the human condition, and have made great breakthroughs in health care. It is enough to think of the possibility of prolonging life and improving its quality, of alleviating suffering and of increasing a person's potential through the use of good, reliable medicines and increasingly sophisticated technologies. In addition to these achievements are those of a social kind, such as the widespread awareness of the right to treatment and its expression in juridical terms in the various "Charters of the rights of the sick". Nor should we forget the significant development achieved in the area of assistance due to the emergence of new medical applications, of a nursing service which is ever better qualified and of the phenomenon of voluntary service, which has recently reached a high degree of competence.

2. However, at the end of the second millennium we cannot say that humanity has done all that is necessary to alleviate the immense burden of suffering which weighs on individuals, families and entire societies.

On the contrary, it seems that especially in this last century the river of human pain, already swollen due to the frailty of human nature and the wound of original sin, as well as the suffering inflicted by the mistakes of individuals and of States, has broadened: I am thinking of the wars that have caused so much bloodshed in this century, perhaps more than in any other in humanity's tormented history; I am thinking of the types of disease that are prevalent in society such as drug dependency, AIDS, illnesses caused by the deterioration of the big cities and the environment; I am thinking of the increase in organized crime, both small- and large-scale, and of the proposals of euthanasia.

I have a mental picture not only of the hospital beds in which so many of the sick are lying, but also of the sufferings of refugees, orphaned children and the many victims of social evils and poverty.

At the same time, with the eclipse of faith, especially in the secularized world there is a further serious cause of suffering, that of no longer being able to grasp the salvific meaning of pain and the comfort of eschatological hope.

3. Sharing in the joys and hopes, sorrows and anxieties of the people of every age, the Church has constantly accompanied and sustained humanity in its struggle against pain and its commitment to improve health. At the same time, she has striven to reveal to mankind the meaning of suffering and the riches of the Redemption brought by Christ the Saviour. History records great men and women who, prompted by their desire to imitate Christ through a deep love for their poor and suffering brethren, started countless initiatives of social assistance, brightening the last two millenniums with good works.

Next to the Fathers of the Church and the founders and foundresses of religious institutes, how can we fail to wonder at and admire the countless people who, in silence and humility, have given their lives in service to their sick neighbour, in many cases to the point of heroism? (cf. Vita consecrata, n. 83). Daily experience shows how the Church, inspired by the Gospel of charity, continues to contribute with many works, hospitals, health-care structures and volunteer organizations, to promoting health and to caring for the sick, paying special attention to the most underprivileged in all parts of the world, notwithstanding the cause of their suffering, whether voluntary or involuntary.

This presence should be maintained and encouraged for the benefit of the precious good of human health, looking carefully at all the inequalities and contradictions in the world of health-care that still exist.

4. Indeed, down the centuries, beside the light areas, shadows have obscured and still obscure the overall picture of improvements in health care, many aspects of which are truly fine. I am thinking in particular of the serious social inequalities in access to health-care resources, which are still present in vast areas of the world, especially in the countries of the South.

This unjust inequality is more and more dramatically undermining the basic rights of the person: entire populations do not even have the possibility of benefiting from primary, basic medicines, while elsewhere even expensive medicines are widely wasted and misused. And what can be said of the many brothers and sisters who lack the minimum to appease their hunger and are subject to every kind of disease? Not to mention the numerous wars which stain humanity with blood and are spreading physical and psychological traumas of every kind, as well as death.

5. With regard to these scenarios, we must recognize that unfortunately, in many cases, the economic, scientific and technological breakthroughs have not brought re-

al progress that is focused on the person and the inviolable dignity of every human being. Even the achievements in the field of genetics, which are fundamental in health care, especially for the protection of newborn life, can become an opportunity for inadmissible choices, callous manipulation and interests that contradict real development, often with devastating results.

On the one hand remarkable efforts are being made to prolong life and even to procreate it artificially; but on the other, birth is not permitted to those who have already been conceived, and the death of those no longer considered to be of use is hastened. Furthermore: while health is rightly appreciated with increasing initiatives to promote it, at times reaching a sort of cult of the body and a hedonistic quest for physical fitness, at the same time we are reduced to considering life as a mere consumer good, setting a new scale of marginalization for the disabled, the elderly and the terminally ill.

All these contradictions and paradoxical situations stem from a lack of harmony on the one hand, between the logic of well-being and the search for technological progress, and the logic, on the other, of ethical values based on the dignity of every human being.

6. On the eve of the new millennium, it is hoped that "the purification of memory" will also be promoted in the world of suffering and health, which will lead to "recognizing the wrongs done by those who have borne or bear the name of Christian" (Incarnationis mysterium, n. 11; cf. also Tertio millennio adveniente, nn. 33, 37, 51). The ecclesial community is called to accept, in this field too, the invitation to conversion which is linked to the celebration of the Holy Year.

The process of conversion and renewal will be helped if we continually raise our eyes to the One who, "in the sacrament of the Eucharist ... took flesh in Mary's womb 20 centuries ago, [and] continues to offer himself to humanity as the source of divine life" (Tertio millennio adveniente, n. 55).

The mystery of the Incarnation means understanding life as a gift from God, to be looked after responsibly and used for good: health is thus a positive attribute of life, to be sought for the good of the person and of one's neighbour. However health is a "penultimate" good in the hierarchy of values, which should be fostered and considered with a view to the total, and thus also spiritual, good of the person.

7. In this circumstance we turn our gaze in particular to the suffering and risen Christ. In taking on the human condition, the Son of God accepted to live it in all its aspects, including pain and death, fulfilling in his person the words he spoke at the Last Supper: "Greater love has no man than this, that a man lay down his life for his friends" (Jn 15:13). In celebrating the Eucharist, Christians proclaim and share in the sacrifice of Christ, for "by his wounds [we] have been healed" (cf. 1 Pt 2:24) and uniting themselves with him, "preserve in their own sufferings a very special particle of the infinite treasure of the world's redemption, and can share this treasure with others" (Salvifici doloris, n. 27).

The imitation of Jesus, the suffering Servant, has led great saints and simple believers to turn their illnesses and pain into a source of purification and salvation for themselves and for others. What great prospects of personal sanctification and cooperation for the salvation of the world does the path marked out by Christ and by so many of his disciples open to our sick brothers and sisters! It is a difficult path, because the human being does not discover the meaning of suffering and death on his own, but it is always a possible path with the help of Jesus, interior Master and Guide (cf. Salvifici doloris, nn. 26-27).

Just as the Resurrection transformed Christ's wounds into a source of healing and salvation, so for every sick person the light of the risen Christ is a confirmation that the way of fidelity to God can triumph in the gift of self until the Cross and can transform illness itself into a source of joy and resurrection. Is not this the proclamation that echoes in hearts at every Eucharistic celebration when the people proclaim: "Christ has died, Christ has risen, Christ will come again"? The sick, also sent out as labourers into the Lord's vineyard (cf. Christifidelis laici, n. 53), by their example can make an effective contribution to the evangelization of a culture that tries to remove the experience of suffering by striving to grasp its deep meaning with its intrinsic incentives to human and Christian growth.

8. The Jubilee also invites us to contemplate the face of Jesus, the divine Samaritan of souls and bodies. By following the example of her divine Founder, the Church, "from century to century ... has re-enacted the Gospel parable of the Good Samaritan, revealing and communicating her healing love and the consolation of Jesus Christ.... This came about through the untiring commitment of the Christian community and all those who have taken care of the sick and suffering ... as well as the skilled and generous service of health-care workers" (Christifideles laici, n. 53). This commitment does not derive from specific social situations, nor should it be understood as an optional or fortuitous act, but is an intransgressible response to Christ's command: "he called to him his twelve disciples and gave them authority over unclean spirits, to cast them out, and to heal every disease and every infirmity" (Mt 10:1, cf. 7-8).

The service rendered to the person who is suffering in body and soul takes its meaning from the Eucharist, finding in it not only its source but also its norm. It was not by chance that Jesus closely united the Eucharist with service (Jn 13:2-16), asking the disciples to perpetuate in memory of him not only the "breaking of the bread", but also the "washing of the feet".

9. The example of Christ, the good Samaritan, must inspire the believer's attitude, prompting him to be "close" to his brothers and sisters who are suffering, through respect, understanding, acceptance, tenderness, compassion and gratuitousness. It is a question of fighting the indifference that makes individuals and groups withdraw selfishly into themselves. To this end, "the family, the school and other educational institutions must, if only for humanitarian reasons, work perseveringly for the

reawakening and refining of that sensitivity towards one's neighbour and his suffering" (Salvifici doloris, n. 29). For the believer, this human sensitivity is expressed in the agape, that is, in supernatural love, which brings one to love one's neighbour for love of God. In fact, guided by faith and surrounding with affectionate care those who are afflicted by human suffering, the Church recognizes in them the image of her poor and suffering Founder and is concerned to alleviate their suffering, mindful of his words: "I was sick and you visited me" (Mt 25:36).

The example of Jesus, the good Samaritan, not only spurs one to help the sick, but also to do all one can to reintegrate him in society. For Christ, in fact, healing is also this reintegration: just as sickness excludes the human being from the community, so healing must bring him to rediscover his place in the family, in the Church and in society.

I extend a warm invitation to those involved professionally or voluntarily in the world of health to fix their gaze on the divine Samaritan, so that their service can become a prefiguration of definitive salvation and a proclamation of new heavens and a new earth "in which righteousness dwells" (2 Pt 3:13).

10. Jesus did not only treat and heal the sick, but he was also a tireless promoter of health through his saving presence, teaching and action. His love for man was expressed in relationships full of humanity, which led him to understand, to show compassion and bring comfort, harmoniously combining tenderness and strength. He was moved by the beauty of nature, he was sensitive to human suffering, he fought evil and injustice. He faced the negative aspects of this experience courageously and, fully aware of the implications, communicated the certainty of a new world. In him, the human condition showed its face redeemed and the deepest human aspirations found fulfilment.

He wants to communicate this harmonious fullness of life to people today. His saving action not only aims to meet the needs of human people, victims of their own limits and errors, but to sustain their efforts for total self-fulfilment. He opens the prospect of divine life to man: "I came that they may have life, and have it abundantly" (Jn 10:10).

Called to continue Jesus' mission, the Church must seek to promote a full and ordered life for everyone.

11. In the context of the promotion of good health and quality of life correctly understood, two duties deserve the Christian's special attention.

First of all the defence of life. In today's world, many men and women are striving for a better quality of life with respect for life itself and are reflecting on the ethics of life so as to dispel the confusion of values that sometimes exists in today's culture. As I recalled in my Encyclical Evangelium vitae, "significant is the reawakening of an ethical reflection on issues affecting life. The emergence and ever more widespread development of bioethics is promoting more reflection and dialogue – between believers and non-believers, as well as between followers of different reli-

gions – on ethical problems, including fundamental issues pertaining to human life" (n. 27). However, beside these there are many, unfortunately, who are engaged in promoting a worrying culture of death, spreading a mentality imbued with selfishness and hedonistic materialism, and with the social and legal sanction of the suppression of life.

At the root of this culture there is often a Promethean attitude which leads people to think that "they can control life and death by taking the decisions about them into their own hands. What really happens in this case is that the individual is overcome and crushed by a death deprived of any prospect of meaning or hope" (Evangelium vitae, n. 15). When science and medical practice risk losing sight of their inherent ethical dimension, health-care professionals "can be strongly tempted at times to become manipulators of life, or even agents of death" (ibid., n. 89).

12. In this context, believers are called to develop the insight of faith as they look at the sublime and mysterious value of life, even when it seems frail and vulnerable. "This outlook does not give in to discouragement when confronted by those who are sick, suffering, outcast or at death's door. Instead, in all these situations it feels challenged to find meaning, and precisely in these circumstances it is open to perceiving in the face of every person a call to encounter, dialogue and solidarity" (ibid., n. 83).

This task especially involves health professionals: doctors, pharmacists, nurses, chaplains, men and women religious, administrators and volunteer workers who, by virtue of their profession, are called in a special capacity to be guardians of human life. However, it also calls into question every other human being, starting with the relatives of the sick person. They know that "the request which arises from the human heart in the supreme confrontation with suffering and death, especially when faced with the temptation to give up in utter desperation, is above all a request for companionship, sympathy and support in the time of trial. It is a plea for help to keep on hoping when all human hopes fail" (ibid., n. 67).

13. The second duty which Christians cannot shirk concerns the promotion of a health worthy of the human being. In our society there is a risk of making health an idol to which every other value is subservient. The Christian vision of the human being opposes a notion of health reduced to pure, exuberant vitality and satisfaction with one's own physical fitness, far removed from any real consideration of suffering. This view, ignoring the person's spiritual and social dimensions, ends by jeopardizing his true good. Precisely because health is not limited to biological perfection, life lived in suffering also offers room for growth and self-fulfilment, and opens the way to discovering new values.

This vision of health, based on an anthropology that respects the whole person, far from being identified with the mere absence of illness, strives to achieve a fuller harmony and healthy balance on the physical, psychological, spiritual and social level. In this perspective, the person himself is called to mobilize all his available energies to fulfil his own vocation and for the good of others.

14. This model of health requires that the Church and society create an ecology worthy of man. The environment, in fact, is connected with the health of the individual and of the population: it constitutes the human being's "home" and the complex of resources entrusted to his care and stewardship, "the garden to be tended and the field to be cultivated". But the external ecology of the person must be combined with an interior, moral ecology, the only one which is fitting for a proper concept of health.

Considered in its entirety, human health thus becomes an attribute of life, a resource for the service of one's neighbour and openness to salvation.

15. In the Jubilee year of the Lord's favour – "a year of the remission of sins and of the punishment due to them, a year of reconciliation between disputing parties, a year of manifold conversions and of sacramental and extra-sacramental penance" (Tertio millennio adveniente, n. 14) – I invite pastors, priests, men and women religious, the faithful and people of goodwill courageously to face the challenges that threaten the world of suffering and health.

May the International Eucharistic Congress, which will be celebrated in Rome in 2000, become the ideal centre, radiating prayers and initiatives that can make the divine Samaritan's presence alive and active in the world of health care.

I fervently hope that through the contribution of our brothers and sisters in all the Christian Churches, the celebration of the Jubilee of the Year 2000 will mark the development of ecumenical collaboration in loving service to the sick, so as to witness clearly to everyone to the search for unity on the concrete path of charity.

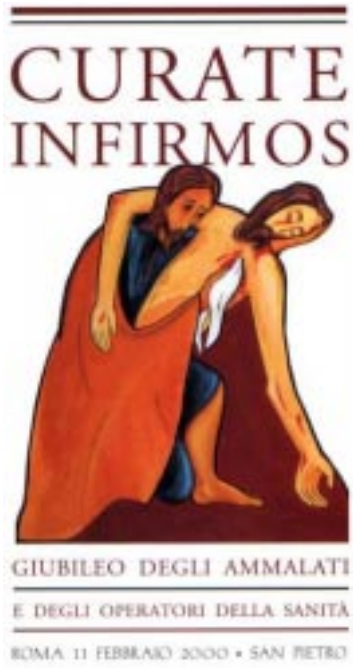
I address a specific appeal to the international political, social and health-care organizations in every part of the world to be convincing promoters of concrete projects to fight all that is harmful to the dignity and health of the person.

May we be accompanied in the process of active participation in the lives of our sick brothers and sisters by the Virgin Mother who at the foot of the Cross (cf. Jn 19:25) shared the sufferings of her Son and, with her expert experience of suffering, offers her constant and loving protection to those who are suffering in mind and body the limits and wounds of the human condition.

I entrust the sick and all those who are close to them to her, Health of the sick and Queen of peace, so that with her motherly intercession she will help them to build the civilization of love.

With these hopes, I impart a special Apostolic Blessing to everyone.

From Castel Gandolfo, 6 August 1999, the Transfiguration of the Lord.



Pilgrimage to Places of Suffering during the Jubilee Year 2000*

1. Why this pamphlet?

The Pontifical Council for Pastoral Assistance to Health Care Workers offers this pamphlet as a support for the gaining of the *Jubilee induglence* by means of activity connected with the health-care ministry, in the spirit of the Papal Bull *"Incarnationis Mysterium"* issued for the Great Jubilee of the year 2000,

"In every place if a visit is made for a suitable time to brothers and sisters who are in need or difficulty (the sick, prisoners, the lonely elderly, the handicapped, etc...), thereby engaging in a pilgrimage towards Christ present within them (cfr *Mt* 25:34-36)..." (Penitenzieria Apostolica, *Disposizioni dell'Indulgenza Giubilare,* n. 4).

2. What is the Jubilee?

For the Church, the Jubilee is a *"kairos"*, a favourable time for grace when the Christian faithful are asked, above all else, to bear witness to the charity of God, to His tenderness towards all men and women, with special care and concern for those who are suffering.

3. The gift of indulgence

We should remember that conversion and forgiveness are amongst the constituent elements of the Jubilee event. The gift of indulgence is closely bound up with conversion and forgiveness. Indulgence involves the remission before God of the temporal punishment due to sins whose guilt has already been forgiven. The gift of indulgence is thus one of the most important fruits of the Jubilee.

During the period of time covered by the Jubilee, all the faithful, after suitable preparation, can abundantly gain from the gift of indulgence, subject to the performance of certain duties, which are as follows: *sacramental confession, eucharistic communion, pilgrimage, prayer according to the guidelines of the Holy Father, visits to places of care and treatment or similar such places, activities and actions involving charity and penance.*

4. Pilgrimage towards Christ who is present in our suffering brothers and sisters

To receive the gift of indulgence a rediscovery of the following is of importance:

– the importance of prayer in its various forms on behalf of the sick, their families, and those who are taking care of them; this involves praying for and with the sick, and pastoral and health-care workers, in the family, in hospitals, and in other places of care and treatment;

* This text is taken from a brochure issued specially for the Jubilee by the Pontifical Council for Pastoral Assistance to Health Care Workers.

– that hospitals and other places where the sick are to be found are a destination for pilgrimage during the period of the whole Jubilee – a pilgrimage towards Christ who is present in our suffering brothers and sisters;

– that the sick and in need person is a special place of spiritual action for the *Christian community:* "I was sick and you visited me" (Mt 25:36).

"No person can say that he is a neighbour to other people if he does not draw near to their pain..."

It is necessary, therefore, to promote initiatives which draw Christian communities near to sick people, and this should involve attempts:

– to achieve improved knowledge of the health-care world (its mission, programmes, and problems);

– to help in some way to find remedies and solutions to the problems which are identified;

– to dedicate special attention to sick people afflicted by specific illnesses (for example, cancer, drug-addiction, AIDS, etc.);

– to offer one's own free time so as to be with sick people and thereby ensure that they are not lonely or marginalised.

5. Guidelines and suggestions for visits to a hospital, a nursing home, or the home of a family which has a sick person...

In the spirit of engaging in a pilgrimage towards Christ present in the suffering – the sick, the handicapped, the lonely elderly, etc. (cfr Mt 25:34-36) – a group of the faithful or an individual believer can visit a specific hospital, nursing home, or family, in order to gain the Jubilee indulgence.

The visit should involve and draw in the people connected with it so as to achieve a shared and fraternal Jubilee celebration of the compassion of God hand in hand with those suffering from sickness and those who take care of them.

When such an event takes place, and after the necessary consultation with the management of the institution concerned or those who are otherwise involved, certain meaningful moments could be planned, such as:

a. *A celebration of the eucharist* or *a liturgical celebration* (Lauds, Vespers), or another pious exercise in devotion (the Via Crucis, the Marian Rosary, the saying of the Akathistos hymn in honour of the Mother of God).

The celebration should make the sick and the health-care workers who take part in it real protagonists of the event (readings of the Word of God, descriptions of the intentions of the prayers of the faithful, forms of offering, different kinds of witness, etc.)

b. In order to give further witness to these expressions of solidarity and neighbourliness, *certain specific wards or sections of the health-care institution* could be visited by all the "pilgrims" or by some members of the group.

c. *A moment of reflection and study* on a subject to do with the defence of health or the salvific meaning of suffering itself could also be organised.

d. If circumstances allowed, *a moment of happiness together and of festivity* could also be engaged in.

6. The penitential spirit and sharing

To receive the gift of indulgence it is also important to promote the spirit of penitence by means of practical initiatives of generosity, of sharing, and of fraternal solidarity, such as:

a. Abstinence from superfluous consumption in order to donate a sum of money to people afflicted by AIDS, to research into cancer and other various forms of disease, to the building and equipping of hospitals, or to bodies and associations active in the world of suffering and health care to help them to meet their various needs.

b. Support for social and charitable works of a religious character, with special solicitude for children afflicted by serious illnesses or infirmities (cancer, drug-addiction, disability, etc.).

c. The carrying out of a practical act of charity which meets the needs of a specific locality (for example, a readiness to meet and receive the relatives of sick people, the organisation of rounds of voluntary work, economic help to support care and treatment of a sick person who lacks necessary financial means, etc.).

7. The meaning of the Jubilee emblem for the World Day of the Sick 2000

The World Day of the Sick of the Jubilee year has a very special meaning, both with regard to its contents and in relation to its unfolding and the participation of people in it.

This emblem symbolically represents the risen Jesus Christ who is tenderly supporting the Crucified Jesus.

He is the Good Samaritan who raises up the wounded man and takes care of him. We should do likewise.

World Symposium
of the AISAC
(International Association
of Catholic Health-Care
Institutions)

"Catholic Health-Care
Institutions as Witness
to the Church"

1-3 July 1999

Nova Domus
Sanctae Marthae,
the Vatican City

Proposals for the Identity of the Catholic Hospital*

Characteristics of a Catholic Hospital

The Episcopal Conference of the United States of America suggests the following characteristics: to be motivated by the Gospel, to have great respect for patients and their families, to demonstrate special care and concern for marginalised people, the promotion of medical research and co-operation with those other health-care centres which accept Catholic principles, the fair and equitable treatment of members of the administrative staff, obedience to what is laid down in the CIC, the presence of pastoral workers who are very well trained, co-operation with the local parishes, a special emphasis on the offering of the sacraments, the preparation of the ministries of the eucharist, special concern for the anointing of the sick, and the promotion of the receiving of the last sacraments.

1. The Ecclesial Nature of a Catholic Hospital

1. Basic Elements

In every hospital we find three indispensable elements, and these are: 1) *service to the sick;* 2) *institutionalised relationships between those people who provide this service and the patients themselves, which must indeed be something very special in character;* and 3) *the management of the hospital itself.* When these three elements – service, institutional relationships, and management – are based upon a Christian approach, that is to say upon the Gospel message and Christian charity, then that hospital can define itself as being Christian. When the Gospel message and Christian charity are those which are practised, lived out and taught by the Catholic Church then that hospital may be deemed to be Catholic.

2. The Ecclesial Mission and the Catholic Hospital

The Catholic hospital bases its identity on the mission received by the Church from Christ to heal the sick (Lk 9:1-2).

3. The Holy Spirit and the Catholic Hospital

In the past and still today the Church is motivated in her service to the sick by that love towards God which is infused in her by the Holy Spirit.

4. The Ecclesial Calling and the Catholic Hospital

The Holy Spirit enables us to understand that Christ is present in a special way in the sick, and in those sick people who are most in need and least potected. He calls upon the ecclesial community to extend its range of action and increase its communitarian links with these people.

5. Bishops, the Eucharist and the Catholic Hospital

The essence itself of the Church is fulfilled in the calling by which she is constituted. Given that today this calling is fulfilled fully by the bishop in the eucharist, the Catholic hospital cannot be understood as something which does not have a bond with him, and at a practical level without reference to the celebration of the eucharist.

6. The Pastoral Care Offered by the Sacraments and the Catholic Hospital

The first dimension which should be stressed in the creation of the Catholic hospital is the pastoral dimension. In the Catholic hospital pride of place must be given in particular to the eucharist and thus to the pastoral care offered by the sacraments.

7. The Chaplain of the Catholic Hospital

It is obvious that in order to be a chaplain of a Catholic hospital the approval of the bishop – of whom the chaplain is a representative – is required.

8. Holy Scripture

Holy scripture in this context is the conscious explanation of the call which God through Christ makes in the hospital environment and which is expressed in the individual circumstances of the patient by means of the gift of the Holy Spirit.

2. Prominent Features of the Catholic Hospital

1. Humanism

Health-care workers must personalise their way of taking

care of the sick person. That person should never be seen as being just another case amongst many others. The example of the Good Samaritan is the model which should be followed.

2. Training

The ministry of health must be carried out through the use of medical science and technology – elements which must at all costs be dominated.

3. Unborn Life

The basic principle is that life is the gift of God. Man receives life from God and he is nothing else but a steward who must give life as God himself has established it must be given. Every transmission of life, and everything connected with that transmission, which is not based on this principle, must be alien to a Catholic hospital.

4. Life at its Terminal Stage

A Catholic hospital must take care of life during its terminal stage. It must make terminally-ill patients and their family relatives aware of the fundamental and decisive reality of the resurrection. It must prepare the patient for his passing away by giving him the spiritual support which he requires and needs.

5. Economics

A Catholic hospital is not a "business" where the ultimate criteria of its existence is profit. This does not mean that a Catholic hospital and the services it provides must be free. It must, rather, be a place where the *Christian communication of goods* takes place.

6. Co-operation

It should be affirmed that every Catholic or health-care centre must not co-operate in any action which is morally unacceptable. Any formal co-operation in this action makes the Catholic institution guilty of the same wrong action in which it co-operates.

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

***** This text is made up of selected parts of the article by H.E. Mons. Lozano which was published in *Dolentium Hominum* n.41/II-1999.

The Canon Law Aspect

The Nature and Meaning of Law

A way of understanding the function and importance of law, quite apart from the only articles of the code which discuss hospitals, could be, paradoxically, the parable of the Good Samaritan, a figure very dear to health-care workers. The Good Samaritan could not only be a paradigm of charity but also a paradigm of what law should be.

Indeed, justice, according to the classic definition, involves "giving to each person that which is his due" *(unicuique ius suum tribuere).* What should be given first and foremost to each and every man, the first duty and basis of every form of law, is recognition of his human dignity. The Good Samaritan, therefore, in a way which is inseparable from his essential act of charity, also performs the first elementary act of justice – he redeems the dignity of a real man who is wounded, forgotten and dying.

Canon Law

Every legal system which honours its own name cannot fail to be a social development of that primogenial dignity. Equally and in the same way, canon law springs from the normative extension of the baptismal dignity of the Children of God and from the dignity of the presence of Jesus Christ within the Church (in turn the dignity of the children of God is the ultimate basis of human dignity).

The Church is the messianic people created by the alliance of God with men, and an alliance which in terms of the new law becomes vital communion. This reality of the Church, which is the admirable union of the divine with the human, also manifests itself in a complex of social rights and duties, and more specifically, in canon law. This last, therefore, is the set of relationships of justice determined by the divine origins of the Church, by her structure, by her goals, by her goods and means, developed down history and the life of peoples. In other words, the nature of the Church as the Mystical Body of Christ, of sacrament of his presence amongst men, and of continuity of his mission, means that canon law is a law of communion – of communion of Christians with Jesus and in Jesus who is in communion with them.

There is a starting and constitutive nucleus of divine law in canon law which is made up of those elements which conform to, and follow, the founding will of Jesus Christ – ministerial priesthood/shared priesthood, universal vocation to holiness/the sacraments, magisterium and government, and universal Church/specific Church. There are also elements of natural law which derive from human dignity because the Church is a people of men (the right to life, to a good reputation, to privacy, to the free choice of status, etc.). Lastly, there are also rights and duties which are of human creation, namely those relating to the self-organisation of the Church at each and every historical moment and to the ways which are considered necessary and suitable in order to defend the fundamental positive elements of divine law and natural law.

In order for every form of activity which people want to carry out within the Church to be in authentic terms ecclesial activity, it must be placed and located within the framework of canon law. This is something which also applies to Catholic hospitals.

Catholic Hospitals and Canon Law

As a social phenomenon, a hospital is an organisation of persons and things dedicated to the provision of certain health and health-care services. Such a dynamic system composed of a set of such elements, operating within the civil-state context, will have a legal status which is most suitable to its mission according to its particular circumstances: a foundation, a civil association, a share-based company, forms of co-operation between public and private, etc. Its activity is governed by specific health-care rules and regulations, and, more in general, by the legislation which governs social and economic activity from

labour law to civil law and from administrative law to criminal law.

In the field of canon law a hospital has a whole host of configurations according to the manifold options of the People of God on its journey, and according to the various legal relationships which can be established in relation to a Catholic health-care structure.

There can be, therefore, hospitals which belong to a diocese, or to other entities of a heirarchical character, or to a religious order, or to a public association of the faithful. There can also be a duality between the owner of the goods (a certain juridical person) and those who are responsible for the health-care services alone (another juridical person), and there can even be more than two persons (the owner of the goods, those responsible for the activity of the hospital, and those who are in charge of spiritual and pastoral care). There are also liturgical requirements concerning the discipline of the sacraments and those sacred elements which are directly relevant to hospitals. With regard to the service offered by people, there should be a harmonisation between canon law requirements and those relating to civil labour, and this is especially the case with regard to members of religious orders or diocesan priests who have pastoral tasks and responsibilities within the hospital structures etc.

In each and every practical situation it is necessary to study the various constraints and also understand the relative obligations, rights and responsibilities both within the health-care organisation and in its relations with the universal Church and with the particular Churches. Furthermore, there will always be a need for the judgement of the heirarchy in order to be able to enjoy the adjective "Catholic". This judgement expresses an appreciation of the presence of the essential elements of belonging to the people of God and of service to the mission of that people.

Law, Guarantee of Identity and Point of Departure for the Carrying out of Mission

To be a Catholic is not merely a title. In the same way it is not a sentimental attachment to certain more or less defined principles. To be a Catholic is to belong to the People of God and in this way to live in communion with Jesus Christ. Law indicates to us the conditions for the existence of this communion and thus becomes the guarantee for the identity of the Christian and of ecclesial works.

Knowing and living canon law in practical and real circumstances is a necessary means and instrument by which to know and develop all the consequences of living in the Church. Catholic hospitals must be faithful witnesses to, and promoters of, the dignity of the Children of God, and they must bring about the Kingdom through health care assistance. A suitable integration into canon law is nothing else but integration into the Church, and this is something which allows the full performance of the mission of Good Samaritans who bring to the sick person not only help and physical relief but also Jesus Christ himself, who heals the body in order to reveal to man the fullness of his being.

Mons. OSVALDO NEVES DE ALMEIDA,
Official of the Secretariat of State, the Holy See

The Legal Identity of the Catholic Health-Care Institution*

1. Premise

This subject is a very complex one because:

– it involves both canon law and state law, and because

– the question of identity is *above all else* a question of the *defence* of this identity.

2. A Categorisation in Terms of Canon Law

It is useful in addressing this subject to employ the distinction made in doctrine between ecclesial institutions, ecclesiatical institutions, and institutions which are simply Christian in character.

a) Ecclesial institutions are institutions which the Church is based upon in a structural sense, which have a divine origin (for example the Episcopate) or a historical origin (for example the episcopal conferences), whose purpose is directly supernatural, and are thus completely beyond the legal system of the State.

b) Ecclesiastical institutions engage in ambivalent activity (or have an ambivalent purpose) in the sense that they have an immediate and well-defined temporal purpose (for example schools, hospitals, welfare and charitable institutions, etc.) but at the same time they are also characterised by the fact of being endowed with an apostolic goal.

In particular, such institutions are instruments which seek the spiritual advance of those people who work in them, or of those individuals who are the subjects of their activity. In relation to these institutions, the Church claims an inalienable right-duty based upon a dual natural and supernatural right (cf 1 Tim 3:15; AA 8: GS 42; GE 3 and 8).

c) Christian institutions are a reality which come into being and work directly and exclusively within the state legal framework, even though their intention is to communicate Christian values to society (for example parties or trade unions of a Catholic inspiration).

Catholic health-care institutions are generally to be placed within the second category (where there is a complete matching of goals and activity). Sometimes they also belong to the first category (their specific health-care activity also forms a part of their general aim).

3. Catholic Health-Care Institutions as *"Res Mixtae"*

– The ways in which they belong to the *"rex mixtae"* (with regard to their activity).

– They bear upon *Libertas Ecclesia* and religious freedom.

– They necessarily have a complex legal status (canonical – state) because they arise from *within* the Church but are directed towards activity *outside* the Church.

– The question of the "compatibility" between obedience to canon law and obedience to state law.

– The question of the distinction between having an ecclesiastical character and having a purpose involving religion or religious worship (Can. 114,2; Can 2,98, art 16; law 222/1985).

4. The "Identity" of Catholic Health-Care Institutions

This is determined by the presence of a number of elements or factors:

a) their origins. Their ecclesiastical character means that they are entities which are expressions of freedom or entities which have structural functions.

b) the specific and defined sphere of their activities (health care).

c) the special goals and aims which cover (but are not limited to) the "good of health" (that is to say institutions which have a special purpose...).

5. The Defence of "Identity"

The question of the compatibility between "identity" and general law. Full respect for the identity of such institutions often requires such institutions to be subject to state law – however not through their automatic subjection to general law but through a special legal arrangement which takes their origins and their special aims and goals into account.

This means that such institutions cannot, for example, be exempt from those controls envisaged by canon law to ensure the safeguarding of their nature, but at the same time it also means that they cannot be subject to obligations, which, although envisaged by legislation applied as a whole to public and private health-care institutions, are not compatible with this above-mentioned character.

For example: national laws which oblige hospital institutions to provide health-care treatment which goes against Catholic morality.

Vice versa, it is completely legitimate for them to be subject to general law in matters involving, for example, administrative authorisation; the (administrative and technical) supervision by public authorities of the health-care activity which they engage in; the control of the presence of certain requirements which are pre-conditions to the exercise of health-care activity; the control of budgets and accounts when the activity of such institutions receives public financing; and their tax status, etc.

There are three ways by which the Catholic character of these instituitions can be safeguarded:

a) solely and unilaterally through state law;

c) by means of concordats (cf Art 7,3, of the Italian Concordat); and

d) by means of a special statute (something which takes place in particular in those countries which have a tradition of common law).

Prof. GIUSEPPE DALLA TORRE
Rector of the Libera Università Maria SS. Assunta (LUMSA), Rome.

* This is a reduced version of the paper given by Prof. Dalla Torre. It was not revised by the author before publication.

ROUND TABLE

"The National Associations and the International Federation: the Renewal of a Project "

I: Summary of the Situation in the Continent of Europe

Catholic hospitals are the promoters of health and of the dignity of man. Their task is the performance of complete service to the sick person in the totality of his or her being. To him or her we provide the care and treatment suitable to his or her needs and according to what is possible and our skills and capacities. Catholic institutions place man at the centre of care in the world of health and health care. Each form of service in the world of health and health care seeks to be a bearer of the Gospel and thereby to build the kingdom of God and promote the wellbeing of man.

At the time of the world congress of Catholic hospitals of 1985 the Holy Father John Paul II observed: "The Catholic hospital, committed to being a witness of the Church, must re-examine its organisation in fundamental terms in order to reflect ever more effectively on the evangelical values expressed in the social and moral directives of the Magisterium. It must not allow itself to become absorbed into systems which are concerned only with economic-financial objectives and by clinical-psychological elements. It must know how to be always near to the sick man and help him in the anxiety which troubles him during the most critical moments of the illness. It must know how to create a culture directed towards the humanisation of medicine and hospitals".

This appeal, which was launched by the Holy Father, must lead those who are responsible for Catholic health-care institutions to search for solutions and answers which make the market economy compatible with the protection of human dignity. Catholic hospitals, their national associations and the AISAC must become a valuable instrument by which to create a shared style of management, care and organisation which bears witness to membership of the Catholic Church and to participation in her mission.

1. The National Associations of Catholic Hospitals

In nearly all European countries a National Association of Catholic Hospitals exists, and this body usually also includes the institutes of care for the elderly and for the physically and mentally handicapped.

Of the fifteen countries which belong to the European Union, eight belong to the "Comité de Liason Europèen du Sancteur Sanitaire et Social Privé à but non Lucratif". Four of these also belong to the "Standing Committee of Hospitals of the European Union" (Hope).

Representatives of the national associations are a part of the "Ethical Committee" belonging to the European organisation of non-profit making institutions in the health-care field. That is to say, representatives of Germany, Italy, Holland and Austria. It is precisely at the level of the European Union that we encounter the problem of ethics in the field of research, of the rights of man, of health-care legislation, of health-care economics, and of the administration of human, technical and material resources.

The hospitals and health-care institutions of the religious orders, the dioceses, diocesan or national "Caritas", and similar Catholic bodies, have already been organised, or must be organised, at a national level, and this must be done in line with the legal conditions and provisions reigning in each country. The episcopal conferences, the national conferences of superiors, and each diocesan bishop must help the foundation and the activities of national associations of Catholic health-care institutions.

Motivations:

– the promotion in the world of health and health care of the gospel of life;

– the ensuring of the presence of the Church in the medical and socio-health care field;

– active co-operation in negotiations with the representatives of national and regional governments;

– the sharing of information at all levels;

– a better and improved distribution of resources at a regional and national level, and also perhaps in relation to the third world;

– the diffusion of a strong sense of belonging in the presentation of the mission of the Catholic hospital in secularised society;

– practical and unanimous implementation of evangelical values and those of the ecclesial Magisterium in bioethics and public ethics;

– the sharing of pastoral plans and strategies of humanisation;

– openness to direct and real co-operation in the economic and organisational field;

– the guaranteeing of the future of Catholic health-care institutions through new forms of ecclesiatical and civil ownership in responsible co-operation with members of the Catholic laity.

2. The International Association of Catholic Health-Care Institutions (AISAC)

The AISAC is an international association of the national associations of the Catholic health-care institutions of each country. It should become the instrument by which to create a style of managment, assistance and organisation which bears witness to membership of the Catholic Church. The AISAC must be the expression of communion in evangelical values and principles for all the national associations and for all the Catholic health-care institutions in the world. The primary aim of the AISAC should be to lay down guidelines which will enable the national associations to reach in effective fashion those evangelical goals with which they and their associate institutions identify.

As a consequence, the statute of the AISAC must include and express, amongst other things, the following principal points and concerns:

a) It must define the nature of the AISAC and thus it should describe:

– the Catholic associations which make up the AISAC;

– the ecclesiatical authority (the ministry of the Roman Curia) which has instituted and created the AISAC and approved its statute with an accompanying definition of the juridical character of the association.

b) The objectives/goals of the AISAC:

– the fostering, promotion and co-ordination of the national associations in order to promote the gospel of life within the world of health and health care;

– the organisation of congresses at a continental and world level in order to help the exchange of experiences in the health-care field, and this in line with the objectives and aims of the AISAC;

– the organisation of congresses, courses and work-shops for those people who are responsible for the national member institutions;

– meetings between representatives of the various categories of associations within the area of concern of the same Roman ministry (for example associations of medical doctors, of nurses etc.);

– the creation and diffusion of an organ of communication which informs, directs and promotes the members in the carrying out of their mission.

c) The member associations and the associate members of the AISAC:

– The definition of that legal and organisational status of national associations and of their objectives which enables them to be members of the AISAC:

- active and full members;
- promotional members;
- "connected" members (sympathisers);

– the definition of the structure of the AISAC:

- the competent ecclesiatical authority;
- the directive council;
- President;
- Secretary;
- General assembly;

– the definition of the legal status of the national associations (definition of the essential elements of the statute at a national level);

– the definition of the legal status and ethical-moral character of the local health-care institutions which belong to the regional and national Catholic associations.

Rev. LEONHARD GREGOTSCH M.I.,
The Association of Catholic Hospitals of Austria.

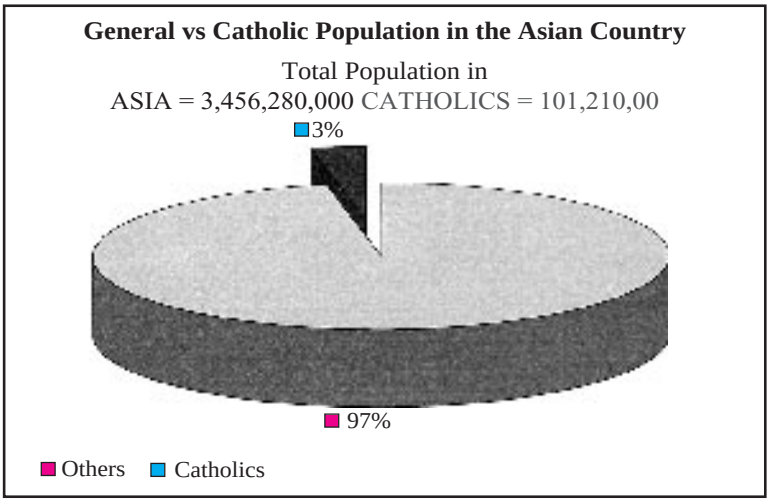
II: The Asian Region

Introduction

Asia is a continent with a multitude of ethnic groups, cultures, languages, regions, socio-economic backgrounds and political systems. These and the ethical values found in the teachings of the great philosophies of Asia shape people's lives here.

Asian cultures today feel the impact of modernisation and globalisation. The consumer mono-culture brought in by globalisation is sweeping away their traditional values resulting in the disintegration of families. These have serious negative impacts on people's health.

The total population in Asia is 3,456,280,000, and the Catholics are 101,210,000 (2.9%) according to the 1996 statistics.



1. Health Facilities in the Continent (Asian)

The Health scene in Asia is characterised by infectious diseases, malnutrition, disabilities resulting from lack of vitamins, minerals and safe drinking water and high infant mortality. Commercialisation of drugs by pharmaceuticals that make medicines unaffordable to the poor and public health care systems that do not have enough funds and which always do not reach the needy poor worsen the situation. (see annexures A, B for Asian health statistics)

In many Asian countries, there is – if not absolute shortage – at least an imbalance between the numbers of doctors, nurses and paramedical staff available and the numbers needed especially in peripheral rural health units. While health reforms are underway many governments and NGOs find it increasingly difficult to meet the basic health needs of the population. A critical analysis of accountability, affordability and of quality of health care is an important concern.

Outright privatisation that allows commercial enterprises to cover the needs of people has proved to have serious negative effects, especially for the poor.

Table 1 - Catholic population and Health Care Institution in Asian Countries

S. No.	Country	Population	Catholics	Hospitals	Dispensaries	Others*
1	Afghanistan	22,000,000	NA	NA	NA	NA
2	Bangladesh	124,000,000	161,000	7	48	51
3	Bhutan	2,000,000	3,000	1	3	1
4	China	1,243,000,000	-			
5	Cambodia	10,500,000	-	-		
6	Republic of Korea (south)	45,700,000	2,168,000	49	30	152
7	India	982,000,000	14,908,000	704	1,792	668
8	Indonesia	203,500,000		318**		
9	Japan	125,600,000	598,000	37	23	309
10	Malaysia	21,010,000	590,000	9	23	35
11	Maldives	273,000				
12	Myanmar	46,700,000	703,000	3	34	190
13	Nepal	22,500,000				
14	Pakistan	143,800,000	653,000	20	48	140
15	Republic of Korea	22,830,000	-	-	-	-
16	Singapore	3,400,000	103,000	3	34	190
17	Sri Lanka	18,300,000	1,957,000	3	9	240
18	Thailand	59,100,000	147,000	12	20	100
19	Vietnam	76,500,000	-	-		
20	Philippines	84,440,000	79,500,000	180	325	700

* This includes leprosy/aged/handicapped/Rehab homes/Centres.
** Hospitals & Health Centre.

Table 2 - National Association and their Membership

S. No.	Country	Name of the Association	Hospitals	Dispensaries	Others
1	India	Catholic Health Association of India (CHAI)	704	1.197	-
2	Pakistan	Christian Health Association of Pakistan (CHAP)	20	48	140
3	Indonesia	Association of Voluntary Health Services of Indonesia (PERDHAKI)	318 (Hospitals & Health Centres)		
4	South Korea	Catholic Hospital Association of Korea	N.A.		

2. Main problems of Catholic Health Care in the Continent

In the Asian continent by and large the Catholic population is in a minority except in the Philippines. The problems faced by Catholic health care are both external and internal. The external problems are due to misunderstanding between the management and the government on issues of ethics and management. E.g., the introduction of income tax and building tax in India placing charitable institutions on a par with other corporate and private health institution. Again, Indian government support depends on how willing we are to ignore the government's pro-abortion and aggressive artificial birth control stand. But then, this is in direct opposition to the Catholic Church's teachings.

The Church within itself faces a lack of human resources (doctors, nurses and paramedical staff) since there are not enough Catholic health institutions in Asia to train dedicated personnel to became doctors, nurses and paramedics. Bringing in personnel from outside the Church is not economically viable because of the high premium to be paid. Since Catholic health institutions are not funded as in the past, the standard of care is compromised and they tend to be profit driven for the sake of survival.

3. National Associations

Four countries in Asia have national health associations.

1. Indonesia: Association of Voluntary Health services

of Indonesia (Perdhaki).

2. Pakistan: Christian Health Association of Pakistan (Chap).

3. India: Catholic Health Association of India (Chai).

4. South Korea: Catholic Hospital Association of Korea.

Though Pakistan had an organisation exclusively for Catholics in the 70's it has now merged with other Christian denominations. India has the biggest number of health care institutions in the voluntary sector in the world with 2900 member institutions.

4. Our contribution to the International Federation

Many Asian Countries, particularly India, have traditional, indigenous medicinal systems and people's participation through community. Though colonisation and the advent of the "wonder medicines" (Allopathy Systems) pushed these systems out of the main stream, Asia is witnessing a resurgence of these systems.

With this experience in promoting health of the poor in a multi-cultural and multi-religious context these associations can offer to the international association a more comprehensive and holistic approach to health. Specific areas could be in:

– Promoting the concept of community health and people's participation.

– Promoting traditional medicines and drugless therapies.

– Facilitating exchange programmes to study the health models developed in different regions.

5. Expectation / Usefulness and an International Association

Coming together with good intention is always mutually beneficial. The Lord himself has assured HIS presence when we gather in HIS name. An international organisation can play a crucial role in facilitating mutual support among the national organisations.

An international association in health care under the Catholic Church is essentially for co-ordinating the implementation of the teachings of the Church in the health care ministry and in a special way communicating the latest developments in the field of medical ethics that give a Christian perspective to health care. It can also assist the national organisations in forming a common policy and action plan based on the vision of the Church and the needs of the poor.

Yet another important role the association can play would be in the area of advocacy and monitoring: advocacy in promoting values in health care and monitoring the way the poor are treated by the health care system of various countries. This monitoring will help the organisation pinpoint the values that need to be emphasised and advocated.

Conclusions

Political and economic changes sweeping across the globe in the last decade have negatively influenced the health care of the poor. In addition, the emergence of new diseases, the re-emergence of eradicated ones, and the resistance to treatment of existing diseases place an extra burden on health care systems. While the need for affordable, good

Annexure A - Health Statistics in Asia

S. No.	States	Life Expectancy At birth		Infant Mortality (per 1.000)	Population (000) in millions	GNP per capita	Maternal Mortality (per 1.000.000)	Hospital Beds (per 1.000)	Physicians (per 1.000)	Health Expenditure (% of GPD) 1995		Midwives population (per 10.000)	Nurses (per 10.000)
		M	F							Priv.	Publ.		
1	Afghanistan	45	46	152	22.1	-	1,700	-	-	27	1.1	0.2	0.8
2	Banglades	58	58	79	124	240	850	0.3	0.2	48	1.2	-	0.4
3	Bhutan	60	62	63	2.0	420	1,600	-	-	-	2.3	0.4	1.5
4	China	68	72	41	1243.7	620	95	2.0	1.6	54	2.1	-	-
5	Cambodia	51	55	103	10.5	270	900	-	-	10	0.7	-	-
6	Republic of Korea	69	75	22	22.83	-	70	4.1	1.2	22	1.2	1.63	3.0
7	India	62	63	72	982	340	570	0.7	0.4	37	0.6	0.37	3.5
8	Indonesia	63	67	48	203.5	980	650	0.7	0.2	78	5.6	-	-
9	Japan	77	83	4	125.6	39,640	18	16.2	1.8	60	1.5	-	-
10	Malaysia	52	55	11	21.01	3.890	80	2.0	0.4	-	4.9	-	-
11	Maldives	63	67	50	0.273	990	-	-	-	-	0.4	-	-
12	Myanmar	66	63	79	46.7	-	580	0.6	0.1	24	1.2	1.2	0.3
13	Nepal	59	62	83	22.5	200	1,500	0.2	0.1	22	0.8	-	2.8
14	Pakistan	63	65	74	143.8	460	340	0.7	0.5	56	1.3	-	-
15	Philippines	67	70	36	70.7	1,050	280	11	0.1	-	-	-	-
16	Republic of Korea	69	76	10	45.7	9,700	130	-	-	37	1.6	-	-
17	Singapore	75	79	5	3.4	26.73	10	3.6	1.4	76	1.4	-	-
18	Sri Lanka	71	75	18	18.3	700	140	2.7	0.1	26	1.4	2.9	5.6
19	Thailand	66	72	29	59.1	2,740	200	1.7	0.2	-	-	1.9	9.4
20	Vietnam	65	70	38	76.5	240	160	3.8	0.4	-	-	2.1	8.6

quality health services is growing, the available means are not sufficient enough to match the demand.

The Church's role is complementary to that of the government. Catholic health care institutions are more used to working on a small scale. They are ill prepared or ill equipped to deal with the major shifts taking place in the health care scenario. The know-how and financial means are grossly insufficient to meet the new challenges. The international association would be able to provide the right directions to look for continuous creativity and long-term commitment and investment in the health structure necessary for the next millennium.

Sr. ANCY ELSAMMA MATHEW SD,
Associate Director
Catholic Health Association of India

Annexure B - Reported Cases of the Following Diseases in Asia

S.	Asian Countries	Leprosy 1997	AIDS/HIV 1997	Tuberculosis 1997	Malaria 1997	Measles 1997
1	Afghanistan	27	0	0	0	-
2	Bangladesh	11,222	0,6	63,471	152,729	4,929
3	Bhutan	37	0	1,271	223,195	9
4	China	1,845	38	463,358	0	68,404
5	Cambodia	2,404	300	14,857	0	2,814
6	India	415,302	5,611	1,400,016	2,800,000	47,072
7	Indonesia	15,071	32	24,647	1,460,569	15,339
8	Japan	-	-	-	-	-
9	Malaysia	293	300	12,902	59,208	-
10	Maldives	-	2	212	17	-
11	Myanmar	6,935	690	22,201	642,751	1,684
12	Nepal	6,602	37	22,970	9,718	8,513
13	Pakistan	1,405	19	4,307	111,836	1,090
14	Philippines	4,051	51	276,295	366,844	-
15	Republic	39	22	31,134	131	71
16	Singapore	-	92	737	316	-
17	Sri Lanka	1,528	11	5,439	142,294	158
18	Thailand	1,197	17,942	39,871	82,743	5,677
19	Vietnam	2,883	375	74,711	666,153	5,156

III: Africa

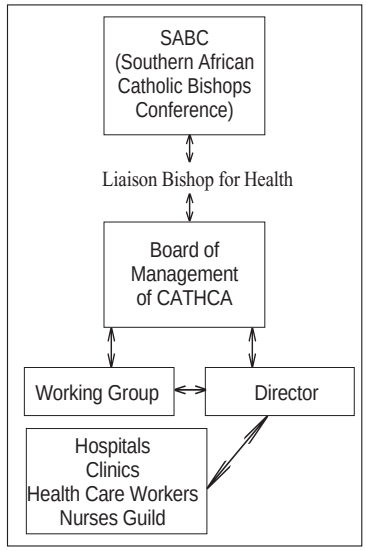
The National Association that deals with all the health care interests of the Catholic Church in South Africa is CATHCA (Catholic Health Care). Since January 1998 CATHCA has been recognised as an associate body of the Southern African Catholic Bishops Conference (SACBC). Our Constitution has been approved by the Conference.

Our Liaison Bishop for Health, Bishop Orsmond, is a member of the Board of Management.

The Management of CATHCA is the responsibility of a Board of Management of which I am the current Chairman.

A working group has day to day responsibility for management. A full time Director, Ms Beauty Malete, has been appointed by the Board of Management to oversee the affairs of CATHCA.

Organogram of CATHCA



Funds have been received from Misereor for CATHCA.

Our tasks are the drafting of policy, lobbying government, interacting with health care groups of other churches, bringing Catholic clinics, hospitals and health care workers together to inspire them with the mission of the Church and inculcate appropriate Church teachings.

The most pressing item we are involved with is a HIV Awareness and AIDS Caring Programme. The HIV/AIDS issue is a major challenge to CATHCA. CATHCA is presently mandated by the SACBC to deal with HIV/AIDS issues. Our Director, Ms Beauty Malete, will therefore be concentrating her efforts on this area.

The other portfolios – Poli-

cy, Liaison, Ethics, Fund Raising etc will largely be the responsibility of designated members of the Working Group.

The first 18 months of CATHCA's existence have proved eventful. In this brief time we have achieved the following :

– Approval of our Constitution by the Southern African Catholic Bishops Conference.

– Engaged in a consultative process to develop a draft document outlining the "Health Policy of the Roman Catholic Church in the Province of South Africa". This document is presently being reviewed by our Bishops and should be ratified by January 2000.

– Conducted a National HIV/AIDS summit in December 1998.

– Assisted the largest remaining Catholic Hospital in South Africa, St Mary's Hospital at Mariannhill, in its successful negotiations to limit the extent of a proposed state subsidy cut.

– A member of our working group was instrumental in establishing an Umbrella Funding Project for a group of clinics run by religious organisations (Catholic and Non-Catholic). This project will receive R 22 million from the European Union over the next 3 years.

– Participated in a process to establish a National Forum of State-Subsidised Health Facilities involving all role players – religious and secular.

The main challenges CATHCA faces are :

HIV/AIDS

As mentioned before, CATHCA is at present mandated by the SACBC to address HIV/AIDS issues.

As HIV/AIDS is not only a health issue, we are co-ordinating our response with that of our colleagues in the Catholic Institute for Education as well as the Development and Welfare Agency of the SACBC.

There is an ongoing consultation process between Catholic health care providers and catholic moral theologians on the HIV/AIDS issue.

An audit of all Catholic role players in this arena is in progress.

Both religious and secular funders have been approached to support our HIV/AIDS programmes.

Ensuring the Sustainability of Catholic Health Care Institutions (Hospitals and Clinics)

In the past year a number of Catholic health care institutions have closed. Others are on the brink of closure. CATHCA is considering providing management support to the smaller institutions that lack management capacity.

In addition, we are developing a model that would enable Catholic health care facilities to maintain their own character and ethos with diminishing numbers of the religious on site.

The increasing role played by the laity in management positions at our health facilities brings with it additional challenges. CATHCA's role here is to support these managers and ensure they receive the appropriate grounding in the Church's teaching particularly with regard to health care issues.

Relationship with the State

CATHCA's relationship with the state is generally cordial. On issues such as abortion and euthanasia we do however differ strongly.

Since the implementation of the Choice of Termination of Pregnancy Act No 92 on 01/02/97 an estimated 19,000 abortions have been performed.

In addition a proposed "Rights of the Terminally Ill (or End of Life Decisions) Bill" is under discussion.

The Catholic Church in South Africa (and CATHCA) continues to reaffirm its commitment to the sanctity of life.

The South African Government remains committed to its macro-economic policy called 'Growth, Employment And Redistribution' (GEAR). This policy aims to ensure that South Africa dramatically reduces its budget deficit over the next few years.

It imposes stringent budget cuts on all government departments – including the Health Department. These budget cuts have been imposed on all public health facilities but especially on CATHCA's state-subsidised health facilities.

The challenge here is to ensure the state continues to support our facilities.

In addition we are exploring other possibilities for income generation.

Continental issues, African issues

Since our meeting of the International Association of Catholic Hospitals in the Vatican City in September 1998 there has been little contact between CATHCA and our colleagues in the rest of Africa. I have been requested to give an overview for Africa.

In brief the generic issues that face our Catholic hospitals in Africa are :

– Consequences of war.

– HIV/AIDS.

– Funding problems and hence sustainability.

– Relationship with the state.

If Africa is to become an active component of an International Federation of Catholic Hospitals we will have to develop our own Continental Federation of Catholic Hospitals.

Dr. D. P. ROSS
Chairman, Board of CATHCA

IV: Catholic Health: Australia's Perspective

The Australian Catholic Health Care Association has undergone a significant restructure in response to the future challenges of the ministry. Some of the lessons from our experience may assist with deliberations over a future international federation.

In was broadly recognised that the paradigm shift from institutional health/aged care towards systems of health care providers has brought with it new challenges for governance, increased pressures on viability and renewed impetus to reaffirm Catholic identity in the health system.

In the broad, the structural changes were driven from a commonly shared vision of the contribution Catholic health providers sought to make into the future; along with a determination to ensure the health ministry remained an essential work of the Church's mission. As a consequence Catholic Health Australia was created.

COUNCIL
↑ ↑ ↑ ↑ ↑
Representatives

→ Provider systems of the major religious institues

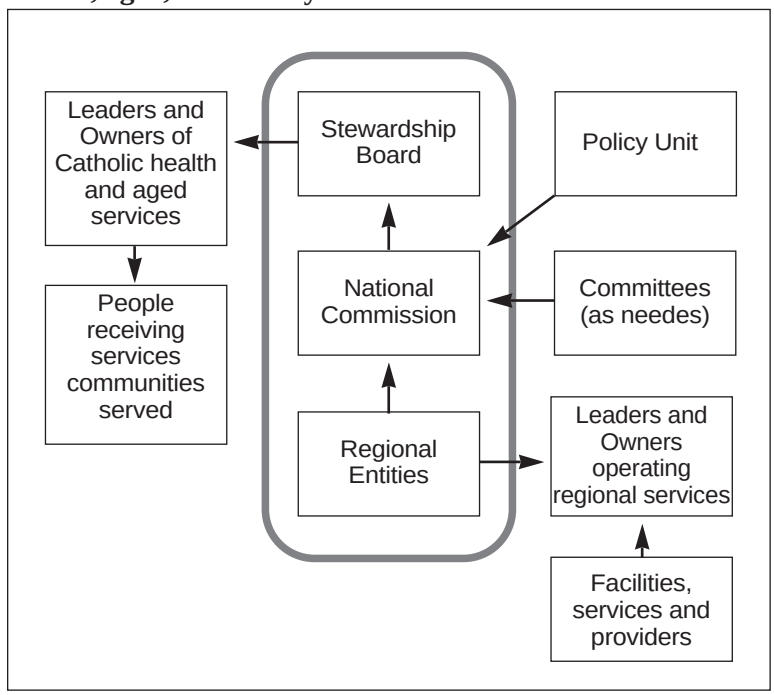
→ Stand alone health and aged care providers

→ Associated state organisations

→ Australian Catholic Bishops Conference

→ Australian Conference of Leaders of Religious Institutes

Health, aged, community care services



At heart the organisation has shifted from being a loose grouping of interests to a consolidated sector of governance concerns. In essence, the restructure has been a governance driven strategy. That is, one which aimed to promote and strengthen the organised expression of the health ministry.

Catholic Health Australia has a comprehensive brief to promote and strengthen the ministry.

The objects for which the Association was established are:

– to promote the ministry of Catholic health, aged and/or community care as an integral element of the mission of the Catholic Church;

– to disseminate, through publications and by any other means, the teaching of the Catholic Church in regard to the ministry of Catholic health, aged and/or community care;

– to make public statements, from a Catholic perspective, on matters relating to health, aged and/or community care;

– to ensure, wherever possible, the presence and effective mission of Catholic Health, Aged and/or Community Care Services;

– to serve as a focus for the solidarity and witness of Catholics engaged in the ministry of Catholic health, aged and/or community care;

– to monitor and analyse significant developments nationally in health, aged and/or community care;

– to monitor, analyse, initiate research on and respond to policies of the federal and state governments, insofar as they relate to the ministry of Catholic health, aged and/or community care;

– to maintain, on behalf of the Association, regular communication with the federal and where appropriate state governments;

– to identify and keep under constant review ethical issues relevant to the ministry of Catholic health, aged and/or community care;

– to advocate and promote the broadest adoption of Catholic values, ethical principles and social justice in health, aged and/or community care;

– to assist in the promotion of the highest standards of service in Catholic health, aged and/or community care services;

– to provide to members of the Association highly specialised advice on matters pertaining to the ministry of Catholic health, aged and/or community care;

– to initiate, promote and facilitate, through educational and other programs, the personal and professional development of staff and other persons associated with Catholic health, aged and/or community care services;

– to provide a forum of communication for issues of common interest and concern to the members of the Association;

– to facilitate where appropriate the integration of the ministry of Catholic health, aged and/or community care in Australia;

– to speak on behalf of the members of the Association in matters regarding the ministry of Catholic health, aged and/or community care so as to provide a unified voice on such matters;

– to provide a resource to, and referral point for, the Australian Catholic Bishops Conference in matters relating to the ministry of Catholic health, aged and/or community care;

– to provide a resource to, and referral point for, the Australian Conference of Leaders of Religious Institutes in matters relating to the ministry of Catholic health, aged and/or community care;

– to liaise with other persons and organisations in any manner deemed conducive to the fulfilment of the Association's objects.

What the New Structure Aims To Deliver

1. Establish a Locus of Authority

With over 116 owners of health, aged and community care services, it was crucial to establish a structural point of authority. Previously the association structure only had a Council to represent the interests of participating services. The new Stewardship Board is elected by owners (those with canonical authority for the ministry). This is a far more authoritative entity. It lays the groundwork for future governance arrangements to emerge between various owners. It also allows the groundwork for future governance arrangements to emerge between various owners. It also enables the longer term identity of ownership to be publicly identified as 'Catholic' whilst remaining specifically congregationally based in the medium term.

It has also created a recognised, authoritative forum which can address issues of mutual concern, particularly for the owners. That is, if Catholic institutions are under threat of closure, or the like, there is a forum where strategic and collaborative responses can be initiated.

2. Develop A "Church-Wide" National Policy Approach

Pressures on the sector which challenge the future contribution of the Church are:

1. declining presence of religious personnel
2. highly competitive service environments
3. valuable assets under control of religious institutes which are seeking options to divest, transfer or sell
4. maintenance of Catholic identity within the context of lay leadership and spirituality.

Consequently, CHA was created to promote collaboration rather than independence, encourage interdependency rather than autonomy.

These pressures require an "umbrella strategy" which aims to strengthen the services, ensure future leadership capacity and realistically confront the future absence of religious personnel.

Since a good proportion of the sector is still robust enough to sustain the medium term, serious analysis over future collaboration, mergers, alliances or transfer of ownership must be facilitated.

3. Create A Structural Environment To Facilitate Systematic Action

There is a general trend towards the development of health care systems in the sector. It appears that further consolidations are in the interests of the viability of the services.

Developing "generic" systems, under the framework of the CHA, will strengthen the sector in general.

Lessons from our Restructure

1. Attention To The Principle Of Subsidiarity

Presupposing a structural relationship requires agreement over a vision for the future. The vision needs to be commonly shared. This in turn requires consensus over the most important aspects of Catholic health/aged services held in common by all providers.

Discernment over which level of governance will best achieve the desired outcomes, i.e. national, regional or local, within a defined amount of resources, is essential.

Consequently, our restructure posited functions nationally which were exclusively of "generic" importance to the ministry. Any function which could best be handled more regionally or locally, was allocated accordingly.

2. Agenda of Owners is Diverse

Although all owners seek to keep their present services within the Catholic Church, it cannot be assumed that all will adopt the same ownership option for the future.

A diversity of recognised options needs to be developed to accommodate the varying circumstances of the religious institutes.

3. Timelines Blow Out

Although some providers articulated a strong sense of urgency for structural reform, this was rarely translated uni-

versally across the sector. As a result, decision making was slower than anticipated.

In addition, with 116 separate owners, changes in leadership structures throughout the period led to some slow down with the consultation processes.

4. Few Precedents for Guidance

The challenges facing the Catholic health ministry at the turn of the millennium have few, if any, precedents.

The intellectual struggle to craft new pathways for the ministry can be exciting, yet daunting.

The content to develop options for the future is not readily accessible. Patience becomes a virtue.

Translating information from other countries can be very helpful. However caution is required to discern whether direct parallels can be immediately drawn.

This challenges the human resource base of providers, particularly in areas of canon law and governance.

Questions Relating To International Structures

1. Australia is moving into health care systems and away from stand-alone hospitals. International structures would be best based on national associations or the like.

2. Governance restructures are the most urgent challenges facing the sector. A pool of high quality advisory support services would usefully assist these challenges.

3. Catholic identity issues are inevitably connected to the broader challenges of the Church in an increasingly secular society. Solutions need to be "local" in order that they are perceived as being credible.

4. Integration of Catholic services into the Australian health/aged care systems have few international parallels.

5. The "critical mass" of religious personnel still active in the ministry is far less than in other countries. Consequently, experience from Australia would assist other countries when similar situations arise.

6. What specific functions or services can an international structure provide which do not duplicate those presently available in Australia? This needs careful exploration to ensure resources are not wasted. There is obvious benefit in sharing the wisdom of Australia's experience. There is also potentially much to be gained from a networking of considered reflections on the development of Catholic health ministry across the world.

FRANCIS SULLIVAN
Executive Director Catholic Health Australia

V: Latin America

A History of Hospitality

The relationship between illness, religion and health goes back to the beginning of the history of man, to the time when he resorted to all the means and instruments that were then available to him in order to recover his health or physical well-being.

Research has shown that in the oldest cultures that we know about this relationship was expressed in a more explicit and direct way. The priest or medicine man had healing powers which went beyond knowledge of the effects of minerals, plants and certain living creatures. This is borne out by the documentary evidence discovered in Egypt, India, Greece and Rome, by the Hammurabi Codex and the Bible – in which we can see a strong presence of health-care and healing activity; by the temples which were homes for the living and the dead of the ancient Egyptians; by the sanctuaries of Epidaurus, Cos and Pergamon in ancient Greece; and by the temple of Esculapius on the Tiberine Island in Rome which had sick people, sacrifices and healing rituals etc. Today the Fatebenefratelli, on this very same island, carry on the ancient religious and healing hospital tradition of the Eternal City.

The strong connection between religious-healing activity in antiquity and present-day history has its roots in the parable of the Good Samaritan and was expressed by our Lord Jesus Christ: "Go, and do you likewise" (Lk 10:29-37), in the practice of the Gospel (MT 4:23-4), and in love for one's neighbour as oneself (Mk 12:31).

From her very beginnings, the Church has given rise to a style of hospitality and of hospitals which we find in many societies of the contemporary world. The receiving of sick people, care and treatment, and the establishment of hospitals have been a constant feature of the evangelisation carried out by the Church. Let us cite by way of example the figure of Lorenzo, a deacon who was certainly Aragonese, or the Roman high-born lady Fabiola, or the hospital orders from the twelfth to the twentieth centuries in Jerusalem and all over Europe, and many other hospital-style institutions.

In Grenada in Spain, where there were eight or nine hospitals belonging to different confraternities or groups, St. John of God, without any other resources than his own beliefs and his commitment to looking after patients in a way that was more effective than was then the case in the Royal Hospital, created a style of hospitality and hospitals which his Order continues to practice in the world today, with a network of 239 institutions which fly the same flag and are moved by the

same mystical approach based on the thinking of the Christian tradition and the ideas of St. John of God. Forty-five of these are to be found in South America.

Latin America

The history of "health care" is closely bound up with the action and activities of the Church. The first hospital to be established in the newly discovered lands in Latin America was that of San Nicola (in Santo Domingo) in 1503. During the same epoch two other health-care institutions also came into being: the lepers' sanctuary of San Lazzaro and the hospital of Sant'Andrea.

In Mexico Ferdinando Cortés established the first hospital on dry land – the hospital of Gesù Nazareno, which was originally called the hospital of the Immacolata Concezione. This still operates today in the capital of the Mexican nation and still has its original endowment bequeathed to it when it was established by Cortés.

In Lima, Archbishop Jerònimo de Loaiza initiated the history of hospitals by creating the hospital of Sant'Anna dei Nativi.

The Brothers of St. John of God (Fatebenefratelli) are one of the few and major evangelising forces in the world of suffering, health and life. This was achieved through the creation of over a hundred hospitals during the first two centuries of the process of colonisation.

Another important initiative in the direction of helping sick people during the first stage of evangelisation in America was represented by the work of the Franciscan friars. Subsequently, their activities were imitated by the Bethlemites and the Congregation of Charity or of Sant'Ippolito.

The list of eminent and illustrious individuals who dedicated themselves to caring for the sick is very long, and these people were not only members of religious orders but also bishops and members of the laity. Let us remember here Vasco de Quiroga, the founder and moving spirit of various hospitals in Mexico, who was a shining example of evangelising work and an individual characterised by a special sensitivity towards providing hospital care and treatment.

This process of expansion in the hospital services offered by the Church continued during the seventeenth and eighteenth centuries, but fell off during the nineteenth century at the time of the wars of independence – marked, as they were, by the persecution of the Church and the expulsion of members of religious orders from a number of Latin American countries. The twentieth century, which is now drawing to a close, leaves us with an admirable history of revival and renewal of the hospital work of the Church in the American continent – there are now 2,200 centres in the form of hospitals, health-care centres, hospices, leper sanctuaries, etc.

The Justification of the Project

In our nations, as well, international companies are now advancing. They engage in activity which transforms the protection of, and care for, people's health into what is merely a money-making business.

Globalisation in the cultural, economic and political field is a reality which we cannot now deny.

Scientific-technological advances in the hospital world are rapidly globalising.

The dangers of the manipulation of life and the ethical problems and issues connected with the practice of medicine and the activities of hospital structures are also becoming global in character and implications.

The Church wants to achieve a shared language in relation to her health-care responsibilities and initiatives and the reform of systems. For this reason, she needs instruments which allow the exchange of information and up-dating in matters connected to bioethics and which will reach all Catholic hospitals throughout the world.

International Catholic associations and federations are an important instrument by which to uphold and promote the "Culture of Life" as an alternative to the "Culture of Death" and the "Culture of Money".

The reform of health-care systems has been carried out almost everywhere. In many countries these systems are coming apart, and governments, under the strong influence of economic neo-liberalism, shown signs of wanting to rid themselves of this social responsibility. The new challenge which faces us is that of providing human quality in service, and in complete and overall care and concern for the sick individual. This requires clarity with regard to ethical principles, spiritual leadership, and bearing witness to the Gospel. And all this should be carried out at a world-wide level.

Functions of the Federations

The upholding of the right to act according to one's own beliefs (freedom of conscience and association) for professionals and Catholic institutions in the different countries of the world is imperative. And this in particular with regard to the exercise of Christian love, free-giving, respect for every life, and all this in a world driven by a lust for money and moved by a utilitarian approach to the human person.

Catholic associations "have a function of mediation through which Christian doctrine can penetrate effectively into contemporary life" (John Paul II).

Training clearly has a fundamental role to play. A direct commitment to ensuring that the academic programmes of faculties of medicine, of the nursing profession, and of the other health-care professions, have proper and well-grounded teaching-chairs of ethics and of bioethics is also required. The creation of services of consultation for the study of ethical questions and issues connected with the exercise of medicine and their theoretical and practical resolution is to be welcomed. The financing of publications which act as a support for on-going training and for inter-communication between

Catholic hospitals and between Catholics is a further necessary policy.

They should also ensure that the ethical and religious dimension of the world of health and health-care is respected, fostered and seen from a dual perspective: as a right of the person and as a therapeutic factor.

In addition they should be an effective channel for evangelisation in the world of health and health-care and of life in a general sense. These federations are an "organic presence within the Church at an international level". "Without Catholic international organisations something would be lacking from the vitality of the Church and from her prophetic and apostolic mission in today's international society" (John Paul II).

Another task is the creation of a context of specific Christian spirituality which ensures that its members have the right conditions by which to consolidate and strengthen the experience of faith. Catholic associations and federations can make a major contribution to promoting and supporting a life of holiness and specific spirituality for Catholic professionals, of which, indeed, they themselves express the *need*.

The Challenge: an Alive and Operational Entity

The social welfare institutes which, we have observed with satisfaction, reached nearly all the citizens of our countries during their processes of growth and development now, on the contrary, seem to have their days counted.

Active compassionate care in its widest expression is one of the most admirable elements to be found in the Church. As we move towards the next millennium of Christianity, the institutions of compassion could well be the fundamental element on this path, and an essential element which could also be ecumenical in its character and impact.

We should think about the new evangelisation taking compassion, social assistance, and hospitality as our starting point.

We should inject new vitality into the almost 28,000 healthcare institutions of the Catholic Church which are spread throughout the world beginning with the spirituality of the continental, regional, national, diocesan, parish and group (etc.) churches.

When we come to examine the historical process which is before us, we can see that the International Confederation of Catholic Hospitals has been carrying on its activity for almost half a century. Today more than ever before its presence and its future are decisive – hospital institutions are experiencing a moment of crisis and are subject to factors which promote accelerating change.

In order to achieve a real and authentic presence we need to establish a system of organisation at a national and continental level in order to then give it representation and force at a world level. We need a campaign of information, motivation and follow-up in those countries where federations of Catholic hospitals already exist, and an effective plan of consultation in order to bring them into being where they do not yet exist or are not operational.

We need to create instruments and spaces for the expression and exchange of ideas, experiences and initiatives. For example: an international journal, national and regional journals, the use of the web network (Internet) to achieve ongoing information on the International Confederation of Catholic Hospitals, the organisation of national and regional meetings and conferences, and the publication of papers and books on subjects and questions relevant to the Catholic hospitals, etc.

The Church has always been a pioneer in the promotion of social and hospital initiatives and today these urgently need spiritual support – faced as we are by the new challenges which have been posed to us by modern medicine. The Church must face up to the ethical and moral questions and issues which now await her.

Rev. JOSÉ ANADON, OH,
Delegate of the CELAM,
Santafé de Bogotà, Columbia

OIC: international Catholic organisations
FIAMC: International Federation of Catholic Medical Associations
FIPC: International Federation of Catholic Pharmacists
CICIAMS: International Catholic Committee of Nurses and Medical-Social Assistants
CICH: International Confederation of Catholic Hospitals

VI: Report of the Catholic Health Association of the United States

I would like to express my appreciation and that of the Catholic Health Association of the United States for the opportunity to speak briefly about the Catholic healthcare ministry in the United States and the future of the International Federation of Catholic Healthcare Institutions (AISAC). Before beginning, I want, in a special way, to express our gratitude to Archbishop Lozano for the invitation to participate in this important symposium.

I also would like to publicly offer congratulations to Msgr. Lozano on the occasion of his episcopal ordination.

The Catholic healthcare ministry was formally established

in the United States in 1727 in New Orleans. In most instances the establishment of the ministry was the work of communities of religious women and men who came to the United States to serve the needs of an important population and who later were invited by diocesan bishops to serve the mission of the Church as the nation expanded westward.

In its original form the ministry was carried on in the homes of the poor and then by the establishment of hospitals. In time these somewhat simple expressions of the corporal works of mercy became a well organized and effective institutional expression of the same evangelical spirit.

Currently, in the United States, there are 601 Catholic hospitals and 1,359 long term care facilities. The hospitals constitute 15,4% of acute care delivery in the United States, and their net worth is estimated to be near $65 billion. Like its companion ministries of education and social service, the Catholic health care ministry is a strong and stable reality both within the Church and society.

The manner in which the ministry is carried forward has been effected in recent years by two forces. First, ecclesiastically, the decline in the number of religious and at the same time as well, a growing realization of the responsibility of the Christian faithful to carry forward the apostolic works and the ministries of the Church. Second, dramatic changes in the manner of reimbursement and the amount of reimbursement given to healthcare providers by government (Medicare for the elderly and Medicaid for the poor) and by insurance companies.

The result has been a movement to develop systems that initially gathered together the hospitals owned by a particular religious institute to achieve needed efficiencies in purchasing and managing. Increasingly these systems and individual institutions were managed by lay women and men. They also extended their focus to address the needs of what is called the continuum of care. Locally and regionally the hospital or acute care ministry requires relationships with long term care facilities, rehabilitation institutes and insurance companies to name a few.

The first wave of development has been followed by a second that involves, on the regional and national level, systems previously identified with particular religious institutes coming together in systems that are "cosponsored" by several religious institutes. This movement also has another important aspect in that in some instances the religious institutes have taken the additional step of alienating their ownership and transferring it to a public juridic person that assumes responsibility for carrying forward the ministry in the future. The leadership of this new ecclesial reality is by and large the laity.

At the same time as these positive realities are occurring, the issues associated with changing and diminishing reimbursement are challenging the very ability to continue the ministry. These same realities are requiring, on the local and regional levels, the establishment of cooperative relationships with other faith-based providers of healthcare as well as secular providers. These relationships pose their own unique issues associated with the preservation of identity and integrity.

Another significant movement has been more philosophical in nature. The goal of the ministry is no longer just the healing of illness, but has expanded to include attention to that which will make possible the maintenance of health both individually and collectively. The goal is a healthy person in a well society. This invites new ways of integrating and coordinating our service—not to mention how we conceive what we are to be about.

the challenges facing the ministry, in part, are:

the need to strengthen ministry identity;

the need to foster ministry leadership;

the need to develop appropriate ministry structures; and

the need to deepen understanding of and commitment to health care as a social or public good.

While each challenge may seem daunting, each offers us an incredible opportunity to reinforce and build on what already exists.

Strengthen Ministry Identity

Over the last years the Catholic health ministry has been very intentional about working to sustain and enhance its identity. Our experience is not unlike that of our colleagues in Catholic education and social services. We, too, are experiencing a greater need to attend to questions of identity as we become more successful at developing large and complex delivery systems that interface with and must respond to demands made by government, big business, and the marketplace. As we discuss how best to respond, we are assisted, of course, by the ethical and religious directives. We know, however, that identity is informed and shaped by much more than the directives.

Thus we seek to strengthen our identity in order to ensure that the *raison d'etre* at the very heart of who we are as a ministry is expressed unequivocally in everything that we do. The consistency between the claims we make and our actions in light of those claims will be what *distinguishes* us in health care as in all other endeavors.

Foster ministry leadership

The second challenge is to call forth and nurture leadership for the future. This ministry has been and is blessed with many wise and gifted leaders – women and men, religious and laity. Many present ministry leaders grew up within a strong Catholic culture that provided a kind of formation for them, a formation that rooted them firmly within the Catholic tradition, a formation that helped shape the way they think and act. However, that strong culture no longer exists as it did in the past. Thus, we are left with the question of how to develop future leaders who are equally rooted in the tradition and imbued with and motivated by the values of the gospel. As in the past, much of this work will be done by the Spirit. But we share responsibil-

ity for the task. We must ensure that the soul of this ministry is passed on in a way that tomorrow's leaders, Catholic and other than Catholic, are up to the challenges of the next millennium. We all know that it is not enough to hand people the Code of Canon Law or a set of directives and expect them to be able to steward the ministry wisely. Nor is it sufficient to rely exclusively on programmatic approaches to identify and develop leaders for the future. We must seek ways to pass on to future leaders the Catholic imagination with all of its richness, depth and complexity. Whether it be those who sponsor or those who govern, those who manage or those who practice the healing arts, or those who collaborate as aids, technicians, and the like, all share a common vision that will make it possible for them to steward well this ministry that has been entrusted to us.

Develop appropriate ministry structures

A third challenge is to strengthen the structures that support this ministry. Immense creativity has resulted already in new forms of sponsorship, new corporate structures and alliances within the ministry. Many of these efforts, however, have been directed exclusively at horizontal integration within what we traditionally understand as Catholic health care.

While these efforts will continue we must also pursue more aggressively vertical integration. This will require that we think of health care more broadly and more appropriately than we have in the past. Spurred on by the "New Covenant" process, partnerships with Catholic Charities, with groups such as Mercy Housing, Catholic schools and parishes are developing. The thorny question, of course, quickly emerges: "who will be in charge?" The answer to that question must be arrived at very carefully and always with an eye toward the goal we are seeking. If we are to create the kind of health care system that truly will serve the integral good and well-being of persons and communities, we must be bold and willing to take risks.

As we move ahead we also must consider new ways to partner with and support physicians. The changes occurring within the American health care system pose significant impediments to the physician's ability to be faithful to the basic commitment at the heart of medicine: that is, to the good of patient. As Cardinal Bernardin has noted so powerfully, in many ways medicine has lost its moral compass. Catholic health care organizations must be places where physicians and all care-givers find a home, places where nothing impedes acting in light of their primary, covenantal obligations.

Deepen understanding of, and commitment to, health care as a social good

The fourth challenge, and perhaps the most difficult, pertains to how we understand health care. The Catholic tradition holds that access to basic health care is a fundamental human right because health is a necessary condition for human well-being and flourishing. We insist, therefore, that health care never be considered a mere commodity. It must always be regarded as a social or public good rendered on the basis of need rather than ability to pay. Moreover, the primary motive for offering health care must never be to return profit to disinterested investors.

Advocacy

Advocacy is an essential function for not-for-profits concerned about serving aging and chronically ill populations. We need to identify legislative and regulatory barriers to providing a seamless continuum of care that places priority on the welfare of the old, the vulnerable and the marginalized. Federal and state policies often work against integration of care.

The heritage of the Catholic health care ministry in the United States is indeed rich. The challenges are many. Those called to carry forward the ministry, however, are hopeful that with the aid of the Holy Spirit the ministry will be able to respond effectively and continue to be a sign of Jesus' compassion and healing.

The Future of AISAC

In this context I would like to speak about one of the important reasons for this gathering: the possible revitalization of AISAC. As we learned at the preliminary meeting last September, and as has been obvious at the interventions we are hearing at this meeting, the modes of expression and the economic and social context for the ministry vary from nation to nation and region to region. Consequently, it should not be surprising that there would be differing perspectives on the role and purpose of a revitalized AISAC.

That very diversity, however, speaks to two of the most important reasons for giving new life and direction to AISAC: providing a venue for experiencing and enhancing a sense of solidarity within the ministry that transcends national and regional boundaries, as well as a sense of communion with the universal apostolic ministry of the Pope and with his Pontifical Council.

From the perspective of my association, this solidarity and communion would be best served if AISAC represented all of the many dimensions of the healing ministry, including those that exist beyond the walls of the acute care hospital.

On another point, we would suggest that the membership of AISAC should not be individual institutions within a nation but should be whatever instrumentality already exists (or could be encouraged into existence) on the national or regional level to serve and support the ministry. We also would suggest that the structure should be as simple as possible and that the initial projects be modest in scope. It is important that the membership have a sense of how the work of AISCA contributes to the strengthening of the daily life of the ministry.

In closing, I am appreciative of the opportunity to share these thoughts and look forward to the success of our time together.

REV. MICHAEL PLACE
U.S.A.

VII: The International Federation of Catholic Pharmacists (FIPC)

In the name of the FIPC I am happy to take part in this Symposium whose principal aim is the relaunching of a project which, among other things, is closely linked to the concerns and interests of Catholic hospitals.

I would like to thank the organisers of this Symposium for having invited the Catholic pharmacists to describe their experiences and to demonstrate their wish to operate within a "health-care pole" at the Pontifical Council for Pastoral Assistance to Health Care Workers, not only in conjunction with the FIAMC and the CICIAMS (the Catholic medical doctors and nurses) but also with all Catholic hospitals. Indeed, many of the pharmacists who belong to our associations also work in hospitals.

Health care has always been one of the concerns of men. The study of health care, therefore, and thus of illness and how it should be tackled, is present to a surprising extent in Holy Scripture.

In the Bible we can find important descriptions of people afflicted by illness and disease and of those who took care of and treated them – medical doctors and pharmacists. Ben Sirach the Wise, for example, discusses the role and the approaches of these healers. Miracles of healing are described in both the Old Testament and the New Testament. The story of Tobias and how he regained his sight, to be found in both the Old and the New Testaments, and the Parable of the Good Samaritan, a lesson on solidarity and an example to be followed, are some of the best known accounts which deal with this theme.

The forms of medical treatment which are described have both a therapeutic and a symbolic value.

In the gospels of the New Testament there are no less than twenty-one miracles performed by Jesus! Blind people, paralysed people, the deaf and dumb, lepers, madmen, those suffering from a loss of blood, Lazarus with his death and resurrection, the son of the widow of Naim – all these benefited, like the centurion, from the compassionate healing of Jesus.

All these events are tied up with faith. The salvific role of faith is proclaimed every time a healing takes place: "Go! Your faith has saved you!"

As a demonstration of this Jesus refers to the healing of both the body and the soul: "is it easier to say: rise up and walk, or say: your sins are forgiven?"

Jesus does not have a monopoly over healing. Indeed, he invites the apostles not only to forgive sins but also to heal in his name.

As the disciples of Christ, we today are responsible for this ministry of healing in which we participate, and which is exalted through the Resurrection which will take place at the end of the world. As a first conclusion it can be said that pharmacists, who are referred to as the preparers of medicines in the Old Testament, take part through their work in a mission of love towards our neighbours in the promotion of health and the exalting of life – elements which are bound up with faith in Jesus. As health care-workers, pharmacists are health-care agents engaged in the upholding of the Gospel message.

How Can Pharmacists Perform this Witness of Holy Scripture?

In order to answer this question we must dwell upon two subjects:

– who exactly is a pharmacist?

– who is a Christian pharmacist? Or: what is the Christian contribution to the practice of pharmacy?

1. Who Exactly is a Pharmacist?

The pharmacist is a health-care actor, a worker in the health-care sector, on an equal level with other health-care professionals but having a role which has one special characteristic: *the pharmacist is a health-care worker who works in the front line and in the rearguard.*

In Europe, the pharmacist on average receives eighty people every day in his pharmacy. He therefore finds himself in the situation of being *a public relations figure within the health-care sector.*

The *advice* which he gives free of charge is often asked for before a medical doctor is consulted. Thus the "sorting" function which takes place before contact with a medical doctor is often carried out by a pharmacist. In this way the pharmacist is a front-line health-care worker.

Furthermore, when a pharmacist receives a prescription he guarantees *not only the quality of the medicine which he hands over but also the safety of the patient* because he is the final point, the final guarantee before the medicine is taken by the patient. The role of the pharmacist in relation to following the dosage, the posology, and the good use of the medicine is of primary importance. The pharmacist is thus somebody who works in the rearguard.

In all sectors of activity, whether in a pharmacy open to the general public, in a hospital, an industry, in clinical biology, or in research and development, the pharmacist is a

specialist with regard to the criteria of the effectivenes, the safety, and the quality of medicines.

2. Who is a Catholic Pharmacist? What Contribution Can the Catholic and Christian Vision of the World make to the Activity of the Pharmacist?

We will find an answer to these questions in the life of the associations of Catholic pharmacists which for over seventy years have encouraged in their members the concept of professional quality bound up with an idea of spirituality which places man – and the sick man in particular – at the heart of their everyday activity.

These associations joined together in 1950 (the year 2000 will thus mark the fiftieth anniversary of this decision) to found the International Federation of Catholic Pharmacists, a body which in Italian receives the acronym "FIPC".

In addition to the goals set out in its charter which call for the promotion of associations of Catholic pharmacists, their creation, and their representation at an international level both in relation to professional pharmaceutical associations and international Catholic associations, the FIPC also has the task of studying and espousing from a Catholic point of view all those questions which bear upon the practice of the pharmaceutical profession and in addition of proposing a Christian solution to them.

The FIPC is thus a part of the Church, of the Ecclesia of Christians, in a profession to which its members belong in order to achieve:

– the welfare of sick people (our neighbours according to the parable of the Good Samaritan);

– their own spiritual enrichment (the deepening of their faith);

– their on-going training, in particular in the field of ethical and bioethical questions and issues;

– the adaptation of their profession in the sense of service to sick people (pharmaceutical care).

Catholic pharmacists practice their profession with a *dual concern:*

– that of the *dignity of man,* and in particular of the sick person; and

– that of the demonstration of charity.

In this way Catholic pharmacists are more servants than men of business. They are also committed to solidarity with the other health-care professions, and this is the reason why they wish to create a "health-care" pole which will bring together Catholic medical doctors and nurses and why they hope to make a contribution to the sound and effective functioning of Catholic hospitals.

For this reason, at their congresses and their local days the pharmacists belonging to the FIPC have always sought to make clear their approach to the following issues:

– AIDS and the people afflicted by this malady;

– drugs and care for drug-addicts;

– the urgent need for social support for the least privileged, the homeless etc....;

– the cancellation of third world debts;

– abortion, contraception, the RU486...;

– support for *Evangelium Vitae;* and

– the promotion of the Charter for Health Care Workers.

Motions on these issues are prepared by the Bioethics Committee of the FIPC.

As this millennium draws to a close, what should our principal concerns be?

1. To be present in the largest possible number of countries (contacts already exist with almost sixty countries but we need to stimulate the creation of new associations...).

2. To help pilgrims of the Great Jubilee of the Holy Year 2000 by providing them with a health-care handbook, advice, a list of equivalent pharmaceutical preparations, useful addresses, contact points, information and so forth..., and all this in five languages.

3. To help to ensure that everybody everywhere has access to medicines and in particular to those which are essential to the defence of life.

Given that the World Health Organisation and the European Union have not followed us in this project, we have drawn up an orginal path to be taken by creating twenty-five basic dossiers on absolutely necessary medicines. We are seeking world-wide certification which will guarantee their quality, safety and effectiveness within a context of free circulation unhindered by taxation, and all this for the benefit of those who fall into sickness.

With the support of an international committee of experts in pharmacology, and through clinical analysis, we have drawn up a list of antibiotics, anti-parasite treatments, antisceptics, pain-killers, AIND, and products which combat lung disease and diabetes.

What is not of interest to the great international bodies will be achieved by means of a new approach which is nearer to the Church. And let it be remembered that the Church is the greatest health-care worker in the world.

This project has been presented to the ambassadors of the African countries and has received a great deal of attention. It has also involved much impatience given that it appears to be very suited to the needs of such countries, especially in the rural areas. Furthermore, Western authorities seem perhaps to recognise an approach by which to respond to the problems of the poorest people to be found in Europe itself.

In conclusion I would like to say that the Catholic pharmacist who is a member of these assocaitions of the FIPC is a man of action who is motivated by a sense of service to health care, a health-care worker active in both the front line and the rearguard, somebody who seeks to have a fully up-to-date professional, technical and ethical training, a person who wants to be near to his patients, and who nurtures in his faith an approach of solidarity and of charity based on the widest meaning of human dignity.

ALAIN LEJEUNE
President of the FIPC

VIII: The International Catholic Committee of Nurses and Medical-Social Assistants (CICIAMS)

1. Introduction

The CICIAMS is an international Catholic organisation which has seventy-four member associations, fifty of which are full members.

The CICIAMS is present in five continents:

NORTH AMERICA AND CANADA

Full members:
United States: National Association of Catholic Nurses USA

SOUTH AMERICA AND LATIN AMERICAN COUNTRIES

Full members:
Argentina: Movimento de Enfermeras Catòlicas
Brazil: Conselho Federal de Enfermagen
Chile: Associacion de Enfermeras Catòlicas de Chili
Ecuador: ACEPAS
El Salvador: Associacion Nacional de Enfermeras de El Salvador
Mexico: MEAC Panama: Associacion Nacional de Enfermeras de Panama
Porto Rico: Movimento de Enfermeras Catòlicas

ANGLOPHONE AFRICA

Full members:
Botswana: Catholic Nurses Guild of Botswana
Ghana: Catholic Nurses Guild of Ghana
Kenya: Caritas Nurses Association of Kenya
Lesotho: Lesotho Catholic Nurses Guild
Liberia: Catholic Guild of Liberia
South Africa: Catholic Nurses Guild of Southern Africa
Swaziland: SACNG
Tanzania: Tanzania Catholic Nurses
Uganda: Caritas Nurses Association Uganda
Zimbabwe: Dominican Missionary Sisters
Correspondent members:
Malawi: Catholic Nurses Association

FRANCOPHONE AFRICA

Full members:
Congo Brazzaville: Groupe Evangile et Santé
Congo: Association Nationale des Infirmières
Ivory Coast: Association au Service de la Vie.
Correspondent members:
Burkina Faso: Association Professionelle d'Infirmières
Burundi: Service Promotion de la Santé
Cameroon: Catholic Nurses Guild of Bamenda Ecole Privéé Catholique d'Infirmiers
Congo Brazzaville: Pastorale de la Santé
Madagascar: Secrétariar de l'USMFM
Mauritius: Eveché de Port-Louis
Togo: Direction Nationale des Oeuvres

ASIA

Full members:
Bangladesh: Bangladesh Catholic Nurses Guild
Korea: Korea Catholic Nurses Association
Hong Kong: Hong Kong Catholic Nurses Guild
India: Catholic Nurses Guild of India
Japan: Japan Catholic Nurses Association
Malaysia: Catholic Nurses Guild of Malaysia
The Philippines: Catholic Nurses Guild of the Philippines
Singapore: Catholic Nurses Guild of Singapore
Taiwan: Catholic Nurses Association of the Republic of China
Thailand: Catholic Nurses Guild of Thailand
Correspondent members:
Burma: Catholic Nurses Guild of Burma
Brunei: Apostolic Prefecture of Brunei
Pakistan: Catholic Nurses Guild of Pakistan
Sri Lanka: Catholic Nurses Guild of Sri Lanka
Vietnam: Catholic Nurses of Vietnam

EUROPE

Full members:
Ausria: Verienigung der Frauenorden Konggregationen Osterreichs
Belgium: La NVKVV Nationale Verbund van Katholieke Verpleegkundigen en Vroedvrouwen
Croatia: Croatian Catholic Society of Nurses
France: REPSA
Germany: Caritas Gemeinschaft fur Pflege und Socialberuf Katolischer Krankenpflege
England and Wales: Catholic Nurses Guild of England and Wales
Ireland: Catholic Nurses Guild of Ireland
Italy: ACOS
Holland: CFO Nieuwe Unie 91
Poland: Société Catholique des Infirmières
Portugal: Assioçao Catolica dos Profissionais de Enfermagen e Saude
Romania: Romanian Nurses Association
Scotland: Catholic Nurses, Midwives and Health Visitors of Scotland Spain: Salus Infirmorum
FERS: Federation Espanol de Enfermeras Religiosas Sanitarias
Correspondent members:
Belgium: Fédération des Ecoles Catholiques
England: Association of Nursing Religious
Italy: Federazione Italiana Religiose

The Lebanon: Hopital des Soeurs du Rosaire
Luxemburg: Ecole des Congrégatione Hospitalières Catholiques
Malta: Nurses Association of Malta
Russia: Caritas Moscow Medical Fraternity of Nurses

THE MIDDLE EAST

Full members:
The Lebanon: Association Catholique des Infirmiéres Libanaises
Correspondent members:
Jordan: Catholic Nurses of Jordan
The Lebanon: Hopital des Soeurs du Rosaire
The CICIAMS has been present in the Middle East for only a short period of time. In February 1999 a national Catholic association was established in the Lebanon at the time of the celebrations of the World Day of the Sick, an event in which a delegation from the Vatican took part. The CICIAMS is presently engaged in initiatives to establish a national Catholic association in Jordan, and is doing this with the support and help of associations of Catholic nurses and Catholic health care workers in the Lebanon. In Jordan the CICIAMS has a correspondent association.

OCEANIA

the responsibility of the Asian region of the CICIAMS:
Full members:
Australia: Catholic Nurses Guild of Australia
Correspondent members:
New Zealand: Convent of Our Lady of Compassion
Papua New Guinea: Catholic Health Workers Association of Papua New Guinea.

The CICIAMS has close links with:
The Pontifical Council for Pastoral Assistance to Health Care Workers
The Pontifical Council for the Family
The Pontifical Council for the Laity
The Pontifical Council for Justice and Peace

In addition, the CICIAMS is a member of the International Conference of Catholic Organisations and has on a large number of occasions taken part in the meetings of the standing committee of this body.

The CICIAMS has a large number of links with the Catholic Centre of UNESCO in Paris and with the Catholic Centre in Geneva. It is in addition a member of the Catholic Centre located in New York.

The CICIAMS has links with a large number of agencies of the United Nations Organisation, and more specifically:
– WHO
– Unicef/ONU
– Ecosoc
– OIT/BIT

The CICIAMS has close links with the various Catholic organisations of the health-care field, and with similar bodies, in the following areas:
– habitat
– social environment
– food

Our organisation has institutional and frequent contacts with other non-professional and non-Catholic organisations in the health-care field, for example the ICN.

2. Questions

a. Evangelical Values Expressed in the Social and Moral Guideliness of the Magisterium

How should *evangelical values* be lived out in the day to day work of the health-care worker? The members of the CICIAMS bear witness to Gospel values every time that they are in the company of sick people, handicapped people and suffering people in institutions, hospitals, rest homes, maternity wards, and so forth.

The CICIAMS works through regional and international structures where Catholic health-care workers bear witness to evangelical values in a clear and evident way.

North America and Mexico

As far as ethical values are concerned, the reports which reach us from Canada and from various regions of North America refer to the phenomenon of the fusion of Catholic and non-Catholic hospitals. As a result of this process, Catholic hospitals and institutions may lose their specific identity. In addition, Catholic female nurses may no longer have the possibility of bearing witness to their faith through times of prayer, visits to the chapel, and initiatives to promote the reciting of the rosary.

Prof.R.Walley of Canada, an Advisor to the Pontifical Council for Pastoral Assistance to Health Care Workers, has already drawn attention to the difficulties which are created by fusions between Catholic and non-Catholic hospitals. In these mixed hospitals, he has observed, the Canadian members of the CICIAMS who are obstetricians have to address themselves to the problems which are raised by the issues and practices of abortion and contraception.

In nearly all the regions of North America and Mexico a major initiative to promote the ethical education of male and female nurses and obstetricians is under way. Specific training projects for female nurses in relation to hospices and pain-reducing treatment designed to enable them to accompany sick people both spiritually and religiously until the lives of these patients come to a close have also been established. Co-operation between pastoral workers and female nurses is very advanced, and this is something which is also a model for the ethical training of health-care workers in Europe.

Anglophone Africa

From 1998 onwards the associations of the CICIAMS have been committed to organising a seminar every two years on subjects related to evangelical values:

1998: Kenya – Catholic nurses weave a path to the Lord

2000: South Africa – healing Africa

Uganda, Kenya, Mozambique, Namibia, Zambia, Zimbabwe, Botswana and South Africa have formally expressed their intention of sending an important delegation to

the international seminars sponsored by the CICIAMS.

The aims involved are to:
– encourage Catholic members at a parish level and within their communities to be more active;
– stimulate them constantly to be more independent;
– encourage Catholic health-care workers to see and define themselves as such in Catholic and non-Catholic hospitals and institutions;
– help health-care workers in these communities to recreate family values, to take care of orphans and promote initiatives of adoption;
– help in support systems so that male and female nurses can look after themselves in an independent sense. For example, accomodation for female nurses so that they can live decently.

Francophone Africa
– At the service of life (the Ivory Coast),
– GES (Congo-Brazzaville),
– Catholic Nursing School of Yaoundé linked to the Catholic hospital of Yaoundé (Cameroon), have all organised a monthly programme for each region and hospital/institution where male and female nurses meet each morning and evening. Under the guidance of a pastoral advisor the specific difficulties and needs of the region, hospital or instition involved are discussed from the viewpoint of Catholic values.

For example:
– the place and time for accompanying sick people to the celebration of the eucharist;
– the opening hour of the chapel for patients and health-care workers;
– the financial means which are required for the provision of pastoral care.

Each month a specific subject connected with evangelical values is discussed.

For example:
– the blessing of the sick;
– the Catholic world day of the sick.

Monthly reports are sent to the general secretary of the organisations listed above and to the various regions of the relevant countries.

Asia
The CICIAMS has a large number of national organisations in Asia. This is the continent where the CICIAMS is undergoing major expansion and growth. Every two years a professional seminar is organised on Gospel values. The eighth regional conference of the CICIAMS will take place in Seoul, the capital of South Korea, in 2001.

The *subject* of this conference will be: 'protection of human life in a changing world'. The conference will discuss such issues connected with life as:
– respect for life
– abortion
– pollution
– alcoholism and drugs
– modern technology and the methods of nurses.

It should be stressed that this conference will be a forum at which Catholic health-care workers will be able to engage in dialogue and provide each other with accounts of their respective experiences.

The CICIAMS organises a world congress every four years. The sixteenth world congress took place in Taipei in Taiwan in 1998. The subject of this meeting was: 'quality of life in a global context – the responsibilities of those who work in the health-care field'.

Their excellencies Archbishop Lozano and Bishop Redrado were invited as representatives of the Vatican. The report on this congress can be found in CICIAMS-Notizie n.3-4, 1998. The papers on Gospel values were those which were most appreciated by the people taking part in this world congress, especially those papers which offered practical advice on the daily work of Catholic male and female nurses.

The CICIAMS also strives to play a role with regard to the problems and issues of health-care workers in non-Catholic member countries.

For example in Malaysia a person loses his or her job if he or she refuses to take part in an abortion operation in general hospitals, and this is despite the fact that there is a charter which allows Catholics to refuse to engage in such operations. In India the CICIAMS, with the help of the World Health Organisation, the Indian government and the Catholic Nurses Guild of India, has established a hospital for AIDS patients (children, adults, the elderly) who are not covered by social welfare schemes because most of them are immigrants from Nepal or clandestine immigrants from Bangladesh. This hospital has a positive attitude towards every patient (who are more or less 200 in number) and accompanies them until their lives come to a close. Each patient can be helped by a Catholic pastoral worker or by a pastoral worker belonging to his or her own religion. This hospital was opened last December even though it was not yet completed and fully ready. At that time the hospital had twelve children suffering from AIDS all under the age of twelve months. A plan will be dedicated to retired health-care workers who lack suitable financial support. This emphasises the solidarity which exists among health-care workers and in particular the female nurses, who, it might also be added, receive a special ethical training to enable them to help patients in a spiritual sense who are terminally ill with AIDS.

The Middle East
The CICIAMS has a member organisation in the Lebanon. The goals of the CICIAMS with regard to the Middle East (for example in the Lebanon and Jordan) are as follows:
– to unite and bring together Catholic health-care workers;
– to promote the union of the associations of the Middle East and the international dimension of the CICIAMS itself;
– to encourage prayer, as for example in the Lebanon:
a) the hospital of the Sisters of the Rosary;
b) the World Day of the Sick. The Sisters of the Rosary pray and give a present to every patient;

– to allocate a special time (towards evening) in the months of May and October to pray with the rosary together with health-care workers and the patients;
– to emphasise the values of the family in the Catholic, anthropological and sociological sense of the term;
– to emphasise prayers and put them into practice through very concrete actions (prayers in sung form).

Europe

The question of *ethical values* during the 1980s was a strongly-felt subject. The CICIAMS dedicated its fifteenth world congress of 1994 to family values. The debates and study-groups discussed the following subjects: the family, health, ethical values, a dignified death and therapeutic means. The report will be finished by the end of the month of October 1999 and will be published in CICIAMS-Notizie. It will then be sent to the health section of the Council of Europe.

A large number of national associations have very high levels of training when it comes to ethical values, bioethics etc., and this is especially true of those associations which are to be found in Belgium, Holland, France, Italy, Germany, Spain and Great Britain. Every public event, such as the Week of Flemish Nurses at Ostend, always refers to ethical values and emphasises the Catholic identity of our members. In the countries of North Europe ethical training for nurses is a part of the work commitments. Ethical training and connected practice are essential for male and female nurses who work in hospices and administer pain-killing treatment.

b. Innovative Solutions in the Organisation of Health-Care Services of Quality.

Fusions between Catholic and non-Catholic hospitals.

The defining of a sort of charter (like, for example, the Charter for Health Care Workers) for hospitals and institutions in order to preserve their *Catholic identity* and provide an opportunity for the living out of the Faith through such instruments, as, for example:
– the open chapel
– time for prayer
– specific actions at times near to Catholic celebrations (Christmas, Easter, Catholic world days of the sick).
– The training of all health-care workers in matters of management so that they can direct a hospital or institution, and this in order to ensure greater affinity in matters of treatment (programmes of treatment, pain-killing treatment).
– The economic training of all health-care workers at their own levels. What price the costs of treatment and care? Each group of health-care workers must reflect upon, analyse and implement plans of activity which guarantee the highest level of care at a competitive price.
– Co-operation between those in authority (in government and in the Church) so that all human beings have access to primary and necessary care and treatment. For example in Europe clandestine immigrants and elderly people who are on the economic margins.
– In Europe co-operation between Catholic hospitals to reduce costs and ensure that every hospital can provide specialised care and treatment in certain fields such as, for example, heart surgery.
– The introduction of modern methods of telecommunications so that all nurses can take advantage of the training and the experience of others (video-conferences with America, courses in computers, such as in Taipei, etc.).
– The possibility of having access at the Pontifical Council for Pastoral Assistance to Health Care Workers to a list of Catholic hospitals along the lines of the index by region and category of health-care workers is something which should be promoted.
– The Pontifical Council for Pastoral Assistance to Health Care Workers should be a linking body for the whole world and *Catholics* should be united.
– The training of delegates (the specialised members of hospitals) to official organisms such as the World Health Organisation, Ecosoc, BIT, and Unicef is necessary. The delegates should have very close links with the Pastoral Council for Pastoral Assistance to Health Care Workers and a detailed experience of daily work in the health-care field.
– In the event of difficulties caused by wars, catastrophes etc.- such as for example in Bosnia-Herzegovina, greater co-operation between Catholic hospitals and direct and precise remedial initiatives are required. Catholic health-care workers must learn to make their presence more acutely felt all over the world. For example in the Kosovo Catholic health-care workers were scarcely present. The CICIAMS, the ACOS (Italy) and Albania have had quite strong contacts with the Catholic hospital in Tirana.

c. Making a Contribution to the Solution of the Ethical Dilemmas Raised by Modern Medical and Scientific Initiatives and Activity

Points to be emphasised:

The definition of the role of male and female nurses in care and treatment in the sphere of medical and therapeutic activity and practice.

The definition of the procedures which establish the role of nurses. For example the establishment of the procedures which should govern the turning off of respiratory aids.

Bioethical training for nurses.

To make contributions of a "daily experience" nature to the people who draw up and decide programmes of treatment and care, for example: should coma patients and the terminally ill receive nutrition?

Should medicines be given to elderly people?

Closer and constant *co-operation* between health-care workers, medical doctors, pharmacists, and nurses.

AN VERLINDE
General Secretary of the CICIAMS

IX: The International Federation of Associations of Catholic Doctors (FIAMC)

1. The Contemporary Situation

For the usual observer, many Catholic hospitals do not possess any visible sign which is able to distinguish them from state hospitals or from hospitals run by organisations which have other goals and aims.

In particular, unfortunately, in certain Catholic hospitals the guidelines of the Magisterium of the Church are ignored, and in many Catholic hospitals – especially those to be found in Western countries – there is an excessive concern with the economic side of things which leads to the practice of favouring only those people who have the financial means by which to pay for the care and treatment that they receive. In yet other cases, very little attention is paid to how medical doctors are chosen and selected, with only secondary importance being attributed to their adherence or otherwise to the ideal model espoused by that hospital. This failing is of an even more serious character in teaching hospitals because it is something that has negative consequences for the training of future medical doctors and nurses.

2. Needs and Requirements

A regaining of meaning for Catholic hospitals (whose importance is no longer evident in many countries, including those which have a Catholic tradition) is necessarily to be achieved through the removal of the failings which have been described above, where, of course, they exist. At a more general level, in order to restore meaning and cultural weight to Catholic hospitals we need to go beyond the concept of definition by a negative (no to abortion, no to euthansia, etc.) in order to reach a definition based upon the positive. Catholic hospitals should be characterised by the witness of the staff and personnel who work in them, by emphasis on the humanisation of the structures, and by the models which are espoused in the contents of the teaching and the training offered on the spot.

3. What Role for the International Association of Health Care-Institutions (IACHCI)?

In the work of re-establishing the identity of Catholic hospitals (an undertaking of great cultural, social and ecclesial significance) an especially relevant role could be played by an international association of Catholic hospitals. Furthermore, such an association could foster the creation of guidelines and working protocols on emerging subjects or subjects which are difficult and controversial from an ethical point of view. This international association could become a special point of reference from which to co-ordinate experiences which are necessarily different and to harmonise different national realities. It could also have an important representative role in relation to the Holy See and international health-care organisations.

4. The Experience of the IFCMA

An activity similar to that proposed for the IACHCI is carried out by the International Federation of Catholic Medical Associations (IFCMA) in the field of Catholic medical associations and their world. The IFCMA is a federation which unites the associations of Catholic doctors of fifty-three countries and has about 25,000 individual members. It was created in 1966 many years after the first experiences of the formation and activity of Catholic associations in the medical field which goes back to the papacy of Leo XIII, and was stimulated by the encyclicals of that great Pontiff. This historical reference helps us to understand the legal status of the IFCMA. It exists from the grass-roots upwards. It is not the international federation which legitimises the national associations but these latter which give rise to the IFCMA as an instrument of co-ordination, allocating to it, in addition, important tasks of representation and direction, without, however, endowing it with authority beyond that of a moral character.

For these reasons, the international federation can decide whether to accept or otherwise a national association within its ranks, and it could also, where serious reasons for so doing existed, actually expell such an association. However, the IFCMA cannot close down a national association which belongs to it or replace its leading officeholders. This is because from a legal point of view each national association is completely independent. These preliminary observations are necessary if we want to understand the difficulties which have been involved in the past in overcoming problems arising from differences of opinion, which, unfortunately, have also existed in relation to moral questions. They are also helpful in understanding the present-day financial difficulties of the federation which can act to limit in a major way its ca-

pacities for action as well as having a negative impact on the activities of its central secretariat. Indeed, it should be pointed out that the financial levy which the national associations make over to the international federation is very modest, and in addition it is not paid by all the associations or is paid only in part. An increase in this levy or the expulsion of those national associations who do not pay it would not solve the problem but would only weaken the federation and make it lose members.

The IFCMA tries to respond to these difficulties:

– by publishing a review which pays special attention to bioethics and the health-care ministry;

– by working in close contact with the central bodies of the Church and with international health-care organisations;

– by promoting activities involving health-care co-operation with developing countries;

– by promoting a "promise" by Catholic doctors which, although it is not obligatory, is a sort of internal "gold standard";

– by running an International Centre of Bioethics in Bombay, India;

– by seeking to raise funds abroad and by obliging those at the top of the international federation to pay out of their own pockets for the expenses that they have to meet on behalf of the federation;

In the future, other initiatives directed towards strengthening the role of the IFCMA could be as follows:

– making the "promise by the Catholic doctors" obligatory;

– creating a direct form of enrollment for individual members for the international federation in the hope of thereby achieving greater authority and more funds;

– offering an archive and records service;

– drawing up guidelines for professional conduct;

– bestowing greater powers for acting on the secretariat and providing it with more robust structures;

– achieving the recognition of a civil legal status for the federation which will then be valid within an international framework.

I have dwelt at length upon these problems and issues of the International Federation of Catholic Medical Associations (IFCMA) because I believe that if we can understand them we can avoid similar errors for the IACHCI. Inverting the title of this round table conference, I would like to suggest that to relaunch the project of the IACHCI we should start with the international federation and then go on to the national associations rather than vice versa. Or, at the very least, we should give the IFCMA strong authority in relation to the national associations.

5. Certain Suggestions for the IACHCI

– Catholic doctors are often not very present at an associative level in Catholic hospitals. This is in part due to the difficulties that they encounter in identifying their choice of faith with the choices made by the owners of their hospital and with the contradictions between the two which may arise. However, it is certain that greater help from Catholic health-care institutions in promoting membership of, and activity within, associations on the part of Catholic doctors, especially in those countries where an association of Catholic doctors does not exist, would be welcome.

– The IACHCI should co-operate closely with the IFCMA, the Federation of Nurses, and the Federation of Pharmacists, and should become a part of the network of good relations which already exists between these three older federations. If possible a shared secretariat based in Rome should come into existence in the year 2002.

– The fall in religious vocations has led to the disappearance of a number of religious congregations and to a shrinking in the programmes of many others. This subject has already been discussed with great clarity by Mr. Sullivan. We have to prevent this leading – as indeed has already happened – to exercises in fusion which do not respect the identity of Catholic hospitals or which involve the institutions being sold off at an unreasonably low price. This outcome would involve an authentic betrayal of the intentions of the founders and of the contributions made by many large and small donors who, through their offerings, have in the past sustained the existence of Catholic hospitals. Catholic health-care institutions should begin to study the possibility of giving more space to the associations representative of the Catholic health-care laity, and in particular of Catholic medical doctors, in the administration and management of hospitals. They should also examine how this can be brought about. All this involves having a sufficiently long-sighted mentality so that in the future the ownership of the institutions is not lost and there is an effective defence of the charism and the ethics of such institutions. This is the question to which Fr. Place referred. Catholic medical doctors, because of their training, can provide this leadership, which should be sensitive to the ethos of the institution and to the ethics promoted by the Magisterium of the Church.

– Lastly, Catholic hospitals should make themselves responsible for an expansion in the programmes and the posts available in the schools of specialisation in obstetrics and gynaecology. This is something which is necessary if we do not want to find ourselves within a few years without any Catholic gynaecologists. In many countries, indeed, there is a process at work designed to force resident students to carry out abortions during their periods of training, bringing about the *de facto* situation that this profession is not be practised by Catholics who are consistent in their faith.

Prof. GIAN LUIGI GIGLI
President of the IFCMA, the International Federation of Catholic Medical Associations.

X: The International Federation of Catholic Universities (FIUC)

The FIUC (International Federation of Catholic Universities) has a medical sector which brings together the faculties of medicine of the universities which belong to the Federation, that is to say about forty faculties of medicine and schools of medicine. I am very happy to represent the president of this part of the Federation, Professor Anthony Barbato of the Loyola University of the USA, who is unable to attend the deliberations of this symposium. I was dean of the Faculty of Medicine of the Catholic University of Louvain and I am presently president of the Belgian Federation of Catholic Hospitals. I hope that in taking part in your work and reflections my knowledge of the university and hospital world will compensate for my lack of experience of international bodies.

The Human, Psychological and Religious Orientations of Catholic Faculties of Medicine

Because their first mission is to ensure the teaching of medicine, faculties of medicine are necessarily linked to hospitals, in whose management, indeed, they almost always participate. In general, therefore, they play an important role in determining the quality of medicine which is practiced in such hospitals.

Faculties of medicine have always been concerned with the human and relational dimensions of their teaching. Because they are Catholic they are also concerned with the religious dimension of sick people. They strive to train their students in their psychological relationships and to teach them to respect the religion of their patients. This takes place most of the time in a pluralistic spirit because on the whole the patients belong to different denominations and faiths. The principal difficulty which is met with in this psychological and religious training of future medical doctors is to be found in the fact that the courses in medicine are very intensive and their character is necessarily technical and scientific. There is thus too little time available to the students for rational and philosophical training. Aware of this difficulty, Catholic faculties of medicine try to remedy the situation in their teaching but they are well aware that much still remains to be done in this direction.

Ethical Training

For a great many years the advances in medicine have raised ethical questions and problems which have become increasingly complex in character. For twenty years Catholic faculties of medicine have dedicated growing attention to these subjects. Not only have they organised courses in medical ethics but many of them have established research teams on Catholic medical ethics. At the beginning of the 1980s, with the support of the FIUC, a group of professors particularly involved in these questions came to be formed. With the help of a benefactor, from 1982 to 1992 they organised about twenty international meetings on ethical questions in which forty to fifty people participated. In 1988 they published a work in three languages (French, English and Spanish). Unfortunately in 1992 the end of the financial support provided by their benefactor put an end to this particularly productive activity. At the present time the FIUC has an ethics committee whose chairman, Dr.Barbato, seeks to make active by all means available.

The Social Dimensions of Medicine

All existing analyses on the teaching of medicine stress the need to train future medical doctors to have an overall vision of the health of populations. This requires training in preventive medicine and in health education but also an awareness of the cultural, social and economic factors which influence health. The economic dimension is acquiring increasing importance because of advances in medicine which make it increasingly effective but also increasingly expensive.

Catholic faculties of medicine are taking part in this development in the character of teaching at a number of levels. They include in their programmes courses of preventive medicine and health education. Some of these faculties have set up internal schools of public health. The above-mentioned study-group on ethical questions addressed itself in some of its international meetings to economic issues to do with access to treatment and care for everyone. Despite this fact, important advances have still to be achieved in the training of future medical doctors in matters concerning the social and economic dimensions of medicine. With a few rare exceptions, these faculties participate too little in an official and organised way in the study and drawing up of health-care policies at a national and international level.

Helping Developing Countries

Catholic faculties of medicine are very sensitive to the question of helping developing countries. A large number of initiatives provide help to the hospitals of the third world and to faculties of medicine in countries which find themselves in conditions of economic difficulty. This is a constant tradition in most of the Catholic faculties of medicine which belong to the industrialised countries.

The FIUC very strongly encourages action in favour of developing countries. Although, as an international body, it helps in the organisation and the co-ordination of such aid it has not been demonstrated that such action actually increases the effectiveness of such aid.

This brief description of the medical sector of the FIUC shows how Catholic faculties of medicine make enormous efforts to teach and develop Catholic ethics in the field of health care. For many years they have carried out and developed this teaching in their programmes and at the same time they have engaged in research in this field. The limits that they encounter in this activity are those encountered by all faculties of medicine – the intensity of the courses and their exclusively technical and scientific character mean that is it difficult to find space in the teaching of medicine for psychological and sociological questions, and indeed for philosophical and religious instruction. Furthermore, their limited financial resources mean that they are no longer able to organise international meetings in the field of Catholic ethics as they did in the past. Catholic faculties of medicine are fully aware of the advances which still have to be made and they are striving to achieve them.

Prof. L.CASSIERS,
Delegate of the FIUC.

XI: The Italian Association for the Health-Care Ministry (AIPAS)

What is the AIPAS? It is an organisation which unites all those who in a continuous way are engaged in specific activity in the field of the health-care ministry: diocesan priests and priests who are members of religious orders, permanent deacons, members of male and female religious orders, and members of the laity.

What are its goals?

– to promote the presence and the pastoral action of the Church in the world of health and health care;

– to advance the human and Christian training of health-care workers;

– to draw up proposals in the ecclesial, political and social fields for the safeguarding and the defence of the human person at all points in the management of his or her health;

– to work in favour of the permanent training of pastoral workers in the health-care field; and

– to safeguard the legal and professional position of the pastoral worker in the health-care field.

In addressing the subject of this symposium on the "catholic health-care institutions as witness to the Church" I would like to emphasise what follows in the light of pastoral action and initiative.

1. The Primary Importance of the Subjectivity of the Sick Person as a Person

He or she is the first subject of pastoral action and is not merely a person who receives treatment, care, attention and compassion. Indeed, he or she also gives through his or her suffering. He or she is also an active member in the building up of the Kingdom.

It is therefore necessary to pass from vision of the illness to a vision of the person. That person is neither a number nor an economic investment.

2. Welcoming

A hospital is a place of *"hospitality"*, and for this reason it is not only a structure which offers treatment and care – it is also *"the home of the suffering man"*.

It is necessary, within Catholic health-care structures, to promote that familial feeling which is not present in state health-care structures where the sick person is pre-eminently an unknown person. The provision of good services is not enough. There is also a need for the service of brotherhood, esteem, and of respect for the sick person.

3. Professional Skill

Economic questions and difficulties, work contracts, political dimensions, ambition, careerism, tiredness – these and other factors often lead the health-care worker to practice his professional skills in a mistaken and uncaring way; indeed often in a way which involves a mere "putting up with" the work he or she has to perform. At times that worker cannot wait for the end of his or her workshift. And this is not to speak of those very many

health-care workers who come to occupy positions of responsibility without having specific talents suitable to that particular sector.

This has very serious consequences for service to the sick person who becomes deprived of one of his or her fundamental rights – that of being guaranteed a serious approach in the health-care service.

In Catholic health-care structures these negative situations should be overcome through encouraging the presence of workers, who, in addition to being professionally trained, are also motivated in the service they provide. Medicine is not only profession – it is also vocation. "From the Hippocratic Oath to the Good Samaritan", the title of the conference organised by the Pontifical Council for Pastoral Assistance to Health Care Workers, emphasised this set of factors.

4. Resources

There was a time when the Christian community also took care of the sick from an economic point of view, and this was especially true with regard to the poor and those who were most in need. The Church was the institution responsible for health care right up until the last century. Today health care is a government service.

The poor person always found a bed in the hospital wards. Friars, monks and confraternities never allowed people to be left outside. There was no need for special wire-pulling or for bookings in order to get in.

The poor person is increasingly disappearing from state structures and drawn into private structures because they receive funds from the state; he or she thereby becomes a kind of investment.

We should not forget the spirituality of the very many saints who founded the hospital orders. They did not do this to create luxurious clinics for well-off people. On the contrary: they expressed an evangelical preference for the poor and for those in need.

I believe that this should be the fundamental characteristic of a Catholic hospital.

5. Pastoral Action

We still have a long road ahead of us, at least here in Italy. A large part of the members of religious orders who are present in health-care structures have a backward and out-of-date way of carrying out pastoral care. A renewal is called for. We need to pass from:

– A *sacramental* form of pastoral care to forms of pastoral care based on *evangelisation and catechesis.* Many of these people still stop at the mere administration of the sacraments and in particular of the eucharist. Personal catechesis concerning the great realities of human and Christian suffering comes to be ignored.

– Pastoral care of a *moralistic* kind to pastoral care of a *relational* character. It is not through giving sermons or merely proffering advice that pastoral work is carried out. It is also, and above all else, effected through fostering a self-exploration of the life experience of the sick person in order to allow him or her to understand his or her potential and capacity for maturation and growth.

– From the *chaplain* to the chaplaincy. Can one really think about the health-care ministry today, with, that is to say, the ecclesiology of the third millennium, as being something which should be exclusively in the hands of the chaplain? Is it not, in contrary fashion, right to think that the entire Christian community through its members should be present in the provision of pastoral care to the sick? It will no longer be a single person but a team of deacons, members of religious orders and the laity who will constitute a therapeutic community which will carry out pastoral action and care within a health-care structure.

6. Training

Anybody who performs a pastoral service should have the training necessary to do so. Good will is not enough – sound grounding is what is needed. In the AIPAS we ask all those people who enter a hospital as religious assistants to attend a basic course in the health-care ministry and we are committed at both regional and national levels to creating such schools of pastoral training.

My hope and wish is that Catholic health-care structures will increasingly be an icon of the Love of the Compassionate Father within society.

Rev. ANTONIO MARTELLO
AIPAS

Fairness and the Compatibility of Costs in Health Care. What Should be the Role of Catholics?

First of all I would like to sincerely thank the organisers of this symposium for having done me the great honour of inviting me to give this paper. If in 1963 when I began my medical studies someone had told me that on the threshold of the new millennium I would speak about fairness and control of costs, in practice that is to say about the ethics of management, and that I would have spoken in Rome in front of an assembly such as the one that is gathered together here today, I would have replied, at the very least, that he was dreaming. But you discover your vocation gradually as you advance in daily experience, where the least expected events lead to a road which was never imagined, and then you discover that it is a road that you like and which encourages you to grow as you move forward.

I have engaged in this brief preamble to tell you, at the outset, that I am a medical doctor and that I have worked in this profession for fifteen years. Although I am concerned with administration, I have never abandoned being a medical doctor, even though, logically enough, I no longer practice. I do not believe that being a medical doctor and an administrator has caused me some sort of trauma or involved some kind of incompatibility. On the contrary: the fact that I once practised medicine has helped me a great deal to understand the problems, the issues and the difficulties which are involved in the processes of management and administration.

The title of the paper which was given to me was broad-ranging and complex, at least when translated from the Italian, and I have therefore taken the liberty of shortening it somewhat. I will try, therefore, to describe the parameters which Catholic managers and administrators should follow in Catholic health-care centres so that our work can be as consistent as possible with, and at the same time display the greatest honesty in relation to, the ethical principles which we proclaim to defend. I would like to illuminate this distinction between consistency and honesty by recalling a phrase of priest who is a friend of mine. One day, when talking about this subject, he said to me: people can understand that at times we are not completely consistent in relation to what we preach but they will never forgive us for not being honest. This statement struck me a great deal and I would like you to reflect upon it.

Honesty: an Indisputable Principle

Apart from these parameters, I want to try to engage in a reflection on the decisions that we administrators, medical doctors or nurses in health-care centres must take in relation to daily ethics and small-scale decisions. I will leave to the experts the areas of macro-economic and large-scale health-care planning. In health-care management and administration there exist a very large number of statements which have become commonplaces, and these are to be heard at all congresses, conferences and symposiums etc. I have selected a few of them and they are as follows:

– the achievement of a state of wellbeing is something which cannot be not striven for;

– we must pass from a state of wellbeing to a society of wellbeing;

– the value of human life cannot be measured;

– health is a universal right of the person;

– health-care resources are limited;

– the person should be treated in his or her totality;

– when resources are limited, priorities have to be established;

– one has to work in an effective way but also in an efficient way;

– the management of resources must be effective and resources cannot be administered dishonestly.

In the last world report of the World Health Organisation the following sentence appears: “if services must be provided to everybody then not all services can be provided”.

I think that we could fill entire pages with statements such as these. If we analyse them we can see that they are all sound and valid, but if one leans towards some of them only it is clear that are contradicted by others. Some of these statements have a language largely rooted in the world of care and treatment whereas others are more phrases of an economic stamp. When a person is a medical doctor and an administrator or an administrator and a medical doctor, he or she wants to be loyal to a philosophy or to certain principles, but at the same time that person must take decisions because it is for this reason that he or she has been appointed. It is then that matters become more complicated.

The Need to Discern and to Decide

I will not talk to you about techniques of management and administration, of “quantums”, or of how to manage budgets. Nor will I talk to you about the philosophy of the ethics of management and administration. This is because I am not an expert in these fields. From a professional point of view, life has been very generous with me. It has allowed me to have different appointments and it has done me the immense favour of enabling me to sit at all sides of the table. I practised as a specialist in orthopaedics and traumatology for fourteen years and held high posts in the central parts of the Catalan administration

where I was responsible for negotiating agreements between the regional government and hospitals. For another five years I managed the hospital of a religious order which was listed amongst those of a high technological level and associated with the Catalan health service (SCS). I was then the administrator of a health-care region of Catalonia and at the present time I am the co-ordinator of the health-care centres in the province of Aragon – one of the three which exist in Spain – of the Hospital Order of St. John of God.

I hope you will allow me to explain briefly the hospital situation presently to be found in Catalonia. In this region 30% of beds are the responsibility of social welfare. The others belong to the public service or receive state support and are owned by communes, insurance societies, the Church and so forth. Each year the social welfare system, which was transferred to the control of the regional government, negotiates with these institutions about their activity and budgets. This process involves the establishment of what is termed a "convention". When I was a part of this regional administration my task was to allocate these subventions.

As I have already said, during these thirty years of different kinds of professional activity, I have sat at different sides of the table and I can assure you that the ability to engage in rationalisation, self-justification and a major shifting of positions is infinite whatever the role you occupy may be. I have been a generator of costs, a supplier, a financial backer and a controller. Although it seemed to me that at every moment I was operating in a correct way, there can be no doubt that my arguments and my reasoning changed according to the position that I held.

Reality is not Ascetic. It Conditions our Vision and our Judgement.

Let is consider, to begin with, what the factors are which contribute to the taking of decisions in the management and administration of a health-care centre. When I say "centre" I refer to state hospitals or to those subsidised by the state system, as I suppose is the case with most of you who are present here today.

The administration which, with the allocation of the budget, can, and in reality does, condition and influence a series of decisions relating to questions concerning care and economic matters, certainly plays an important role. The direction of the centre, the middle management, the health-care professionals (chiefly medical doctors and nurses) and the mission, goals, philosophy and institutional culture of that centre can all be of decisive importance at the moment when decisions have to be taken.

Here I would like to give an example from the time when I was an administrator. A member of the kitchen staff had retired and there was a permanent post which was thus advertised. Various people answered this advertisement. One of them was 62 years of age and for over ten years had worked as a substitute member of the kitchen staff, and in this capacity had proved very satisfactory.

There were also very young people who had equal qualifications. The job could be given according to the wishes of the government team. When it met, the centre's management, given the philosophy of the hospital and considering the fact that the oldest candidate had the best qualifications, decided to give the post to him even though his performance in the few years left before retirement would not have been that of a young person, not least because he suffered from serious, although not critical, arthrosis.

It is possible that if this post had been advertised by a public administration and the appointment had taken place in line with rules of a very rigid character, then this person would have obtained it anyway. Otherwise, a court case could have been made against the decision. But it is also possible that in the same situation, in a clinic devoted to profit, a young person would have been chosen who could have guaranteed a higher level of performance and that this decision would not have been subject to criticism.

I have chosen this small example in order to make us aware of two elements: that not all the problems and difficulties of management which arise every day are to do with economic matters (whether, for example, the salary of a young person and an older person should be the same), and that a decision can be correct although different from that taken elsewhere because it needs to take into consideration the spirit and the culture of that particular institution.

We Need to Face up to these Decisions in all their Breadth and by Considering all the Relevant Administrative, Economic, Care and Cultural Factors

When we analysed the different factors which were connected with the ethics of management, I told you that in part such ethics were conditioned by what the public administration agreed with the health-care centres. In this hall many countries are represented and the systems of finance and health-care are very different. In Catalonia, which has a system which is rather different from the rest of Spain, 70% of beds are subsidised through the state system.

When I shouldered the responsibility for negotiating the subsidies of the hospitals within the public network which supply beds to the social welfare

system, each administrator who entered my office explained the good that his or her hospital was doing, the high quality of its health-care services, and how badly it was treated in comparison with the nearby hospital which was specially favoured by the regional administration. When I administered a hospital it was my responsibility to go into the various offices and explain in what ways my hospital excelled and to try to obtain as much as possible in order to balance the accounts and achieve the highest possible level of care and treatment.

This is logical and normal. Every individual tries to gain as much as possible for his or her own cause. But I knew that some of those people who entered these offices were not so spotless and, furthermore, that their method of management was not a model of virtue.

What, as Catholic hospitals, should be our relationship with the various public administrations or state entities? In institutional relationships there are two extreme dangers: on the one hand that of allowing ourselves to be swept along by the dynamics of public administrations and thereby losing the identity of the centre, and on the other that of wanting to be so pure that in distancing ourselves from their dynamics we lose our sense of reality.

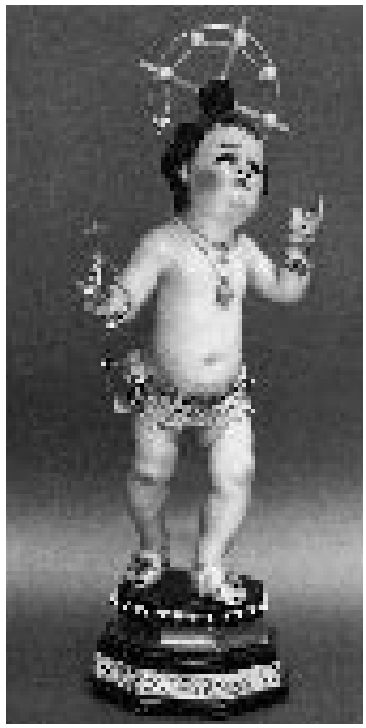
It cannot be doubted that the desire to keep up with the society in which we carry out our work can involve problems and internal conflicts in our daily management and administration, especially with regard to care and treatment and the ethical questions to which they give rise. Some of these are unpredictable in character and we have to solve them with the best good will and intentions possible, although at times we can make mistakes or live in the doubt that the decision which has been taken is not perhaps the right one.

With regard to their activity, our health-care centres have a public orientation and in many cases it has been possible for them to remain an integral part of the network of the public health service or of the social welfare system. This requires a close relationship with the government administration, being well informed about the present, foreseeing future requirements not only with regard to what we would like to do but also as concerns what citizens need, and, at the same time, a readiness to inquire into what that administration wants from our centres. There is no point in having a health-care centre simply to possess such an institution if it is not useful to the society which we serve.

Being Present in the Health-Care World Starting from Catholic Principles which Oblige us to be a Part of the Social Reality, the Needs, and the Culture in which we Live.

Our relationships with the government administration must certainly be honest, and at the same time they must be clear and transparent. When I say "clear and transparent" I am speaking of a centre as a whole, including the financial data which should leave no shadow of doubt as to how the money which is received is actually spent.

We can understand what the role of managers should be by examining their decisions concerning the economic side of things and by looking at their styles of management. Firstly, they must preach through practical example. We all know that



once a wage has been agreed upon, which obviously will be based upon the market situation, the value of the person, and the readiness of the institution and the other party to reach an agreement, there are a certain number of limits which can be treated in an elastic fashion. There is, for example, the question of the costs of representation. In my administration I saw some civil servants invoice their lunches or nearly all their lunches as "work lunches" whereas others limited such invoices to where they really applied. There was also the case of very great differences in the invoices presented for the institution-owned mobile telephone. We need to be rigid with ourselves when we apply pressure every day to reduce costs. The administrator or director cannot have wonderful furniture if the chairs in the waiting room cannot be changed because the money is not there. In the same way the most sophisticated computers on the market cannot be used if there are employees who have to wait for their colleagues to finish before working because there are not enough computer terminals to go round.

These small details, which seem to be of little importance, are in fact those which lead to credibility being achieved.

A Directive without Credibility is a Dead Letter for the Management. Our Principles as Believers Place us Increasingly at the Centre of Attention. We must be very Careful about the Words we Use, our Actions, and our Attitudes

In my opinion one of the qualities which cannot be dispensed with in any person who occupies a position of responsibility is that of common sense. That person must know that rules and regulations can never be dispensed with in order for them to function, but at the same time he or she must have the gift of being able to sense when a certain situation requires special handling and cannot be assessed along the lines of general situations. This is something which can be compared to what the referee does during a game of football. For me the best referee

is the referee who knows how to apply the advantage rule. Even though a foul has been committed, he allows play to continue because the possible benefit is greater than the value of the punishment for the foul as such. It is for this reason that I do not like those sports – such as basketball – where the advantage rule cannot be applied. Common sense also means knowing how to solve an unforeseen situation which does not belong to the usual, and is not covered by the standard manuals, with those doses of prudence, justice and fairness which do not come into conflict with the culture of that institution.

The Fact of Thinking and Discerning Enables us to Evaluate Various Decisions Without Falling into Uniform Approaches which are Purely Mechanical.

In my opinion managers must know how to leave their offices, go round their hospitals, and meet and know the staff and personnel of their place of work. But it is horrific to see the managers on the last floor esconced in their offices, being served coffee and not going to the employees' bar even by mere chance. How can they aspire to know what daily reality is really about? Workers like to have a manager or middle manager sitting next to them in the common dining hall because the next time this happens they can explain a small problem which can be easily solved which, however, those higher up in the heirarchy did not even imagine existed. At the very least this proximity enables managers to know the state of mind of their employees, their worries, and their small daily problems. And this move towards proximity in order to understand what the realities are can also be applied to patients. An American review reported that most of the clinical indiscretions in hospitals take place in the lifts. The doctors or nurses comment on matters connected with the patients without being aware of the presence of a relative or acquaintance of the sick person whose personal affairs are being revealed or who is being treated by a doctor that they are criticising. But lifts, like bars or the dining halls used by patients and their relatives, are a magnificent field of study to really know what those who are the objects of the services of our hospitals really think. We need to mix with people, become anonymous and listen to what is said about the services offered, thinking about the criticism that is made so that once we get back to our offices we can correct the defects that exist.

We need to pursue a policy of "open offices" within the framework of certain rules and guidelines. It is clear that a heirarchical structure exists which must be respected but at times an employee has a personal problem which he or she thinks is vital and he or she feels the need to explain it and to ask for help or advice from the director of his division or the administrator of the hospital. My personal opinion is that not only are we obliged to receive this employee but we must do this without reservation. When someone insists on speaking with the director it is because they are anxious and if we are able to calm this state of mind we have no right to hold back in receiving that person. In addition, we must be very transparent with the representatives of the workers. We should never make promises that cannot be kept or if we are not absolutely sure that they can be kept in the future. It is very easy

for a manager to say that the following year certain requests will be met so that social peace can be secured for a year. But are we certain that there will be the material means to meet such requests? If such certainty does not exist this needs to be explained clearly because otherwise the peace which reigns today will become war tomorrow. People do not forgive, and with good reason, false promises or agreements which are reached and then not implemented.

We need to involve the middle managers, and through them the workers as well, in the drawing up of budgets and the taking of the key decisions of the centres. Once the budget has been drawn up and the decisions have been taken, explanations should be given as to why priority has been given to certain areas and not others and of the ultimate goals of the centre. A little time ago the administrator of a hospital who had asked all the middle managers to produce written proposals containing their proposals for the annual budget observed to me that once the high managers had taken the final decision he had called every one of these middles managers into his office and explained to each one why certain proposals had been rejected and other accepted. His opinion on these meetings was extremely positive.

We need to be next to the medical doctors and nurses when they are the objects of legal action – always and as long as there has not been manifest neglect. Legal procedures are increasingly common and the same can be said for our professionals having to appear in court, at times in criminal proceedings. Some of these cases are baseless but others may be reasonable but caused by errors committed in good faith. The professional is infinitely grateful that in such instances the management supports him, helps him in his defence and does not neglect a problem which for him can involve very deep anxiety and worry.

Proximity and Attitudes Towards Others as a Model which can Differentiate and Identify our Work.

The cases which have been

commented on so far in this paper belong to the realm of daily ethics and in most cases do not concern the budget of the health-care centre. But what happens when we have to face up to "Mr. Money"? It is clear that for many honest and transparent Catholics our centres function with a budget and if their management does not behave correctly we endanger their on-going presence and that of the place where they work. It is equally undeniable that in order to engage in correct management rooted in the ethical principles on which we are based, there is no manual, master's degree, or computer programme which provides the right answer to the problem. Imagine how wonderful it would be to have a computer programme which, once the relevant information about income had been fed in, told us how to allocate it in a way which avoided all forms of injustice. But given that such a thing does not exist – if it existed the subsidies would not exist – this responsibility falls on the administrators and the management. After all, we have to ask ourselves: why give priority to this service and not to another? Should we increase wages and reduce investments? Should we favour the maintenance and safety sector or should new initiatives be engaged in?

Let us speak first of all about wages, an element which can represent 60-65% of the budget in intensive care units but which is much higher in psychiatric and socio-health care institutions. The social doctrine of the Church considers wages the most important, but not the only, practical test of social justice in social relations. We cannot pay low wages to our personnel and thereby generate resources to be destined for other areas. We must strive to provide wages which are fair but which at the same time are most suitable to the internal conditions of each individual health-care centre, without, however, endangering the vitality of that institution.

But wages are not the only thing. These centres are morally obliged to allocate the resources they have available so as to guarantee – to the extent to which this is possible – conditions of safety for their workers in line with the existing legislation of that particular country, or to improve these conditions when such legislation is weak. Where possible, continuity in the job should be striven for in order to avoid situations of demotivation which give rise to a bad work environment and have negative repercussions on the care provided to patients. Naturally enough, because a health-care centre works round the clock every day of the year we must have a "pool" of people available who can never be fixed employees. However, I believe that with them a relationship which is as permanent as possible should be established.

Hospitals are also obliged to allocate a part of their budgets to training. I am not referring here solely to scientific training but also to humanistic training – corses in bioethics, relationships of mutual help, how to carry out a mandate, etc. To summarise: we can say that as Catholic hospitals we must ensure that this training is not limited merely to the scientific side of things but also embraces those human values which enable our professionals to fulfill themselves further as people in an overall sense.

With regard to the carrying out of certain investments or the priority allocation of funds to certain services, the management team must be sufficiently informed to ensure that in agreement with the health-care administration it can allocate such funds to those services which are most needed by society. It would be absurd to become committed to a new service of angiography only because the hospital can thereby increase its prestige within the health-care network, and to do this without having the necessary funds for such an expenditure. It would be ethically mistaken to launch into new expensive investments when the high-risk equipment of the hospital (incubators, respirators, equipment for anaesthetics etc.) is obsolete and its upkeep can no longer guarantee that an accident – with consequent harmful effects for the patient – will not take place. As a general rule I would suggest a goal in the form of a slogan: what we have we must maintain in perfect condition and as long as this is possible we should acquire new technology for which we do not have the resources. We know about health-care centres which systematically purchase the latest equipment in order to gain publicity and thereby obtain a certain prestige while their basic instruments of surgery in reality only merit criticism from those who use them every day.

There are, however, certain moments when management involves the taking of risks for the board of directors or the owners. The general manager must assume responsibility for these risks even if this can lead to certain changes having to be made to the budget. The purchase of a very expensive drug or medicine which in a certain case represents the only way of saving the life of a patient must be accepted. The same may be said of replacing a piece of equipment which it was hoped would last longer but which the maintenance team now believes to be at risk. Our hospitals must be pioneers in the rigid control of everything that involves safety for our patients. We cannot accept the occurrence of foreseeable errors in matters of safety, nor can we accept the neglected purchase of a drug or medicine or the acquisition of equipment if this endangers the life of a patient, caused by a citing of the lack of resources provided for

by the budget. Responsible institutions must also strive to understand these decisions and provide their own funds when such expenditure is justified. Furthermore, we should not forget the responsibilities required by solidarity, in the communion of believers, towards those health-care centres in less developed counries which find themselves in very precarious situations. Hospitals which achieve good economic results are morally obliged to help in an economic sense those which belong in one way or another to their own congregation.

Let us now consider the professionals, those, that is to say, who play a very important role in the management of funds. Have you ever thought of what a medical doctor can spend simply by wielding his pen? He prescribes, places crosses on laboratory analyses, orders complementary tests, etc. And of the replaceable material which a nurse responsible for surgical instruments can waste when preparing such instruments for a small operation as if a total hip replacement was about to take place? There are many other examples of this kind.

When we studied medicine we were trained to cure and treat but they did not talk to us about costs. The same was the case in the nursing schools. Today we can witness a significant improvement in this field but there is still a long way to go. One part of the personnel, especially the medical staff, continues to hold that this is a question for government and the management of the centre because their mission is to engage in treatment or to carry out clinical research and not to be concerned with expenditure. This is a serious mistake which can be corrected only through training and through a strong institutional culture. Such training must be rooted in universities but must be developed and strengthened in the health-care centres whose managers have an important mission in this respect. This training should be especially incisive in relation to the resident young medical doctors who begin to work in a hospital immediately after finishing their university studies and do so in order to engage in specialisation. They begin to spend but many of them will have to be the administrators of tomorrow.

One day, when I was the administrator of a hospital, I sent a very direct letter to the service heads in which I explained how much each magnetic resonance cost. I did this because the demand for this was increasing at an alarming rate. I did not add anything else in this letter. I wanted merely to inform them of the situation. Over the next three months there was a marked decrease in the number of requests for such resonances. This is a banal example on my part but if we do not provide complete information on the costs of what we are doing the ability of professionals to spend is limitless. I remember the expression of surprise of a head physician in orthopaedics when I explained to him the price of the equipment which his team had installed over the previous year.

Most of the time uncontrolled expenditure is not carried out in bad faith. At times it is caused by the implementation of the criteria of preventive medicine, at times by requests for tests which are not really necessary, and at times it is because “given that we are asking for a hematocrit we may as well carry out a complete analysis” without reflecting on the possibility that perhaps a complete analysis had been carried out the previous week and had produced a result of normality.

We should never strive to economise on expenditure in favour of a sick person because it is the medical doctor who is ultimately responsible for the patient. However, we must be patient and lose time (which in essential terms means to gain time) in explaining to the professionals that they must be careful about costs every time that they engage in a medical or nursing act. Most of the time such acts involve a slight bite at the budget of the hospital, and as a result, of the country as a whole. What you waste today on your patient is money which tomorrow will be missed by another. The health budget, declared an ex-minister of health of Catalonia, is like a large cake from which everyone takes a slice but which, when it is finished, has no more slices to give. The dough is the quantity it is, and the baker cannot produce more, and if we do not distribute it well there will be somebody who eats a great deal while others remain hungry. This is a subject which bears a great deal on Catholic principles.

We must often ask in whose Interests we take our Decisions or Allocate Budgets.

A few months ago I read a document drawn up by a committee on ethics of a hospital which gave me great satisfaction. A child had been operated on for a malign tumour of the abdomen which reappeared after two years. The family had refused new treatment in the hospital and turned to a healer who had treated him with herbs. This was contrary to the opinion of the doctors. A year after this alternative treatment the family returned to the centre and asked for a magnetic resonance and a number of analyses for their sick child in order to know the nature of the development of the illness. But once again they refused conventional forms of health care and treatment. The medical doctor who had previously treated the child consulted the committee to see if it was right to spend public funds on complementary tests given that

the patient refused the proposed treatment. Quite apart from other considerations, what seems to me very positive is that in a situation in which the easiest thing would have been to carry out the tests and avoid problems the doctor had asked himself whether it was ethical to use public funds in a case such as this.

We will need years for our professionals to absorb this culture. Special attention will have to be paid to the intermediate levels so that such a culture is then transmitted to the lower level staff and personnel. We are, however, now gathering the first fruits. Previously a discussion about matters concerning the budget with a service head or ward sister was very difficult. Now this is becoming a routine occurrence even though some people still find this difficult to believe. Gradually a culture is being created.

We should consider the inputs which our medical doctors receive, in particular from the pharmaceutical industry. These inputs are very strong and directed towards a single direction – CONSUME, BUY. This is something which means SPEND. The health-care professional does not have sufficient information (and if he or she does, time is short and the will weak) to verify if that new pharmaceutical product, or that new method, have been sufficiently tested. He or she has implicit trust in the person who explains the marvels of the product, and the natural tendency is to try it out. Let us imagine that every new product (a machine, a video, a perfume etc.) advertised on television could be tried out free of cost. Would we accept the proposal? Each product tells us that it is the best, the most reliable, the product which produces the best image. And yet many are more expensive than the ones we are already using and with which we are very satisfied.

Hence the importance of demonstrating the value of sound pharmacological guidance for the centre where there are only drugs and medicines which offer a high quality/price ratio and where the introduction of new techniques which have not passed a severe analysis carried out in line with the criteria of so-called evidence-based medicine is not allowed. We must strengthen the committees and work groups composed of highly trained and at the same time very honest people who are able to discern what should really be done at an innovative level and what should be rejected. The prestige of that group must be based on its high level in relation to the other professionals who work in the hospital.

In order to Advance in a Culture of Management which Begins with Ethics a Good Personal Approach is not Enough. Methods and Instruments should be Created and Developed which Render it Effective.

Lastly, among the factors which shape and influence decision-making should be listed the culture of the institution and the institution itself. On the identity card of the Hospital Order of St. John of God, which, as some of you probably know, is one of the few ecclesial congregations whose centres are for the sick or the marginalised, one reads: “A motto of our centres could be this: know how to be able to achieve a correct allocation of the available resources by favouring the most characteristic features of the institution. In relation to the centre this will act to guarantee its future; at the level of services and departments it will lead to overall care and treatment for the sick person and the person in need”. This seems to me to be a good declaration of the institutional principles which could be applied to Catholic hospitals as a whole.

Which factors could we list as being essential to an institutional culture for hospitals which want to have a Catholic ideology, and which in turn directly affect the criteria of management? I will attempt to list some of these essential factors:

– we must choose our professionals, from the adminstrator to the lowest wage-earner, according to their technical competence but at the same time by assessing and evaluating their human capacities. Before employing them we should explain to them very well what the philosophy and the culture are of the enterprise they are about to join and how an undertaking of this sort could be defined according to certain norms which are formed day after day down the years and which infuse the institution with an invisible but palpable glow. When such a culture exists in a hospital or a health-care centre it is easier to take decisions from an ethical point of view. For this reason, before being employed by an institution it is important for us to reflect upon our values because they should be similar to those of the ethical culture which reigns in that institution. Where such a similarity does not exist, we could rapidly enter into a situation of opposition and friction or situations of conflict. On the other hand, when an individual enters such an institution fully convinced, he or she, aware and happy, leaves a part of himself or herself within it. This small element of oneself becomes incorporated, invisibly but tangibly, into the patrimony of that institution’s culture.

What is the use of a great administrator if he or she does not share the project of the institution? And what is the use of an auxiliary in the nursing department who is excellent from a professional point of view but unable to understand the needs of patients? This does not exclude, however, that the processes of selection should be

transparent or without ambiguities or friendship. This is because the credibility of the institution is at stake in a realm of great sensitivity.

– We should not be frightened by the changes in organisation which we think are necessary to ensuring that the centres are administered in line with business criteria of efficiency. Nor should we be afraid to keep the philosophy and the approach which belong to each one of them.

– We must be clear and transparent in relation to the administration and the workers. I would like to stress this point once again because I believe that it is a key point if we really want our undertakings to be managed honestly and we want this honesty to be recognised.

– Beginning with high management, all programmes of quality should be strengthened. When reference is made to quality one usually thinks of quality in terms of care and treatment. We should go well beyond this – to the quality of general services, of the administrative circuits, and of concern for our internal customers, our workers. Why not search for formulas which enable us "to measure" or to assess the quality of the personal services of our centres? This will surprise some of you but it is worthwhile asking ourselves if the pastoral services of a health-care centre are the most suitable to that reality, if they are what the patients expect to receive or wish to receive, or, in contrary fashion, if they are constrained by a standard model which is the same for all institutions and which is never questioned.

– Especial sensitivity should be felt in relation to looking after the environment. Hospitals are great creators of refuse of every kind and a very major consumer of products which can be recycled. It is not sufficient to obey the norms relating to the collection of contaminating substances. We should go much beyond this and engage in recycling wherever this is possible. Here we encounter a new obligation and a new culture which must be developed.

Other things could be said which would take up the whole of the morning but the time available to me is limited, as indeed is your patience. I hope that my paper will have been useful in making us reflect upon the correct distribution of funds and upon the ways in which we should manage our hospitals from an ethical point of view. I believe that the boom in bioethics will be followed by the development of entrepreneurial ethics, by the institutional ethics of management, and for this we must be prepared by daily and on-going training.

If we re-read the gospels, although they were written two-thousand years ago, we can see that Jesus, in order to orientate his doctrine, employed economic examples and even examples of management in his parables. I would like here to refer to the parable of the workers who go to work in a vineyard at different times of the day where each one of them receives the wage that was agreed upon, or to the parable where the master returns after a long absence to ask how his workers had used the talents that he had given them. I would also like to bring to mind the comments made by Jesus on the coin which bore Caesar's effigy. I have no doubt that if Christ were to come to earth during our times he would include in his Gospel message parables with themes which have been spoken about today in this paper. Although this eventuality will not take place, it is up to us, using our experience, our studies and our training, to look for the light that can act as a guide when we take our decisions.

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The Principle of Subsidiarity and its Presence in Relation to Catholic Institutions

Catholics cannot withdraw from the vast area of service to the sick person who is in need of care and treatment of both a social and a health-care nature.

The impelling Gospel commandment must be implemented in time and space, and today we are called upon to be reliable and credible witnesses to that commandment in every culture and tradition, whether that culture or tradition is of a civil or a political character. Our encounter here today certainly involves comparisons between very different experiences. But the so-called "principle of subsidiarity" is applicable in every realm and clime.

This principle involves:

a) organisational autonomy;

b) responsibility in relation to planning;

c) a specific aim in a context of pluralism.

With the exception of the special situations to be found in developing countries where the Church (or a non-profit organisation of a different complexion) is the only presence in the socio-assistance field, Catholic institutions act within a legislative and economic context where they take part in the planing of the supply of services to people subject to the limits which govern their activity.

The criteria which must determine the relationship between Catholic institutions and the communities where they emerge and work cannot neglect the basic reality of the "sacrament" of the Church, which is an evangeliser, healer and *one*. Above all else, I would venture to say, unity must be the most evident characteristic perceived by those who observe our work, activities and initiatives.

For this reason, the autonomy of the Church – and especially the autonomy of local Churches – is based upon internal planning which involves:

a) the promotion of the defence of her own resources and her own "policies" of solidarity; and

b) bearing witness first and foremost from within.

Another element connected to autonomy – which should be secured and defended – is the specific character of the Christian approach.

It is this characteristic which requires our presence, even when this is fatiguing and painful, in order to keep ethical values alive in the social context – ethical values which correspond to the existential needs and expectations of people and which are often not met by the state.

The right to the defence of health – as is well known – is a recent "right" in the history of human rights and as such is not called for or implemented with the same awareness within the different political systems which can be encountered in the world today.

In Europe, for example, it is easy to encounter universalistic systems financed by a system of contributions by the citizens for whom access to such systems is free and generalised.

There are also free-market systems which are based upon insurance coverage by citizens who have a suitable income. These systems, however, do not offer coverage to those people without a suitable income.

Lastly, there are those countries where the health system is almost non-existent and where citizens receive what their financial resources can obtain for them in contexts, which, in addition, are not well organised. Of course those countries which have a higher level of prosperity and scientific and industrial development are exceptions to this rule.

The Church, because of her institutions, is "immersed" in all these different situations. How, then, should subsidiarity be expressed "in relation to" Catholic institutions?

It is self-evident that certain guidelines can be applied to subsidiarity, understood in a general sense, between institutions at all levels of society, with, of course, the due differences and proportions.

"Subsidiarity" is a definition and a choice which the social doctrine of the Church, before all other agents, drew up and proposed to all men who wanted to build States and economies which would be free from a certain *dirigisme* and "free marketism".

Subsidiarity expresses itself:

a) vertically

b) horizontally

Every higher level must not "invade" the authority, activities, and responsibilities of the lower levels, but also, and above all else, it must not fail to supplement and help the lower level – when that level is in need – with suitable lines of action.

In the same way, every level must feel that it is "engaged" and must offer support and technical and human resources

to structures of the same nature which are limited in their action in the environment where they must carry out their mandate by the fact that that environment is poor or politically conditioned in a negative sense. For Christians, subsidiarity thus also involves "organising charity". In this way subsidiarity becomes an exceptional instrument by which to exalt "fraternal" co-operation between institutions, wherever, that is, differences and divergent goals are respected.

Indeed, at a human (or Christian) level subsidiarity is an organised method by which to express solidarity between institutions, which is, however, connected to the first social network of individuals, as is demonstrated by daily life. It is almost a way of achieving salvation from abstract, anonymous and bureaucratic formality.

Obviously enough, although subsidiarity has a basis in law codes this does not mean that it is automatically something which can be implemented in the organisation or management and financial planning of the state or of the different institutions at various levels and their relationships.

Hence the need perhaps to draw up models or study ways by which to define the procedures, within our context constituted by the Church as well, by which to achieve effective subsidiarity, and this is something which can also apply to our own specific sphere.

It seems to me in this sense a good idea for the Pontifical Council for Pastoral Assistance to Health Care Workers to produce a reference system available to all Catholic health-care institutions so that we can create that network which might be described with the term "self-help", which in turn can bring about that "unity" of intention, purpose and values which makes our "diaconate of health" visible.

The Pontifical Council can provide resources and energy so that the more people have they more they will commit themselves. And for those who have little there will be those indispensable forms of help which will enable them to achieve those goals which may be required to make witness visible in the place and at the time where and when Catholic health-care institutions make the Church, as a sacrament of salvation, effectively present.

Prof. MARIA PIA GARAVAGLIA
President of the Italian Red Cross

The Relationship between Catholic Health-Care Institutions and the WHO

Background

The WHO Constitution states in its introduction that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"; it also expresses the idea that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

A striking contrast emerges if we compare today with the world of 1948 when the WHO was established. The risk of conflict on a global scale has diminished sharply but in its place there are a multitude of regional and civil conflicts. Relationships between countries, which in the late 1940s reflected paternalistic colonial patterns and the Cold War, are now mostly shaped by the spread of neo-liberal market values and resulting increased interconnectedness between countries.

The Holy Father in his speech to the XII International conference organized by the Pontifical Council for Pastoral Assistance to Health Workers on the theme: "Church and health in the world expectations and hopes on the threshold of the year 2000", in November 1997, referred to the main principles of the "Charter for Health Care Workers". His Holiness stated: "to safeguard, recover and better the State of Health means serving life in its totality". He also highlighted in recognizing the positive signs of hope present in the last part of this century scientific, technological and medical progress in the service of Human Life, the importance of a greater awareness of our responsibility for the environment, efforts to restore peace and justice wherever they have been violated, and a desire for reconciliation and solidarity among different peoples.

The Charter for Health Care Workers recalls that medical health care service is both a "therapeutic ministry" and "service to life" and concludes by inviting them to consider themselves as collaborators with God who in Jesus is shown as the "physician of soul and bodies" so that they may really proclaim the Gospel of Life.

The Holy Father acknowledging with appreciation the declaration and principles of the WHO "Health for All in the 21st Century" document, wishes also to urge the responsible international bodies to commit themselves to drawing-up effective legal guarantees to ensure that the health of those who do not have a voice will also be promoted in its entirely and that

the world of health care will be imbued with the logic of solidarity and charity rather than the dynamics of profit.

All the above shows clearly the conceptual basis and principles in which the Catholic Church's foundations rest with regard to health and health care.

While the end of the Cold War relieved the tension between East and West, hopes were high that this would reduce spending on arms and increase spending on health development. So far, this so-called peace dividend has not materialized or seems to have been absorbed by peace keeping and peace efforts leaving still meager resources by which to accelerate human development.

The rate of globalization of trade, travel and migration, technology and marketing has accelerated dramatically over the past two decades resulting in gains for some and marginalization for others. The communication and technology revolution, which characterizes today's world, has facilitated certain of these trends. The countries of the world are made aware of their interdependence by the fragility of our shared environment, a global economic system and our common humanity. Global forces and policies affect as never before national and local decisions. While there is extreme poverty and preventable disease on a massive scale, there cannot be long-term prosperity or health for all in any nation nor can there be security for all while some nations continue to invest heavily in military power.

There is concern that rapid globalization fails to acknowledge the richness of cultural and ethnic diversity. Discrimination against certain groups, particularly when poverty pre-

vails, has led to an increase in civil conflict and in the number of refugees in the world.

The number of people living in absolute poverty and despair is growing steadily despite the fact that the past two decades have seen unprecedented wealth creation. Approximately 1.3 million people currently live in extreme poverty. Within all communities and countries there are growing disparities and inequalities. Relative poverty and the increasing gap between rich and poor in many countries threaten social cohesion.

Violence is one of the features of social disintegration. It manifests itself in different ways in different societies. Social disintegration is also evident in the current crisis in value systems. This is seen in the weakening of human relationships based on sharing and caring, the bonds sustaining and controlling intergenerational relations, and the institutions which in the past governed and preserved primary social units such as the family. The pursuit of material well being at all costs is, in many cases, eroding value systems and beliefs that gave primacy to spiritual well being. Ethical and moral values cannot be ignored when we pursue the common good.

Discussion

A rapid transition to a world in which a "culture of health" is established and where health is central to sustainable human development is vital. The basic policies and strategies to guide that transition must be specified and agreed to urgently by all in order to maintain cohesion and coherence of effort over the coming decades. Three fundamental actions are the required:

1) To ensure that the HFA value system is adopted everywhere;

2) To make health central to human and economic development; and

3) To develop sustainable health systems based on equity, solidarity, and moral and ethical concern.

Scientific and technological progress is testing the boundaries of ethical norms and challenging the very notion of what makes us human. Advances in biotechnology and genomics, and the pervasiveness of information and communication systems, offer both threats and opportunities for health. If we are all to share in progress, moral and ethical principles will have to anticipate and guide developments in science and technology.

As we can see from the above broadly-described vision and principles of health and health care espoused by the WHO and the Catholic Church, these two institutions are in agreement as to fundamentals, especially when we consider that the spiritual dimension of the human being and his health has been globally recognized.

If in addition we also equate the concepts and purposes included in the Charter for Health Care Workers, prepared by the Pontifical Council for Pastoral Assistance of Health Care Workers, the above-mentioned coinciding frameworks become even more evident.

Two questions then arise for discussion:

1) If there are so many points of coincidence why then has work with the WHO not been more productive?

2) How can the present status of cooperation between these two universal organizations be improved so that the ultimate beneficiary of these efforts are the people of the world and Christian values?

To better analyse these issues, it may be important to understand fully how the WHO works, how its policy is conducted and how decisions are made.

The fundamental premise to remember before any further consideration is that the WHO is not the Secretariat in Geneva or the Regional Offices only. Today, the WHO consists of 191 Member Sates with the World Health Assembly as the highest government body and the Executive Board as its executing body elected by the Assembly. At a regional level, the Regional Committee fulfills similar functions to the EB. The Secretariat assists them and carries out the mandates emanating from the governing bodies.

The WHO is an inter-governmental organization. The WHO also comprises collaborating centers, centers of excellence, expert committees (panels), NGOs, observer members and other associated institutions.

To further explain the policy and decision-making process in the WHO, it might be useful to perceive it as a concentric circle, where the Secretariat prepares proposals reflecting member states' concerns and priorities, elaborates technical background, the implications they may have, including scientific, social and economic issues, as well as the instruments needed for their implementation (for example: the Alma Ata Declaration on Primary Health Care).

The proposals are generally submitted to expert opinions and inputs through different means (Expert Committees, Scientific Groups, Consultations etc.). After further improvement by the Secretariat it is presented to the EB for approval and/or amendments. Only then it is submitted to the WHA for final consideration and approval (for example: the WHO budget approval).

How can the Church and Catholic institutions cooperate and work more efficiently with the WHO?

In my opinion, the first step is to develop a workable strategy for the Pontifical Council for Pastoral Assistance to Health Care Workers for this purpose. In this regard, it would be important to complete an inventory of the institutions and activities related to health and health care that the Catholic Church is carrying out worldwide. This inventory should not only be of a quantitative nature but also provide indications of qualitative value. This updated information should be widely known since

it is of utmost importance, and should not be ignored. It is probably valid to affirm that the Catholic Church is the largest health and health care provider in the world as a single state or institution.

This is a very powerful message. Questions such as "do we actively work in health and health care in every single country of the world?" can be very useful to tangibly demonstrate the magnitude of the Church's action in health.

Another general concept I wish to submit for future consideration is the role that education plays in constructing healthy populations. Here again, the Catholic Church can and should take the opportunity to demonstrate its large participation in the education of the world community, particularly children. Further deliberation on this matter might be of great value.

The strategy to increase cooperation with the WHO should include three levels of action and three or four transversal themes, which are universal and therefore easy to create consensus around.

Levels for action

Global: WHA, EB, Secretariat HQ, global organizations/institutions

Regional: RC, regional secretariat offices, regional organizations/institutions

National: Governmental authorities, national organization/institutions, WHO country offices

Themes for analysis and participation in the following areas:

– Scientific
– Social/Political
– Technological
– Economic

Although all levels of intervention are important, as are the themes indicated above, implementation at a national level is very important since everything in health and health care should start and end in countries and their communities.

Often Catholic institutions are shy in international forums dealing with health and the Church's central bodies alone cannot make the difference. Catholic institutions, organizations and the practicing community at large should also assume these responsibilities, not only as a humanistic duty, but also as a Christian-moral issue.

Conclusion

In conclusion, I would like to make the following points:

– the WHO, the Catholic Church and its institutions have a lot in common regarding principles, goals and mission.

– The existing differences alone should not be a cause for antagonism between the Catholic Church and the WHO.

– Health and life are the most precious human values.

– Both institutions are universal and can collaborate much more.

– Global strategic planning by the Pontifical Council for Pastoral Assistance to Health Care Workers is very important in providing guidance, proposed mechanisms, coordination and support to national and local efforts.

– To identify areas and priorities for action by the Pontifical Council.

– The Pontifical Council may like to consider broadening its scope and to be seen as providign pastoral care in health for all with particular concern for health care workers.

Thank you for your attention!

Dr. FERNANDO S. ANTEZANA-ARANIBAR
WHO – Ginevra

Telemedicine, Internet and Catholic Health-Care Institutions

It is an honour and pleasure for me to participate in this conference.

As a pioneer in the world of Internet and especially in medical online businesses it is of major concern to me to share the following subjects with you:

What is the status of telemedicine today?

What are the potential benefits of this telemedicine and the world of Internet for your organisations?

What is the special offer "The Internet Company" wants to present to your organisations to reach these benefits?

Telemedicine or more precisely "Medical health information and humanitarian support" via Internet means that the revolutionary technical and organisational development offers completely new possibilities.

It offers innumerable innovative solutions in organising quality health services. It enables a much greater harmonisation and coherence within the work of Catholic institutions and much higher efficiency in working together.

It becomes easier to give a better future to the Christian Community.

The Internet is both a media and distribution channel.

It offers the possibility in one solution for Information, Communication and Transaction.

Information

Access to unlimited information.

The priest, doctor or nurse in a mission in the wilderness can have the same access to healthcare information as a doctor in an American or European university clinic!

There is no better or more inexpensive way than multimedia services over the Internet for continuous medical education.

All necessary information existing in authorised digital libraries and databases of the medical associations can be provided to anybody with authorised access.

You can exchange information with all your members easily through e-mail at costs lower than a telephone call.

An important example: in April 1996 we were able to show the first "live" operation in real time over Internet. It was a new much easier way to operate on the crucial ligament of the knee. Within the first minutes of the operation more than 60.000 Internet users simultaneously joined the operation. It was practically the world's largest lecture in medicine, with participants all over the world and at the cost of a local telephone call.

Nothing will revolutionise learning and continuous learning more than Internet. What started about three years ago with simple video transmissions and much explanatory text is now continuously being improved.

For organisations like the Roman Catholic Church, which run health centres all over the world, this presents an enormous chance to reach improvements at low cost with a maximal number of employees.

Communication

Consultation between experts and general practitioners or doctors wherever they might be is no problem any more. Advice can be given within seconds in real time. In no other field has Internet proven its high performance better than in the medical field where time is a very critical factor and where the right information at the right time can be a matter of life or death.

Communication means

– e-mail: one to one or one to many;

– online conferences: co-ordination of projects and logistics, help in case of catastrophes;

– video conferences: e.g. continuous medical education;

– consultation: use of the knowledge of medical capacities whenever necessary. Communication between experts groups at different locations world-wide.

In most interpersonal situations it is important to see the other person face to face.

This is particularly important in the relation of doctor to patient. Whenever there are not enough experts the contact and help via telephone and fax have always been helpful for a local doctor. Yet how much easier would it be to exchange knowledge and advice via Internet. In addition to text and pictures (e.g. x-rays) it is also very simple to send video and audio contributions via Internet.

Of course it is still a technical reality that the bandwidth in many countries, which are particularly important for the work of the Roman Catholic Church, are not sufficient for such transmissions. Still, progress is so fast in information technology that it is only a question of a few years before unlimited Internet access will be affordable for many and not only in industrialised countries.

Transactions

Internet as a network offers the chance to be used as a huge platform for transactions: for ordering and exchanging med-

ical equipment such as drugs or technical instruments and machinery. It is also an ideal marketplace or bourse for organising human resources. In day to day business or in catastrophes, helpers can be requested and managed through Internet.

The request for donations is also one of the transactions possible.

Another example is that books can be ordered via Internet. Companies like amazon.com are the world's largest bookshops. So far they can not deliver to all countries, but there are solutions to this problem.

All this is possible through Internet and demonstrates the possibilities for using it for telemedicine in general and the solution of other important tasks.

Today 150 million people are using Internet – within some years there will be 500 million users.

The whole medical world is networking via Internet.

I myself started in 1995 with the "Health Online Service" the first Internet Service for medical professionals on a global scale. Based in Germany we spread out to other countries. This provided us with an excellent network and experience.

I deeply believe that there is no other group of organisations that could benefit more from a global common Internet platform than the healthcare organisations, associations and orders of the Roman Catholic Church.

How could that platform look like? How could it be launched? What is the special medical impact?

1. The existing Internet website of the individual organisation of the Church would stay the same. The impact is that many more people can see it and you get much higher notice and response for the needs of the organisation.

2. A part of the service could be for authorised members only as an Intranet. This is exclusively for doctors and employees of the medical institutions like hospitals or also another one for priests and nurses in missions and other places.

There are unlimited possibilities of implementing several different intranets for specific user-groups or organisations, e.g. congregations, professions, areas, clerical hierarchies or orders.

This could enable very efficient work through excellent interior communication and information.

3. The part open to all Internet users could have a different content than the interior service and offers to the public general information about healthcare and the related institutions of the Roman Catholic Church.

The immediate allocation of the necessary information enables help organisations from all countries and institutions to be more effective than today. All international crises demonstrate the necessity of improving logistics as far as information and the delivery of goods is concerned. And you can manage that from every point on earth.

In the Internet service the possibility for online donations would be included and linked to your organisation presentation and account. We saw an immense success of online donation during the "Mitch" catastrophe and the crisis in the Kosovo.

You can profit from the new way and win new donators from all over the globe you can not reach today.

4. It is very important to mention that a service like this has to be designed and built in a way so that everybody can use it easily. It has to be multicultural and multilingual, respecting the national systems of medical treatment. The medical content will be authorised by the relevant associations.

What does the user need?

A PC or one of the less expensive tools with web access to use Internet and a telephone line.

All that is possible today. It was not possible half a year ago. Only now does the technology exist to realise a world-wide healthcare online service organisationally, technically and economically.

The Church is a healing community and now we have the possibility to create the living network for the healthcare community.

Thank you very much.

Dr. HELMUT FLUHER
President of the German "Internet Company"

Telemedicine: What is its Future in Relation to Health-care Institutions?

Without entering into the details of this technology, I would like at the outset to draw attention to certain principles of our faith and to apply them to the subject which concerns us at this meeting of thought and reflection.

God the Creator: grow, multiply and govern the earth!

God placed *a thousand treasures in his work* and down the centuries the genius of man has known how to disover their secrets and to take advantage of the resources which are already present in the Creation.

One could list all the inventions of modern times: the steam train, newspapers, solar energy, aircraft flight, x-rays, radio and television – all are based upon mastering the elements of the Creation. Down the years man has been able *to understand them, discover their secrets and put them to use,* often in a wonderful way and in a way which is useful for all the men and women of our times.

In order to introduce the subject of my paper, reference should be made to another reality, which is unfortunately very sad: although the services of telemedicine are already employed in developed countries, they could markedly improve the health-care situation in developing countries where they are very short on the ground. According to the World Report on Health Care published in 1996:

– of the 52 million people who died in 1995 almost *40 million* lived in developing countries;

– the probability of a child *dying before the age of five* is ten times higher in developing countries than in industrialised countries;

– *life expectancy at birth* in developing countries is eleven years lower (64 rather than 75) than in industrialised countries.

These differences can be attributed to differences in the quality of medical services between the two categories of countries and to the quality of diet in the first five years of life, which are the most critical years in a person's development.

All this requires an intrepid and courageous initiative which must take place at the level of causes, and this with a view to changing this situation, which is one of profound injustice.

Fortunately enough, there are solutions to be found to this problem.

Telemedicine

Traditional medicine has numerous limitations which arise from economic, geographical (the distance which sick people have to travel) and professional (a clinic may have too few resources to deal with all the situations which present themselves) factors.

We therefore need a system:

a: which is *centred on the patient* rather than on technology, even if there is always of course a need for technical means and instruments;

b: which ensures that services reach *the patient*, to the extent to which this is possible of course, through favouring every system which involves moving the patient to a centre of medical services;

c. which ensures the greatest *privacy* possible for the patient and the medical staff and their activity;

d: which above all else is not based on the availability of a certain instrument of telemedicine (the advertising which is seen in specialised journals or perhaps once in popular magazines can at times be very attractive) but on the *real needs* of a given region;

e: which offers the *means* which can help the *greatest possible number of people* in difficulty, and above all *the most disadvantaged*;

f: which requires the *lowest costs* in terms of investment and functioning; and

g: which has a structure of services which protects the intellectual property of individuals or institutions who or which have helped to make the practical services offered by telemedicine actually possible. All this should take place in line with, and in the spirit of, the Jubilee. The Jubilee should certainly be a celebration but it should also involve a sharing of resources in a spirit of solidarity, something which conforms to the remission of debts. In this sense the *twinning of hospitals* of European or North American countries with health-care centres of the South of the planet, especially in Africa, would be a good and appropriate policy.

The building up of solidarity.

As in the case of many other fields, individual action will often be extremely difficult, if not actually impossible. The costs of certain investments which are involved in the installation of telemedicine could be prohibitive. In contrary fashion, if different sectors come together, if applications of a different nature can use the same infrastructures, then their justification would be enormously facilitated and thus also their financing. The installation of VSATs (very small aperture terminals) could be employed for the transmission of data, for video conferences, for programmes of tele-education and for electronic mail.

Antecedents

In the bible we can find examples of healing at a distance, and therefore of telemedicine:

1. The serpent of bronze which Moses placed on a staff – the person who looked at it after being bitten by a snake was thereby healed.
2. The prophet Eliseus healed Naaman the Syrian simply by telling him to immerse himself in the Jordan;
3. The centurion asked Jesus to heal his servant who was lying down at his home in pain and suffering – let it be done according to your faith! And the boy immediately got better! Treatment had been provided from a distance...

According to how medicine is practiced today, we are dealing here with the diagnosis and treatment to apply. For this reason, there is a certain need for the *gathering and transmission of data* accompanied by suitable classification and memorising of that data.

The modern forms of technology involving *transmission* which are based on Hertz waves and on conducting lines enable us to do from a *distance* what at one time could only be done personally, and this in the direct presence of the communicator and the person he or she is talking to. Today telecommunications have become so transformed that distances no longer exist – the world has become a "global village".

At one time a medical doctor could examine and treat a patient only in his or her presence. Now it is known that this can be done at a distance. This can take place in a number of ways:

– by telephone, by video-vision or by video-conference. The medical doctor can by such methods talk with, and see, his or her patient;

– by consulting a specialist, making him or her see an x-ray or an echography, in order to ask his or her opinion on a difficult case;

– today a medical doctor could even carry out a surgical operation at a distance – the surgical instruments act under his or her command as if he or she were actually in the operating theatre!

Technology

Today we are offered sophisticated means of telecommunications and practical methods of engaging in telemedicine.

Through the gathering of information.

If a sick man has a small apparatus – for example a cardio vox, something widely used in Italy, Spain and Portugal – which allows the recording of an electrocardiogram of his heart beat, and has access to a telephone, he can attach his apparatus to the telephone and the electrocardiogram will appear on a screen of the centre. He no longer needs to go to hospital and thus can save time and money. He can also continue with his work and interests.

For consultation.

If for example a nurse only has basic training and works in a small dispensary in the savana and encounters a complex case which goes beyond her knowledge and her capacities, or the resources she has available, she would be certainly upset at the prospect of not being able to carry out a diagnosis which could help her to find a remedy for her patient. Let us suppose that she has never found these symptoms in other patients. Should she say to him merely: "I am very sorry my friend, but I am unable to help you! If you can't make it to the departmental hospital 150 kilometres away then go home and put up with your illness"? If the nurse was equipped to ask for help from a specialist she would be able to suggest a suitable form of treatment to her patient.

The Interpretation of data.

The gathering of information is one thing – for example the taking of an x-ray; its scientific interpretation is quite another.

A nurse can certainly take an x-ray but from here to actually reading it is a great leap. If that nurse is connected through a video-conference to a hospital well-equipped in staff and personnel, a diagnosis can be obtained by using that x-ray and thereafter seeking a second opinion. This is possible if both parties use the same platform.

For the construction of a data base which can be easily administered.

A hospital should be able to count on instruments which facilitate the construction of a medical dossier on every patient and the consultation of different dossiers, not to speak of providing information of cases previously treated and the different medicines which are available, with their various advantages and disadvantages. During this meeting a concrete and practical system will be proposed and there will be a demonstration of the working of this system.

For everyone.

Modern technology enables us, therefore, to perform amazing actions which only a few years ago would have seemed to be absolutely impossible!

These advances are not in the least limited to a specific area of the world or to the making of profits by a privileged few or to certain forms of well defined activity with the concomitant exclusion of other forms.

God wanted the Creation to serve *the whole of humanity*, the men and women of *all ages*. Those of us who live in the northern hemisphere of the planet are privileged; the development of modern technology renders us satisfied beings because it enables us (much more than those who live in the southern hemisphere) to use the thousand artifices which our ancestors could not take advantage of: the telephone, the radio, the television, x-ray machines, computer systems, and the list could be continued almost *ad infinitum*.

All this gives us a double responsibility: first of all *to use*

modern technology in a spirit of gratitude towards the Creator who gave it to us to use it *to the advantage of all men* and especially those who are most disadvantages – the poorest amongst us not only from an economic point of view but also because they are unable to use that which, for us for example, seems to be an acquired right, and more specifically the machines and instruments which produce a wellbeing for us which at times can even save our lives, as in the case of an emergency surgical operation.

It will be necessary to invest in *training programmes* which meet new needs and requirements and which among other things alllow pastoral workers to reconquer the terrain which has been lost.

We should, therefore, devote care to understanding *the different possibilities* which are offered to us by modern times. We should be open, and at the same time critical, in relation to *technology which can increase wellbeing* amongst our brothers and sisters in need. We should improve *the quality of treatment and care* which is provided in regions which do not have all the possibilities offered by a modern hospital, and help those who have limited means and patients who do not have access to forms of care and treatment which are theirs by right.

And this at all levels:

– from the isolated patient at a dispensary or a health-care centre to a distant medical centre;

– from the small hospital in the interior to a regional or national hospital;

– from the regional hospital to a university hospital which is well equipped with skilled and experienced professors;

– from the university hospital of a small African country to a hospital which is specialised in a certain kind of treatment, etc.

May the Holy Spirit give us the intelligence by which to understand the potential of the modern instruments available to us and the opportunities which are thereby opened up, especially for developing countries, and to understand how they work! May the Holy Spirit also give us the generosity to come to the aid of our poor brothers and sisters!

I was ill and you visited me! Thanks to your inventiveness and openness of spirit, you gave me the care and treatment which I needed and which my resources or my condition did not allow me to receive.

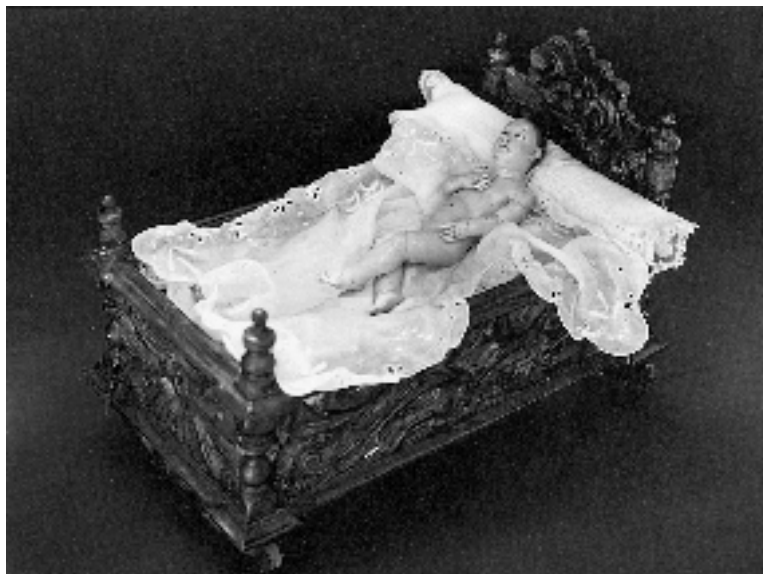
I was sick and you made available to me forms of technology that I gave into your hands to develop, and you reduced my suffering.

I was sick and recognising your limits you did not hesitate to consult specialists who helped you to diagnose what I had very well, thereby enabling you to find the remedy which healed me! Come and find your answer! We can all experience the joy of listening to such words spoken by the Lord.

I would like, in conclusion, to express to the Pontifical Council for Pastoral Assistance to Health Care Workers my strongly-felt gratitude for the invitation which I received to take part in this Symposium and for the trust displayed towards us.

We wish to place at the service of the Pontifical Council our strong desire to help in the planning of the services provided by telemedicine and to energise the contacts we have already established, especially with the members of the Midijan Group (an entity to which we belong), who, indeed, have great experience in this whole field.

Rev. JEAN-PAUL GUILLET
Director of the International Cinema Association, Missionary Service.



ROUND TABLE

Which Models for a Form of Management/Administration which is Consistent with Christian Values? The Identity of the Catholic Manager

I: Economic Questions in the Health-Care Field must be Subordinated to Ethics

Mr President,

I have been entrusted with the task of introducing this session of the Symposium, a session dedicated to the discussion of the system of values which should direct and guide the action of the Catholic manager in relation to the management and organisation of health-care systems.

This is a by no means easy task which, however, I will address myself to with due simplicity, and with the personal conviction that it is important to reflect upon the mission of Christian workers independently of the context of social commitment and the actual place in which their activity takes place.

This is borne out by the fact that after me eminent speakers will give papers – speakers who represent the various geographical areas and regions of the world and each of whom carries out his or her activity in situations and contexts which are very difficult in cultural, economic, social and political terms.

The values that they have are shared by them all, and this is true in all latitudes and in all countries. However, their problems and their systems of assessment and evaluation are very different.

I would like to present and outline an argument which links together certain observations which it seems to me are of contemporary relevance:

– In all the areas and regions of the world, but in particular in the most developed parts of the planet, there is an increasing demand for health-care services and similar provision. Against this phenomenon, which in part is connected to the advances which have taken place in medical science, we find counterposed an availability of resources which are by their very nature limited.

– The volume of resources available for health-care provision represents an indirect index of the level of wealth of a country and of its level of economic development. Paradoxically, the poorest countries, where there is the greatest need for help, care and assistance, are those which have the lowest level of health care.

– The need to limit health-care expenditure is a question which affects all the economies of each country of the world, whether that country is already developed or on the road to development.

– This opposition between the *limits* which exist to the available resources, and the potential lack of *limits* to the needs which have to be satisfied, requires decisions as to the allocation of resources not only at a "macro" level – involving the government of a country or a specific geographical area – but also at a "micro" level – that is to say in relation to the management of individual health-care structures and entities. Allocation of resources to an individual or to a group of individuals necessarily means a reduction in the resources that could be allocated elsewhere.

– There is the problem of *which criteria and which mechanisms should be adopted in the distribution of the resources that are available.* Practical objectives of justice

and distributive fairness should be followed in this area. Fairness should be aimed for both within the health-care systems of individual countries and within the wider framework of a "global" vision of peoples and nations.

– In the richer countries we can observe the phenomena of so-called "health-care consumerism". This phrase expresses how the demand for health-care services is not always the expression of actual need and of "real" health-care requirements. This is why in recent years the concept of "suitability" in economic as well as clinical terms has gained so much ground in medical activity.

– When reference is made to the right to health, the subject of resources and costs cannot be addressed in a logic which is merely economic in character – this subject concerns above all else the ethical aspects of human behaviour and action. The economy must be a means and not the "end". The economy is subordinated to ethics.

Each choice, if it does not have clear and strong objectives which people want to pursue and achieve, runs the risk of taking a wrong direction and thereby of giving rise to the danger that situations of serious imbalance and unfairness will be brought into being.

One needs only think here of certain choices which are being taken, even in countries which are very advanced, to limit treatment and care according to age, or to allow only the richest sections of the population to gain access to certain kinds of care and treatment.

I believe that this subject of the criteria to be adopted in the health-care field is a subject which every Christian worker, at whatever level of work or responsibility, can and must address him or herself to in a spirit of fundamental commitment. With force, and at all levels, it must be stressed again that the authentic goal of every health-care system is the defence of the person and of human life.

In relation to these subjects I would like to describe my own direct and personal experience.

– At the "A Gemelli" polyclinic, not least as result of the legislative changes which have been introduced in Italy over recent years and which have profoundly changed the rules by which the health system functions, we are engaged in a very major effort to re-organise our hospital.

– In this work we are moved by the conviction, which is not only theoretical in character but also something which has been demonstrated at a practical level on many occasions, that the placing of the sick person and his or her needs at "the centre" of our activity not only meets an imperative of an ethical or moral character, but also enables us to achieve the best form of organisation possible in terms of the optimal employment of human and material resources.

– When one has to deal with problems and difficulties involving the management and organisation of resources, one should always bear in mind the ultimate aim of the action which is taken, namely the best possible treatment and care for people which can be achieved in a context of organisational effectiveness and efficiency.

– I am convinced that good and effective organisation not only depends on what is done but also on *how* things are done. The "how" concerns a dimension which is strictly individual in character and which relates to the independence of the individual, his or her values and his or her vision of life. But this "how" also concerns the overall identity of an organisation which must know how to achieve both the objectives which it pursues and the organisational values which it promotes and embraces.

As I was saying, at the Gemelli polyclinic we have over recent years set in motion a project involving the re-organisation of the activities and structures of this health-care institution.

– Within this wider project, which concerns the whole hospital, we also set in motion a specific programme to improve the quality of the services which are provided. During the initial stage of the wider project a document was drawn up which summed up the scale of priorities and the guiding considerations which are needed to achieve the goals of quality which we have set ourselves.

I would like to finish this brief paper by referring to an objective which takes pride of place as the primary commitment of all the professional and human elements which are involved in health-care activity: *to take care of the sick person with full and overall respect for his or her dignity, his or her needs, his or her suffering and his or her hopes.*

I am convinced that it is the task of every health-care worker to translate this objective or goal into practical actions in the small or large choices which have to be taken each and every day.

I would like to thank you for your attention and I would now like to hand over to the other speakers, who represent the different continents of the planet.

Dr. ANTONIO CICCHETTI,
General Director ,
The A. Gemelli Polyclinic, Rome.

II: The Legal Aspect

Introduction

The Church proclaims her right to manage institutions in the field of health and health care and considers her commitment and undertakings in the world of health and health care as an integral part of her mission.

The post-Vatican Council II debate "for and against Catholic hospitals" has become somewhat less intense. However, Catholic hospitals now find themselves in great difficulty because of the decline in the number of religious members of their staff, something which has led to economic and administrative problems.

It must be taken for granted that a Catholic hospital must in all respects set standards and constitute an example to be followed:

– in modern medicine which respects the dignity of man;

– in qualified and human nursing care; and

– in exemplary and economic administration.

The objectives of a Catholic hospital are as follows:

– A Catholic health-care institution is an ecclesial community which takes part in that mission of the Catholic Church which is dedicated to engaging in the ministry of healing.

– The administrators adhere to this mission of the institution, which is seen as a Christian community dedicated to service.

– A Catholic health-care institution is committed to offering treatment and care which is of quality to the person considered in his or her entirety in order to heal as Christ himself healed.

– A Catholic health-care institution offers pastoral service to its patients, to their families, and to all the people connected with the institution.

– A Catholic health-care institution practices policies and engages in procedures which conform to Catholic rules and guidelines in the sphere of medical ethics and offers an on-going education and training in medical morality to medical doctors and other members of that health-care institution.

– A Catholic health-care institution develops and promotes suitable and appropriate relations with civil and religious organisations.

Fundamental Principles of the Administration of Ecclesiastical Institutions

1. The Ability of the Church to Possess Material Goods

In "Lumen Gentium" (n.8) Vatican Council II strongly emphasised the ability of the Church to possess material goods, arguing that the Church was established by Christ as a visible community and as such is in need of material goods in order to carry out her mission in the world: therefore "she will use all those, and only those, goods which conform to the Gospel..."(GS n.76).

The code of canon law published in 1983, in relation to internal and external questions, lays down in canon 1254 §1 that "the Catholic Church, by innate right, independently of the civil power, can acquire, possess, administer and alienate temporal goods in order to carry out her aims". The juridical independence of the Church in relation to every other power is at the base of a relative independence in the administration of temporal goods. Although in canon 1254 §1 the ability of the Church to possess temporal goods is presented as an innate and independent right, it is nonetheless also helpful and useful that this ability is recognised by the relevant state. In some states it is not recognised, or is recognised only in part, and this is something which paralyses the effectiveness of this declaration of the Church.

2. The Purpose of the Material Goods of the Church

The material goods of the Church also include the property of those various kinds of legal entities (that is to say dioceses, parishes, orders and congregations) in their capacity as ecclesiatical agents which, first and foremost in order to achieve their aims, are established in a way which brings goods together. In the early Church, material goods had a single goal and purpose – the spreading and diffusion of the Christian message. Vatican Council II confirmed that the goods of the Church "must be used for those goals for the achievement of which the Church can possess temporal goods" (Vatican Council II, PO n.17). In the canonical code of 1983, in canon 1254 §2, this text of the Council is elaborated upon and there is a detailed description of the binding aims which apply to the legal entities

or agents who or which are responsible for earthly goods: "in reality these goals are principally: the organisation of divine cult, the provision of honest support for the clergy and the other ministries, and engagement in the works of the sacred apostolate and those of charity, especially towards the poor" (can.1254 §2).

On the subject of material goods and special circumstances, attention should also be paid to the statements of the other canons of book V of canon law. In can. 1254 §2 the list of the objectives is not heirarchical in character and therefore does not contain an explicit evaluation of such objectives. Such an evaluation should, however, emerge from the circumstances of time and place of a community or an order. Calculations can thus be made regarding which objective should be chosen.

The definition and description of the objectives of ecclesiatical goods involves the placing of limitations on their use. Vatican Council II made relevant and significant comments on this subject in PO n.17 and GS n.76. In relation to the goods of the Church and thus also of the institutions of consecrated life, their use, as laid down by the code, is binding. The competent ecclesiastical authority has the task of establishing in practical terms the limits to such use, of insisting that such limits are observed, and of carrying out the role of supervision in ways which conform to its authority.

3. The Administration of Ecclesiastical Temporal Goods

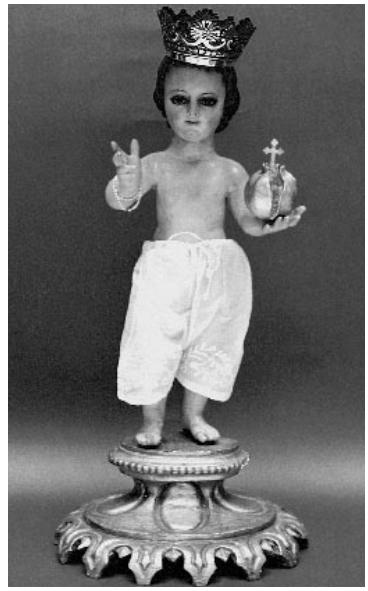
Ecclesiastical goods are those goods which belong to the public juridical agents of the Church (can. 1257 §1). These public juridical agents are those entities that "are constituted by the competent ecclesiastical authority so that according to their goals which are previously laid down in the name of the Church they can carry out, in conformity with the norms of law, their task entrusted to them with reference to the public good". Their right to temporal goods, therefore, is thus regulated by the rules of the Church (can. 1255; n 1257). In certain cases canon law refers back to state law (can. 22; 197; 1290) and bases itself in dealing with temporal goods upon the national legislation of the country concerned. This right is seen as involving the right to acquire, keep, administer and alienate (can. 1054; 1255).

Administration belongs to the subject of government, to the power of government. Book V of the code, which deals with temporal goods, refers only to the *munus regendi* of the Church. When it deals with the administration of the goods of religious institutions this subject is placed explictly under the heading of government (can. 634-640). Public juridical persons administer goods through administrators.

The code discusses and outlines the responsibilities of the administrators in general in canons 1273-1289. The specific responsibilities of the administrators are listed in canons 1279-1289.

The administrators are to act according to their mandate in the name of the public juridical person. "To act in the name of the Church" can also mean "according to the spirit of the Church in conformity with her nature and her mission".

The administrative acts are supervised and controlled by superiors and bursars or their equivalents. Canon 1280 lays down that each juridical person must have a council of administration or in addition advisers who work with that council. It should be remembered that such bodies are not really involved in government but instead are engaged in advice and participation. The superior must act in a way which demonstrates complete respect for the norms laid down by canon 127, which also has a large number of restrictive clauses.



The supervisory power of the superior. In a significant number of cases the administrative act must be subject to the supervision of the superior authority, and this can take place either before or after it is effected. Subsequent supervision takes place at the report stage whereas previous supervision occurs when there is a need for permission or consent prior to the administrative act.

4. Civil or State Legislation within an Ecclesiastical Context

The majority of European states do not recognise canon law as an independent source of law. In almost all European countries the legislation of the Catholic Church is recognised only in part. In most cases regulations exist which have been established through concordats with the Holy See or between the local/national Church and the relevant state. These regulations govern the Church's property and the administration of that property.

The essential points here are:

– The recognition of ecclesiatical entities as juridical persons. This is a subject which requires a concordat with the Holy See.

– The definition of religious activity or activity in relation to divine cult and of other kinds of activity related to works of charity and education.

– The legal representative is the person who represents the juridical person in relation to the law, whether canon law or national law. This person does not carry out the act of the juridical person but only expresses it.

– The controls exercised by the Church and the state require

ecclesiatical and state regulations.

– Canon law requires respect for national law in order to achieve juridical guarantees (canons 1274 §5; 1284 §2.2; 1292 §2).

5. The Identity of the Catholic Manager

We live in a heterogeneous and liberal form of society which often expresses itself in a libertine propensity to follow personal tastes and in the strong individualism of contemporary man.

True and genuine liberalism involves tolerance for the various systems of fundamental values and principles of society which are expressed in such human communities as the family, religious communities, groups or entities which live out a specific ideal, and ideological or political groupings which seek to transform society in line with their systems of values and goals.

We can also observe, however, that there is a strong tendency in the present age to create a personal religion by taking from the various systems available those which the individual most likes, with the consequent creation of a personal-synchristic system.

Disorientation seems to be the greatest and most difficult problem of our society and this is something which expresses itself in disobedience and the denial of formal authority. Natural or charismatic authority, connected to the personal qualities of man, seems to be the only kind of authority which is seen as being valid. For the Catholic manager, the system of evangelical values is the basis and the foundation of administrative life and activity. Christ himself provides us with the example of this and the Church herself, in preaching the Gospel, provides the direction to be taken in administration and management.

"Whoever would be a great man among you, must be your servant, and whoever has a mind to be first among you, must be your slave" (Mt 20:26).

These words provide an idea of the direction which should be taken by the Catholic manager of every epoch. This direction also applies to the management and organisation of our works and to health-care institutions of every kind.

The organisation and shape of our works need witness which is felt and lived out by the Catholic manager and by the Christian community of service.

Rev. LEONHARD GREGOTSCH
M.I.,
The Association of Catholic Hospitals of Austria

III: The Catholic Health Care Institutions as Church Testimony in Taiwan: The Identity of the Leader/Manager

General Introduction

On the map of Asia, Taiwan is the leaf-shaped island situated between China, Japan and the Philippines. The total population is 21.9 million. Catholics are only 1.7% of the population. But we are visible in being a formal, mainstream, solidly based religion with many good works for society, especially institutes of health care and education.

The Catholic Health Care Association comprises 8 acute care hospitals distributed throughout the island; each has from 65 beds to 600 beds, making in all 2,600 beds. There are 6 nursing homes within the administration of these Catholic acute care hospitals, and 11 independent long term care facilities managed by various Catholic religious congregations. Five of the 8 acute care hospitals are diocesan sponsored, the remaining owned by religious congregations. All the chief executive officers are priests or sisters.

Cardinal Tien Health Care System

My hospital began 30 years ago, and was named in memory of Cardinal Tien, the first Chinese-born Cardinal of China. It belongs to the Archdiocese of Taipei; the Archbishop is the president of the Board of Trustees. The main hospital has 658 acute care beds with outpatient service averaging 2,300 patients daily, 134 doctors, 377 nurses and a total of over 1,000 employees. When the conference at the Vatican talked about solidarity and subsidiarity, I see that we have done just that. The Cardinal Tien Hospital (CTH) is now a network of 3 hospitals, each with its a health or welfare subsidiaries (table 1). We have shared finance but independent accounting.

Let me give a more detailed description of each of the 3 partners in this system.

A. The main CTH will be the chief teaching hospital for the newly approved Catholic Fu-Jen medical college. A new wing will be built soon, upgrading to about 1,000 beds, to

provide the teaching and finance needed for the future students and faculty. In addition to an excellent acute care facility with 4 class A intensive care units, we have several special units:

1) a 19-bed *hospice* unit dedicated to St. Joseph, patron of the good death, for late-stage cancer patients. The hospice unit is the second one established in the country, but at its fifth anniversary the quality of service was judged the best in the country. The Christian spirit is so evident there, the number of baptisms of patients and their relatives probably outnumbers many local parish churches. It is definitely an appealing alternative to euthanasia, where people suffering from cancer can be relieved of their pain and sufferings, and depart this world with love and peace in their heart. I wish every Catholic hospital would invest in such a unit of love and mercy. The Ministry of Health is very supportive of the hospice care concept, and will soon endorse it with increased payments from the national health insurance system.

2) In response to society's needs in a rapidly aging population, we established the first registered *nursing home* unit in our country as a teaching model. It has only 51 beds, but the care is excellent, e.g no patient got a bed sore in the 7 years of its existence.

3) Jointly managed with the nursing home is a *day care center* for the sick elderly, licensed for 35 occupants.

4) Psychiatric care is a newly recognized need also. We have a *psychiatry* division with 20 acute in-patient beds, a day care rehabilitation center that can accommodate 50, and outpatient clinic 15 sessions a week.

5) We have a multi-specialty Holy Family outreach clinic, preparing that service area for a possible future branch hospital eventually.

6) A year ago we accepted the management of a provincial government owned *retirement home* for 320 elderly, creating an atmosphere of love and care there. At Pentecost, 3 of the elderly piously received baptism. The old priest exclaimed, "it was the first time I gave baptism in the past 17 years of my ministry"! Converts are not easy to get in Taiwan.

7) On the off-shore island is a small St. Camilus Hospital, which served the needy well for 40 years as a mission hospital by the Order of St. Camilus. In recent years it has not been able to survive the competition in acute care, so we have accepted the challenge of helping to transform it from an acute care unit into a long term care facility, with an outreach clinic and rehabilitation center, at a loss financially so far, but fulfilling the current needs of the people there.

B. Our Yung Ho Branch hospital is 15 years old and has 243 beds with an average daily outpatient clinic of 1,200. It operates a nursing home owned by the county government, and another home for the mentally and physically severely handicapped. In the planning is a day-care center for Alzheimer and related dementia patients, and a 68-bed inpatient Alzheimer center, as one of the 100-plus projects of charity offered to the Holy Father for the new millennium.

C. We also manage a mercy hospital in the neighboring diocese, in a formerly medically deprived area. The hospital is 2-1/2 years old, 250 acute care beds, not yet financially sound, but being a witness to the Mercy of God by providing a large 100-bed psychiatric service, and managing a government owned home for 150 low-income dementia and 50 unconscious patients, serving with love and quality care.

Our Mission Statement

This network of the Cardinal Tien Hospital illustrates our mission statement formulated in 1993: to manifest the spirit of Jesus Christ who loves unselfishly and unconditionally, we promise with our whole heart and power to carry out the mission of a Catholic Hospital:

1) We promise: to practice the Gospel spirit of "Love God and people", to value and obey Catholic medical ethics, provide holistic care for the patient's physical, emotional, and psychological healing.

2) We promise: to care for the health needs of our society, to fulfill the duties of a teaching hospital, in cooperation with government health care policies, to improve the health care quality of all, to provide medical service with diligence and excellence.

3) We promise: to love our co-workers, to use well our resources, to treasure our blessings, and to develop each person's God-given talents.

Characteristics of Catholic Care in Practice

We advocate "care in the 4-holistic principles" i.e.

1. Care for the whole person, his physical, emotional, and spiritual needs.

2. Care for the whole journey of life, from pre-natal care to terminal care, and the whole journey of his illness.

3. Care for the whole family, as family members are also involved unavoidably in everyone's life and illness.

4. Care with the whole team of our many available professionals in the health care institutions.

We advocate these 4 principles of holistic care first for our patients, then we extend it to the care of our co-workers, and last but not least, to the care of ourselves.

To accomplish the above, aside from consistent advocacy from top management, the Hospital Pastoral Care Team has the key role. Over the years, our effort in promoting a strong pastoral care team has shown efficacy in their 3-fold works of

1) pre-evangelization: all our efforts to show God's merciful love by daily patient visits, personal care for our co-workers at their time of special needs such as marriage, childbirth, illness, bereavement, etc. Also numerous group activities and self-enrichment programs for our colleagues.

2) Evangelization: instructions for the sick and dying, inquirers' classes for colleagues, catechism classes for employ-

ees and their family.

3) Pastoral care: strictly speaking, this is for those already baptised but needing continued care and preparation for receiving various sacraments.

Unlike some of my Anierican colleagues, I insist that hospital pastoral care is NOT just for the emotional support of patients!

Identity of a Catholic Leader/Manager

We are proud of the Church's 2000 years of leadership in serving the sick and the suffering, following the mandates of Our Lord Jesus Christ. The charismata of Catholic leaders vary according to the gifts of the Holy Spirit in various situations.

There are eight qualities we consider of paramount importance in a Catholic leader:

1) Personal harmony with ideals of the Church. 2) Clear vision of mission and strong personal commitment. 3) Sensitivity and compassion towards contemporary health care needs. 4) Ability to transmit vision and enthusiasm to others and into action. 5) Competence in management of money, people and material goods, especially in this world of strong business competition where we must be cunning as wolves yet pure as doves. 6) Resourcefulness in stewardship, as we are not owners of the company, but steward of the Lord in his works of Mercy. 7) Collaboration, innovation and team building are indispensable skills for a Catholic leader in today's competitive world. 8) Finally, we must be possessed by the spirituality of Jesus Christ, through prayer and inner communion with Him.

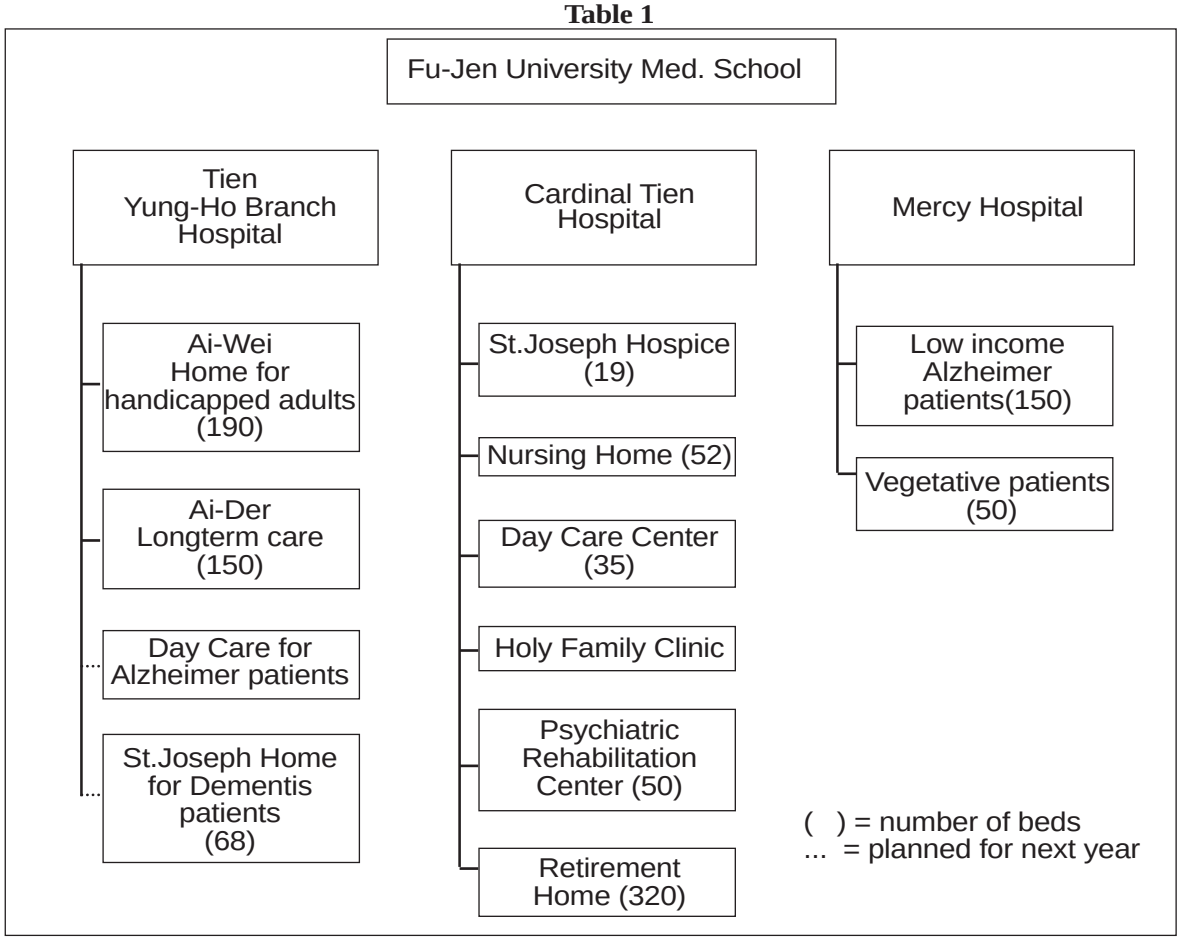
What is His spirituality? Here are some examples:

1) Integrity: actions match words and thoughts, to proclaim his love and mercy in truth and in deeds. 2) Compassion: for all the suffering and sick, whether in physical, mental, or spiritual arenas, we do our best to help, without blaming restrictive conditions. 3) Spontaneity: in offering help, in innovative and creative services, in pathfinding for the future. 4) Ability to awaken life and creativity in others, like Jesus did. 5) The ability to turn apparent failures into growth experiences for all concerned, so as to overcome the obstacle of fear, but cultivate habitual self-examination and insightful learning. 6) Strong concern for justice in our social circles and society at large.

In summary, the significant Catholic leader must be a *missionary* with vision and a *visionary* with a mission. We may not be supermen in ourselves, but we must be superbly united with the Lord, diligently and ambitiously, be good instruments in his work of love and mercy. The Lord is our shepherd and model, we must follow and walk with him confidently, because he promised to be with us daily, till the end of times.

Sr MARY ANN LOU M.D.
Sister of Society Devoted to the Sacred Heart Fellow, American College of Surgeons
Director of Cardinal Tien Hospital, Taipei, Taiwan

Table 1



IV: Catholic Health within the Australian Health System

Context

The Australian Health system relies on a mixed system of public (government owned) and private (non-profit and investor owned) service providers. This extends from primary care services through acute care to extended/long term care and involves community/home based services.

The health system is primarily financed through taxation, private health insurance, compensable insurance and consumer fees.

Australian's universal tax-funded health insurance scheme is known as Medicare. It covers all citizens. It finances free access to public hospitals, general practitioner services, subsidises pharmaceuticals and in-patient acute medical services. Individuals purchase private health insurance to access private hospitals, have personal choice over the selection of medical specialists and to obtain coverage for fees for some allied services, such as dental and optometry.

In addition, residential aged care services and an extensive home and community care system are funded through the taxation system, with some contributions from consumers.

Even with this significant budget allocation to the health system, Australia can still contain the grown of health costs to 8,6 percent of GDP.

The Catholic Church's Contribution

The Church is the largest single provider grouping of non-government owned health services in Australia. It's services straddle both public and private sectors, primary, acute and extended/community care settings. Apart from direct services, it conducts world ranking research institutes and bioethic centres.

Catholic Health Australia, formerly the Australian Catholic Health Care Association, represents the following services:

– 116 owners of Catholic health, aged and health related community care services;

– 500 aged care services;

– 400 approved residential services;

– 16,000 residential aged care beds;

– 3,700 retirement and independent living units;

– 8,500 beds in 60 hospitals;

– 22 public hospitals;

– 38 private hospitals;

– 7 teaching hospitals;

– expanding home and community care services.

Health

– approximately 8,500 beds in 60 hospitals;

– 22 public hospitals, including 7 teaching hospitals (of approximately 650 public hospitals in Australia);

– 38 private hospitals (equates to approximately 12 percent of 319 private acute and psychiatric hospitals in Australia);

– a number of these are public and private collocated facilities;

– approximately 3,100 public beds – this represents only about five percent of total Australian public hospital beds. Many of these are the larger teaching hospitals and so they comprise about nine percent of Australian teaching hospital beds;

– approximately 5,400 private hospital beds representing about 23 percent of Australian private hospital beds. Again the concentration is in the larger size hospitals covering around 42 percent of the 200 + bed private hospitals and 35 percent of the 100-200 bed private hospitals.

In the private sector, religious, charitable and community hospitals account for 50,2 percent of separations, and 50,6 percent of patient days in 1996-97. The Catholic sector comprises half of the not for profit sector (38 of 75 hospitals). The for profit sector provides 49,8 percent of separations and 49,4 percent of patient days. Occupancy rates average 73,8 percent in the religious and charitable private sector compared to 67,4 percent in the for profit sector.

Increasingly the sector is developing pathology and radiology services. It is also involved in the provision of health care services in correctional units and prisons. The major teaching hospitals have close affiliations with medical research institutes as well as ethics centres.

Aged Care

There are approximately 500 Catholic aged care services, comprising almost 400

approved residential services providing a total of 16,000 beds. This includes 5,665 nursing home beds and 10,275 hostel beds. This represents approximately 15 percent of the national total number of aged care beds. There are also 3,645 units provided within the sector making a total of 19,585 beds. Services comprise nursing homes, hostels, home and community care services, community and aged care packages, independent living and retirement units.

Community Care

The community care sector is undergoing significant growth in response to the increase in early discharge and resultant increase in the provision of care in the home. Many health and aged care services coordinate care with the community sector. Some of the services include:

– residential and community based disability services;
– family and early parenting services;
– the range of home and community care services;
– palliative care services; and
– extensive mental health services (residential, supported accomodation, consulting rooms, employment assistance, for example, St John of God Brothers are the largest mental health provider in NSW.

Employment

The Catholic health and aged care sector employs approximately 20,000 people.

Catholic Health Values

The values which underpin the identity of Catholic health ministry and inform the public advocacy of the Catholic health system are:

– Respect for the dignity of each person;
– Community;
– Enrichment of Life;
– Diversity;
– Equity;
– Courage;
– Service to the poor.

Major Challenges for Catholic Health

From a solid values based foundation, Catholic health providers must negotiate a series of major challenge, both internal and external, which will determine the future shape of the health ministry.

Declining Presence of Religious Personnel

The major religious nursing institutes have conducted health services on behalf of the Church. They have established health systems of high acclaim and heavy capital investment.

Generally speaking the religious institutes are in the last decade of active participation of personnel at the governance level of the health system.

This raises a series of strategic questions:

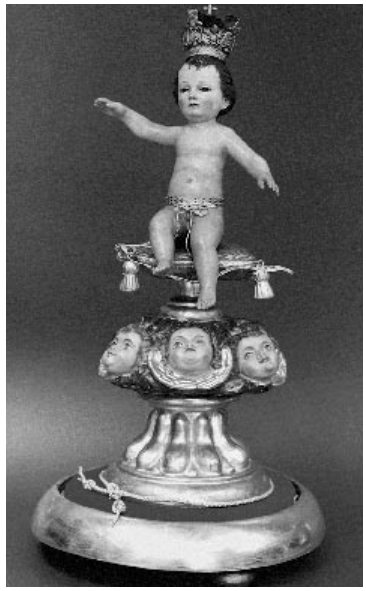
a) What governance structures will be established to ensure the preservation of the Church's ministry in health care?

b) How will Catholic identity and leadership be formed in the emerging lay leaders?

c) What roles will the bishops embrace in the future governance of the system?

d) How will public confidence and expectations be maintained in a system devoid of the presence of consecrated religious?

To date, these challenges are being addressed through the creation of public juridic persons, the consolidation of health systems, the establishment of lay leadership formation courses, encouragement of lay executives and boards of management and the public participation of the Australian bishops in the evolving structures and contributions of Catholic health.



Increasing Competitive and Aggressive Investor Owned Providers

Investor owned companies now duplicate the basic services conducted by Catholic hospitals, in public and private sectors. This challenges the distinctive identity of Catholic health services.

In the public sector, investor owned companies will conduct terminations and sterilisations. In the private sector, health insurance companies increasingly baulk at funding cross-subsidised services.

The case for non-profit health care faces significant hurdles. Also, since only 24 percent of Australians identify as Catholic, of which only a quarter would regularly practice, the identity and daily relevance of the Church to the lives of Australians is also under challenge.

Outsourcing of Government Services

Many Australian provincial governments are seeking to divest themselves of owning hospitals. Instead they seek to fund hospitals to provide public services.

Although there are presently 22 Catholic hospitals which deliver public services, these days the insistence of governments on hospitals to deliver "a full range of services" (by implication, termination and sterilisation services) is marginalising Catholic provider groups.

Consequently, ethical issues

surrounding the principles of co-operation are increasingly guiding Catholic providers in establishing effective working relationships with other providers and payers.

Integration of the Medical Profession

The Catholic health system evolved through a strong partnership with the medical profession. There continue to be very substantial loyalties between local hospitals and medical specialists.

These days, however, there are less substantial organisations of Catholic medical professionals, as compared to years past. The identification of the Catholic medical profession is far more fragmented and in many instances not functioning in any public sense.

The necessary structural changes that Catholic health organisations have embraced has required serious attempts to integrate the medical profession to ensure the effectiveness of the reforms.

"Welfare Reform"

As with other Western democratic economies, Australia's Commonwealth Government is seeking to reduce the growth in health, welfare and social security payments. This process has been labelled as "welfare reform".

With an ageing population and a heavy reliance on taxation-funded entitlement schemes, the health care system (inclusive of residential and home based aged care) is a major target for reform strategies.

In particular, the broad policy setting is to encourage individual responsibility for health care. Self reliance, user charges and more risk rated insurance/savings schemes are being embraced.

Catholic health's commitment to the common good and its resolve to promote distributive justice sees it regularly involved in public debate and advocacy surrounding these public policy issues.

Taxation Status of Catholic Health Services

With the increasing presence of investor owned health and aged care organisations, the not for profit tax exempt status of Catholic health organisations is under threat.

Recent tax reform in Australia has meant that certain services now deemed as being "commercial", even though conducted by Church and charitable groups, will be taxed through the imposition of a consumption tax.

This sets a precedent for further instrusions on the tax status of Catholic health organisations.

Evolution of Catholic Health Services

The management of Catholic health facilities has evolved models with the following characteristics:

– High levels of professional competence.

– Integrated systems to achieve critical economic power and purchasing capacities in the market.

– Economies of scale to deliver cost effectiveness.

– Restructured middle management to reduce duplication and achieve competitive labour overheads.

– Leadership formation courses.

– National and regional coordination of services to eliminate service isolation and to support facilities

Reassessment of facility – based as opposed to system – based incorporation.

– Movement, towards the accreditation of Catholic facilities by CHA

– Identification of joint endeavours with ecumenical and other like-minded organisations.

– Examination of future Church governance structures to ensure continuation of the ministry.

– Adoptions of lay trustees in the exercise of reserve powers of religious institutes.

FRANCIS SULLIVAN
Executive Director Catholic Health Australia

V: The Principles upon which the Action of the Catholic Church should be based in the Field of Health and Health Care in Developing Countries

Introduction

It is difficult to define what should be done at certain moments in African countries in order to be truly effective in the field of community health. The needs are very great in number and the circumstances are very different in the various countries and so it is not possible to examine in detail all the factors and elements which bear on health (density of population, access to supplies of drinking water and sewerage systems, infant and adult mortality rates, birth rates, malnutrition, fertility rates, rates of maternal deaths at childbirth, levels of access to health care centres, policies regarding the distribution of medicines etc.).

For this reason, the objective of this paper is to examine the tasks which we believe to be the most useful in practical terms in order to achieve the provision of concrete help by institutions belonging to the Catholic Church or which are financed by the Catholic Church.

First Part: Reference to the Orientations of Ministers of Health in Europe

Although the conditions which obtain in African countries are very different from those to be found in their European counterparts, reference to these latter serves to demonstrate that thoughout the world a debate is going on about the need to rationalise health care and make it more effective. Because of the process of globalisation, health care has become a mass phenomenon and despite the very high levels of technology which are now available health care has lost a large part of its real effectiveness.

The European ministers of health held a meeting a few years ago in Lubiana, the capital of Slovenia, to decide upon shared principles in order to achieve greater effectiveness with regard to the reforms introduced into the health care systems of their respective countries. This was because in such countries health care had become very largely a matter of government provision and organisation. Without going into detail, and without dwelling upon the motivations which led to the drawing up of these principles, I will draw attention to some of those principles on which these countries thought that they should base their policies. Because the goal of our meeting seems to be the same, it seems to me that an enumeration of such principles will be of help in a subsequent definition of principles which can also be useful *"mutatis mutandis"* for Africa.

The Fundamental Principles

In the European context the health-care systems must be based upon the followng principles:

1. A "motor" element: the *fundamental values.* These values are as follows:
   – human dignity;
   – fairness;
   – solidarity;
   – professional ethics.
2. An objective: *health. The protection and the promotion of health must be the objective of every reform of the health-care system.*
3. An essential protagonist: *the individual. If real effectiveness is to be achieved every reform which is effected must respect the needs of the individual and his or her opinion as well.*
4. A pole of covergence: *quality and its constant improvement must be at the basis of every reform, and must include the cost/benefit relationship.*
5. A method of financing: *which is long-lasting. Governments must ensure that the whole of the population has access to health services in a permanent way.*
6. A fundamental element: *primary care and treatment. Those who implement reform must guarantee the protection of, and improvement in, health; the quality of life; prevention, treatment and rehabilitation with regard to illness; and care for the terminally ill.*

In order to achieve these objectives it is believed that the implementation of health-care reform must follow certain *principles of the implementation of health-care reform, and more specifically:*

1. The development of health-care policies. Such policies must form an integral part of the general policies of the country and their development must obtain a very broad consensus involving the largest possible number of the relevant social groups and interests. These policies must be transparent for the public which has to use them.

2. The paying of attention to the opinion of, and the selection of, responsible citizens. The views of the citizens must be listened to when the various services and programmes are conceived, in the management of waiting lists, in the organisation and opening hours of dispensaries, and so forth. Information and health-care education should be provided to achieve this end.

3. The restructuring of the health-care services. The services should be restructured beginning with the shouldering of responsibilities for health by the family, a reduction in the incidence of hospitalisation,

and an increase in home-based and clinic services.

4. The redistribution of human resources dedicated to health and health care. The preparation of staff and structures for this new philosophy of the prevention of illness and the promotion of health. To achieve this end, suitable incentives in which everyone takes part should be brought into being.

5. The improvement of management. Health-care institutions and structures must enjoy the highest levels of responsible and creative autonomy. In order to achieve this the heads of every department should be suitably trained so that they can follow and correct the workings of that department. Obviously enough, there must be a process to ensure correction and improvement where this is necessary.

6. Learning from experience. The exchange of data and of information at a national and international level will lead to the experience of individuals being placed at the service of everyone. To achieve this end, every reform carried out in a country of the European Union must be communicated to the others and information about it must be made available through periodic meetings and encounters.

Second Part:
Orientations for the Ecclesial Institutions in Africa

Following these orientations of the ministers of health of European countries, we in turn believe that it would be profitable for those who work in institutions of the Catholic Church or in government-run institutions in this field to have access to representatives of the Catholic Church whose work is dedicated to helping developing countries or to the humanisation of aid.

It is difficult to speak about the hospitals of the Church in Africa in a general way and provide guidelines for the creation of a model which can be of use to everyone. This is because the socio-political situations and levels of development are very different.

It is an evident fact that these countries, with the exception of those of the Magreb, are on the lower rungs of the ladder of development in all the statistics and graphs of the United Nations and of the UN programme for human development. Furthermore, the differences which exist are large in number and different parameters could be given priority in each individual country.

The reasons behind the existence of aid in the countries of the third world are also very varied. Sometimes it has been the Church which, animated by a missionary spirit and given the fact that concern for the sick person has always been one of her primary fields of apostolic action, has lain behind works and initiatives of aid in these countries, and this in order to perform activity that governments – which were poor or reduced to poverty by the development of the world economy – could not finance themselves.

For this reason, there are very different levels of contribution to be found in the health-care statistics of the state and private sectors. At the beginning, and before these countries achieved independence, the role played by private initiative – and especially that of a religious character – was very significant. After independence, each country decided to face up to its social responsibilities and thus developed public health-care institutions, thereby diminishing in proportionate fashion the role played by corresponding religious and secular institutions.

In countries under a totalitarian regime the institutions in the hands of the Catholic Church and those runs by lay professional associations were nationalised and came under the control of the relevant governments. In countries where a democratic regime was established such institutions continued to exist and contined to support the state system in a spirit of partnership and collaboration.

Now that public health is something to which all citizens can have access, it would not be seen as fitting, and in many cases would not even be allowed, for the Church to establish health-care and welfare institutions with the goal of fulfilling an apostolate without obtaining the authorisation or seeking the advice or the opinion of that country's ministry of health. Indeed, the creation of such initiatives without suitable planning and co-ordination would certainly be unfruitful and anti-economic. This would set a bad example in the case of countries which have to draw the maximum advantage from their financial resources.

For this reason, given that we have here groups with great experience in this field (hospital congregations, medicial associations, and non-governmental organisations), the Catholic Church must study the development of medicine and health care in a specific country and co-operate with its ministry of health in order to carry out initiatives, or participate, in those fields which are most in difficulty or which are of greatest potential benefit for a population which has few resources. Once these fields of greatest utility have been identified, this institution should adapt itself to the needs that are present and even put a stop to those forms of traditional treatment and care which in today's circumstances are not suitable to the real needs of a country.

1. For this reason the first principle of each and every Catholic institution which dedicates itself to working in the field of health and health care in Africa is that of collaborating with the government of that country in order to contribute to primary care (dispensaries, health-care centres, mother-child care and assistance, etc.).

It should be borne in mind that this care is the form of care which is most effective and this should be carried out in conjunction with preventive medicine (vaccination campaigns, etc.) which should reach the whole of the population and thus be free to all if this is possible. We should remember the slogan of Alma-Ata: "Health for all in

the year 2000". Helping poor countries to reach this objective will always be a very great contribution.

2. Given that in many African countries, both because of the prevailing situations of poverty and because of low salaries and a general lack of control, there is a dishonesty in the use of resources in the field of medical care and treatment, it would be advantageous to demonstrate an effective and efficient way of using such resources. To this end, Church institutions in this field should set a good example and demonstrate how, even with few means available, it is possible, if such resources are well used, to administer a clinic or a dispensary, and even a hospital. For this reason the second principle could be as follows: the creation of systems of management and of management control at an economic and financial level in health-care centres so that they could be an example to be followed in their country of location.

This practice, which already exists in many places, provides a stimulus to governments and provides a model for the management of official health-care centres run by the state. In this way a contribution is made to a good employment of resources and means when they are short on the ground in the health and health-care field. The offering of external forms of help without a rigorous control of their use means that the plans which have been drawn up are not carried out and furthermore that such aid is gradually withdrawn.

I believe that the help which Catholic organisations can offer in this field is more effective than the scientific or technical elements of the various institutions which, if they are not accompanied by efficient management and a rigorous control of costs, can turn out to be more of a scandal than an example of real effective help.

3. Thirdly, I believe that ecclesial institutions in the health-care field, both those which provide care and those engaged in prevention, must lay emphasis on the training of their personnel. In this way what were once authoritarian norms imported from outside by people who managed an institution can become norms assimilated through example and accepted by the native personnel. This is a good way by which to multiply the effects of an institution created in a Christian spirit. For this reason the third principle is: the health-care institutions of the Church should be especially concerned with the training of the local personnel in techniques of management, management control and participation in management.

In this way the personnel can take part in management and the work of the institution will be more forceful and supported by all those who work in it. This is something which does not take part in state institutions which are neglected by people and in which people feel they do not participate.

4. Fourthly, the ecclesial institutions should encourage the whole of the community to be interested in health and health care. Today it is said that the community must contribute to the management of its own health and not feel that it is dependent upon those who are technically trained. Health and health care have many aspects connected to lifestyle, diet, environment etc., and these are elements which can be managed by the community itself. In this field the Church should act as a stimulus so that, to the extent that this is possible, parishes, dioceses etc. will take part in campaigns in favour of health and health care and also encourage their faithful to look after their own health.

This undertaking could be formulated in the following way: Church institutions should promote an awareness on the part of the community with regard to the management and maintenance of its own health. This should be done through information and health-care education which give priority to the use of such natural resources as personal hygiene and environment, a balanced diet, the suitable use of water, and so forth.

In many countries there are diocesan committees dedicated to the health-care ministry whose purpose is to be concerned with, and to spread, these principles, in addition to being concerned with the sick and the humanisation of their medical care and treatment.

If were were to go even deeper into this subject we could dwell in detail upon the very real problems and difficulties which Africa now has to deal with in the field of medicine: endemic diseases which are decimating populations: maleria, cholera, meningitis and above all AIDS. But this would be to go beyond the concerns of this round table discussion. The Pontifical Council for Pastoral Assistance to Health Care Workers has already carried out monographic studies on this subject whose conclusions are still valid today. This brief paper of mine has sought to draw attention to, and reflect upon, the general needs of developing countries as a prior step to deciding upon the most effective form of help which could be given.

The exchange of views which we can engage in during this meeting will help to improve the prospects which await us and help all of us who work in these countries to offer a more effective form of collaboration in all fields.

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Mozambique

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VI: The Identity of the Catholic Administrator: Models Based on Christian Values to Achieve Organisation and Management Characterised by Integrity

"A hospital is an integral part of medical and social organisation whose mission is to provide the population with complete curative and preventive medical care and health care, and whose services extend to the family context. A hospital is also a centre for the training of health-care personnel and for the carrying out of research" (WHO).

A Catholic hospital expresses its own identity, as a family of faith, by providing medical care and health care, by rendering the compassion of God present, by following the example of Christ and acting through the mediation of Christ, and by conserving its spirituality and its ethics at every moment in its capacity as an institutional decision of faith.

For this activity Christ is the fundamental model – a model which has been followed and lived out in various ways during the history of the Church and which is unique as a way of perceiving and living life. Christ makes identity possible and devotes especial concern to the poor.

The adjective "Catholic" means that "in it Christ is present" "because it is sent on a mission by Christ to the whole of mankind" which "receives in full and total form the means of salvation" (cf C.C.C. nn. 830 and 831) and a whole way of being and proceeding.

Given that health-care administration is not an exact science, methodologies exist by which to learn it and to practice it. In many of our nations a professional certificate is required in order to engage in administration in the health-care world. In Brazil the exercise of this profession without being registered as qualified is illegal and punishable by the courts.

A Catholic hospital administrator is a person who is loyal to the fundamental criteria of excellence in hospital administration and is also loyal to Christ, the living norm.

There are different traditions in the ethos of Christ which interpret that ethos beginning with the supreme importance of love. But what really matters is the person of Christ as a whole and his destiny.

Models of Relationships of Care

– *Parental or paternal*, according to which the good hospital or the good health-care worker is the person who behaves like a caring father, who wants the best for his child but always in a way which reflects his own judgement. A good sick person is the individual who behaves like a pious son and submits to the orders of the father.

– *Horizontal or a relationship between equals.* Here three pre-requisites are required: that the participants have more or less the same power; that they need each other (interdependence); and that they are involved in an activity which satisfies the interests of both parties. In this instance the therapeutic team and the patient take part in a relationship based upon comradeship.

– *Technical*. When emphasis is placed upon the technical-scientific aspects and the component part of friendship or comradeship are put to one side, the body is seen as a machine and the therapeutic team is conceived as the engineers and the technicians of a laboratory. In this case the relationship is distant and cold, something which exists between strangers, and people enter it with fear and a lack of trust. In this model what really matters is the rules, the procedures and the formalities which have their own utility when it is necessary to protect the rights of the patient in the large hospitals or in research programmes.

– *The "contract" model.* This model is influential within a context where the hospital provides the patient with goods and services and this latter in exchange has to pay the hospital (personally or through the welfare system) and respect the norms of the hospital. Going beyond the contract model, the relationship of care is seen as a negotiation where the patient expresses his or her needs and options and where the hospital, the medical doctor and the health care worker in general expresses theirs until an agreement is reached. This approach reminds us that hospital health care is not limited to a specific instance or moment but is a process which needs time, sincerity, trust and so forth.

Models of Hospital Administration

a) Religious. In the remotest history of medicine and hospitals recourse to those methods which were most advanced for the time, and to people, structures, learning and economics – without forgetting magicians and religious figures – was what was sought after in order to achieve people's health, and this because "*medere infirmos opus divinum est"*.

In the religious tradition of mankind there are different approaches within hospital care for the sick. One need only bring to mind the hospital traditions of ancient India, Egypt, Greece, Rome, Arabia etc.

The cornerstone of our hospital tradition is Judeo-Christian in character. The concern, welcome and service which Abraham demonstrated towards the stranger influenced hospitality within Christianity. In the Book of Numbers reference is made to cities which were refuges for the Israelites and for the emigrants and guests which lived amongst them (Numbers 35:15).

We all know the attitude and actions of our Lord Jesus Christ towards the sick (Mt 9:35; Lk 4:40). In the mission which Je-

sus entrusted to his apostles, care for the sick was an imperative (Mt 10:1;7-8). The four evangelists describe many acts of healing carried out by the apostles (Lk 4:40).

"When you did it to one of the least of my brethren here, you did it to me" (Mt 25:31-45), *"Eclesiae Instituta Valetudini Fovendae Toto Orbe Terrarum Index"*. The history of the development, growth, variety and appearance of health-care institutions within the Catholic Church is very long. In a thousand ways popes, emperors, kings, princes, bishops, priests, religious – first in their convents and monasteries and then with the creation of *ad hoc* institutions – religious houses, Christian brotherhoods or groups etc. have all been involved with such institutions.

In many cities in our countries there are hospitals described with the phrase "Spanish charity", but these are losing their religious elements.

Today some welfare institutions rely upon our parishes – hospitals, homes for the elderly, country retreats, emergency first-aid clinics, hotels, dining halls etc.

Social. The right to protection, recovery and rehabilitation in order to live in health was first of all acquired by the world of workers, then followed by the rest of the citizenry, and has been gradually accepted by the world's States.

The slogan "health for all in the year 2000" was based on a universal vision and was parallel by a challenge for the world's nations which then became a goal of the World Health Organisation.

In Colombia, law 100 which was passed in 1993 and entitled "System of Overall Social Security" made advances possible and has meant that all citizens have access to the protection of their health.

b) Public or official health care. Different countries have drawn up or accepted different models for health care and have created a Ministry or Department of Health through the enactment of practical legislation and norms. Countries feel that they should be concerned about the right to health of their citizens. These are rights which are in a state of constant growth, which go beyond the most optimistic forecasts, and which have forced official health-care structures and budgets to enter into a state of crisis.

c) Rural health care. This is present in many countries because of the agrarian character of their populations. Those people who wish to belong to the health-care professions are selected by the drawing of lots to provide one year's service in this sector once they have finished their studies.

d) Military health care. This takes place on land, at sea and in the air, and usually is higher in quality than the health care provided to the other citizens of a nation.

e) Health care as a business. Profit-making enterprises involved in the administration or production of health-care services and institutions which provide health-care services, some of which are international, are now spinging up. The reasons for this are manifold: the frequent low quality of services provided by the state, the liberalisation of such services by governments, the ethics of pluralism, the right to belong to associations, and so forth.

Monotheistic religions create hospitals beginning with forms of spirituality and ethics which have many points in common. It would be sterile to emphasise the differences in the ministry of providing hospitals. The variety of the hospital institutions of these religions enriches and characterises them and gives emphasis to the elements which make up their identity.

The Christian models of hospital services are those which have essential Christian values. Such hospitals become such when the local Churches approve their establishment, their spirituality and their norms.

Our Models

Without forgetting about their charisms, our models are the fruit of our founders' decisions to follow a specific feature of the compassion of Christ and to provide an answer to a social need which was seen with a special sensitivity and met with a desire to provide solutions.

The Latin American Catholic hospitals have their origins in the hospital model of the peoples engaged in discovery, conquest and colonisation. Their points of reference were the land and sea armies of these peoples and their original countries. They had the same characteristics at a functional level, to which should be added the specific features of being places of evangelisation of a group or an ethnic group. In the broad geography of Latin America there have existed the "convent hospital", "missionary hospital", and "teaching hospital", all of whose members laid stress on a specific aspect by expressing evangelisation through the establishment of health-care structures rooted in Christian compassion which were designed to take care of poor people given that rich people had themselves treated in their own homes.

Because violence and the culture of death have spread within our populations like an infectious disease, evangelisation must take responsibility for the health care provided to our weak and suffering peoples.

The Rights of the Sick

In addition to religious faith, the hospital must guarantee "minimal ethics" upheld and respected by all those who belong to the therapeutic team. Such ethics are expressed in the definitions of the rights of the sick.

The sick person always has his or her dignity and never ceases to be the bearer of fundamental values which give a meaning to his or her existence. He or she continues to possess inalienable rights, many of which become of priority importance because of the condition of being ill.

During the periodic assessments of the organisation and performance of the hospital, attention should be paid, in what is assessed, to the defence and promotion of the rights of the patients because these are the protagonists and the heart of the hospital.

The hospital administrator should define the rights of the sick person with reference to the following three main activities:

– informing, instructing and educating the personnel and pa-

tients of the hospitals as to the rights of the sick person;

– creating policies and procedures which are in harmony with these rights in the fields of the admission, treatment and discharge of patients;

– channelling the complaints of patients who feel that their rights have been violated and then applying suitable corrective measures.

Ethical committees play a fundamental role in ensuring the reality of the rights of sick people and in the ethical training of the staff and personnel who work and operate in health-care institutions.

The world of hospitals needs the clear direction of ethics, faced as it is with the complexity of the questions which present themselves. Today we cannot escape ethical considerations in the administration of a hospital. The power of technology, the at times uncontrolled advances of science, and the possibilities that exist to engage in manipulation at all levels (whether social, psychological, biological, genetic etc.), all require a process of self-up-dating by the Catholic administrator.

The management of health includes health-care organisation, financing and policy. From all of these points of view, ethics play an irreplaceable directive role.

Looking after health has become transformed into a highly technical service which allows us not only to treat a healthy body but also to greatly improve it (cosmetic surgery) or even to manipulate its creation. All of this directs us towards the question of how values are perceived by every person and by every culture.

The Relationship of Assistance

This word comes from the Latin *"adsistere"* which means to be next to. It means to accompany another person, to help him or her to be himself or herself during the search for personal fulfilment.

A relationship of assistance has a dual dimension – the interpersonal element and the social element. The interpersonal element leads us to the dimension of love, to human accompanying. The social element leads us to respect for rights and requires effectiveness in diagnosis and treatment.

When we consider the sick person as a person we are led to practice a series of values towards that individual, which are as follows:

Hospitality: frank and cordial welcoming, the creation of a loving environment of trust.

Good will: which strives for the doing of good to the whole person of the patient. "Do all good possible and avoid causing harm".

Respect: this requires attention being paid to, and an assessment of, the circumstances of the sick person and his or her scale of values. This requires visual contact and physical proximity.

Solidarity: halting before the suffering of the other person, making his or her problems our problems, accompanying the patient during his or her journey, and walking together.

Within the organisation of the hospital all this should be reflected upon. The administration is responsible for ensuring an environment which is favourable to all this and which renders the personnel and staff aware of the need to practise such elements, in addition to educating them to this end.

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Representative of CELAM, Bogotà, Colombia.

VII: A Proposed Organizational Model With Christian Values Aimed at Supporting the Catholic Healthcare Manager in Today's Challenging Times

Introduction

Beginning in 1965-1966 with the passage of the Medicare and Medicaid legislation,[1] healthcare in the United States began its transition from that of a benevolent, charitable service to its current state – that of a "big business". Healthcare today in the United States has become a very attractive business for-profit companies and conglomerate entrepreneurs. Federal and state monies flowed freely through these two governmental programs for many years, and opportunities for large financial profits soon attracted healthcare providers and investor owned companies competing with the traditional non-profit and philanthropic groups. Pursuit of financial margin replaced the call of mission.

Healthcare today in the United States is a highly competitive business and many of the Catholic hospitals are facing serious jeopardy. The challenges faced by the Catholic healthcare managers are most difficult indeed, and include not only financial competition from for-profit companies, but from government agencies as well which are placing greater restrictions on hospitals, and a society in general which respects less and less, the principles of social justice, charitable concern for the poor and vulnerable, and the sacredness of life. Failure to overcome these challenges may actually result in the closure of many of our hospitals and the loss of our Catholic healthcare ministry's identity as our Church has known it to be for almost 2000 years.

The Catholic health care network of the Archdiocese of New York

Recognizing these crucial challenges and maintaining a steadfast commitment to protect and preserve the Catholicity of our healthcare institutions and agencies, John Cardinal O'Connor took forceful steps soon after arriving at the Archdiocese of New York. He guided the leaders and managers of Catholic healthcare within the Archdiocese of New York in the formation of what is called the Catholic Health Care Network or CHCN.

CHCN is a healthcare network which is sponsored by the Archdiocese and which was established to provide each of the Catholic healthcare institutions and agencies within the Archdiocese of New York (as well as other dioceses) with support and coordination in the following areas:

– Mission activities, including mission development, leadership education, ethical and moral issues and pastoral care.

– Strategic planning and marketing, including physician services, managed care, shard services, affiliations and medical education.

– Communications, both internal (including inter-facility) and external of CHCN.

– Finances, including monitoring of financial conditions, budget development, capital expenditure and financial arrangements.

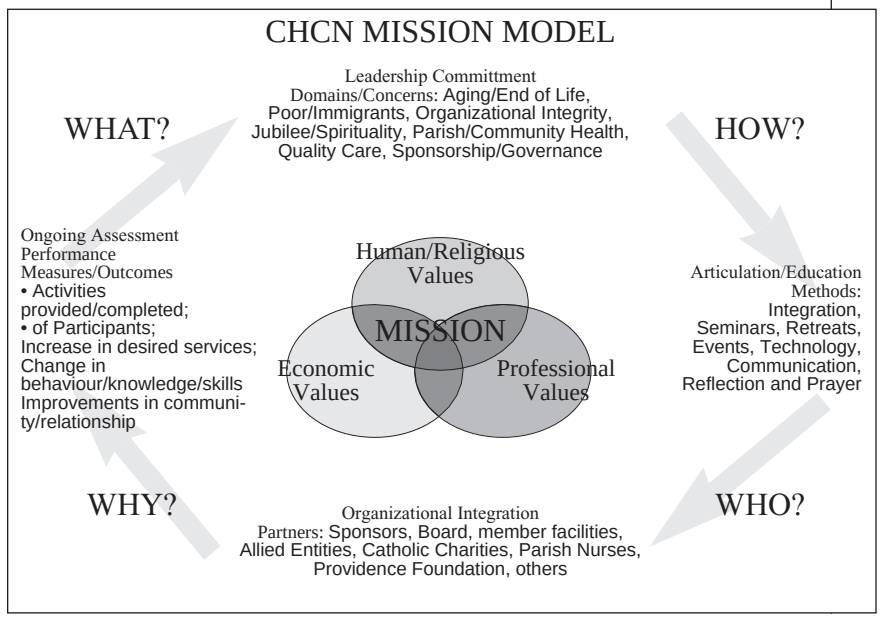
– Management information systems, the combination of systems and services and external information exchanges.

– Human resources including the coordination of employee benefits administration, employee relations and personnel policies and procedures.

– Continuous quality improvement including risk management activities and maintaining and coordinating quality improvement activities in the institutions.

and

– Legal services which pertain to coordinated or collaborative activities.[2]



CHCN
A mission model network

CHCN is a "mission model" network, a model adapted from some of the foundational work done by the Catholic Health Association of the United States, and each year CHCN establishes as its principle organizational goal the enhancement of leadership development and mission effectiveness in each of its institutional members.

The CHCN Mission Model recognizes the important and evolving role that leaders and managers of Catholic healthcare in the Archdiocese of New York play in strengthening the identity and mission of Catholic healthcare and in carrying this ministry into the 21st Century. The CHCN Mission Model recognizes that its healthcare managers need to articulate and witness to our values, morals and principles inherent in our Church's healthcare mission.

Our managers need structured support and guidance if they are going to be able to give witness to these truths, in the face of the many internal and external challenges which pressure them on a daily basis. CHCN's leadership is responsible for identifying and assessing how organizational structures (such as programs, policies and procedures) enhance or diminish the Mission and Ministry of Catholic healthcare.

The Mission Model of CHCN demonstrates that people (and organizations) act and make decisions based on values (human/religious, professional, economic). To live and incorporate Catholic identity and mission and to carry the Catholic healing ministry into the future requires that each person and organization 1) identify the values out of which they act and make decisions; and 2) evaluate how their decisions and actions support or are in conflict with the principles and teachings of the Catholic Church.

This model highlights the importance of leaders and managers in Catholic healthcare, who, as role models, mentors and decision makers, have tremendous influence on their employees as well as their organization's culture, policies and practices. Ultimately the decisions made by our leadership and managers transcend the organizations and are manifested in how we care for those for whom we have been called as servants.

From its inception the Catholic Health Care Network demonstrated its commitment to leadership formation by establishing the Office of Mission Leadership and organizing itself to have at the level of the Board of Trustees a Mission Committee, as well as a Mission Leadership Task Force to support all our program and educational efforts. One of the first efforts of this Task Force was the development of a CHCN Mission Leadership Plan. After significant study and discernment, this Plan was completed and adopted by the Board of CHCN and is now in place, providing a high level of support and continued affirmation to our leaderes and managers.

As part of the effort to develop this Plan, the Task Force first had to develop a series of guiding principles and/or documents which all of the member institutions and agencies within the Network embraced. Additionally, existing source documents developed by other groups were utilized. The major principles/documents utilized in the Mission Leadership Plan formation included the following:

– *CHCN Mission Statement* – adopted by all CHCN institutions and agencies and shared with all employees throughout the entire network.

– *Ethical and Religious Directives of the Catholic Bishops of the United States.*

– *CHCN Mission Due Diligence Protocol* – used to insure the adherence to our principles within each of our institutions and agencies.

– *CHCN Guiding Principles for the Mission Function Within a CHCN Institution.*

– *CHCN Principles for Accountable Managed Care Contracting.*

– *CHCN Ethical Guidelines for Contract Negotiations.*

– *CHCN Methodology for a Values-Based Conflict Resolution.*

– *CHCN Public Policy Statements.*

1. Preferential Option for the Poor and Vulnerable.
2. Quality of Care at the End of Life.
3. Welfare Reform Act and its Effects on Legal Immigrants and Nursing Homes Within the Archdiocese of New York.
4. Healthcare Coverage for the Uninsured/Under-insured and Children.

The CHCN Mission Leadership Plan, a plan formally adopted by the Board of Trustees of CHCN and each of the member institutions and agencies within CHCN, includes six strategic mission areas. Through a series of meetings and interviews, these areas were identified by the CHCN leadership in the member institutions and agencies. These are:

– Ethics: Organizational and Clinical

– Sponsonhip and Governance.

– Quality of Care.

– Organizational Culture/Values.

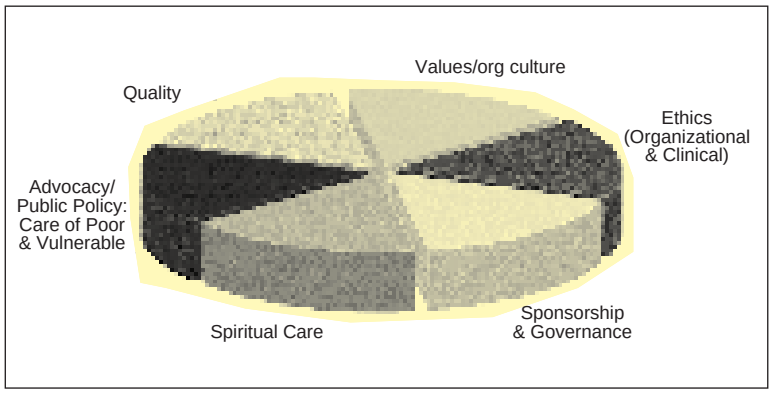
– Spiritual Care.

– Public Policy Advocacy: Concern for the Poor and Vulnerable.

It is the long term strategy of CHCN to eventually develop network-wide initiatives in each of the above strategic areas. Presently, the three areas under development are Organizational and Clinical Ethics, Quality of Care and Organizational Culture/Values. In further studying the area of organizational and clinical ethics, it became apparent that the real need to develop a network strategy around organizational ethics as opposed to clinical ethics. Similarly, as we listened to the needs of our member institutions and agencies in the area of quality of care, it emerged that the particular need became quality of care at end of life. The need for support in this area was rooted in the needs of those involved in spiritual care, public policy advocacy and all other

organizational components of the total healthcare team.

In order to better articulate and to eventually develop network-wide initiatives in these three areas, CHCN engaged and organized the leadership from each of its institutions and agencies through subcommittee work of the Mission Leadership Task Force. These subcommittees are charged with the responsibility to identify agreed upon strategies, standards and assessment criteria in their respective areas. Over time, initiatives in the other strategic areas will be identified and explored.



The CHCN Mission model
A plan in action

By way of illustration, in the area of Organizational and Clinical Ethics, the Task Force planned for a two day workshop with national leaders in this area.

The workshop was very well received and was attended by the leaders and managers of our Network institutions and agencies (over 150 attendees), and one of the outcomes of this program was the development of a set of CHCN Organizational Ethical Principles. These principles are now being formally incorporated in the various policies, procedures and practices throughout our Network.

These Principles are as follows:

– Respect for the Sacredness of Life (Human Dignity and Holistic Care).

– Unifying Body, Mind and Spirit.

– Special Concern for the Poor and Vulnerable.

– Promotion of the Common Good.

– Responsible Stewardship to Ensure Excellent Quality Care.

– Commitment to Just and Right Relationships.

– Ensuring Healthcare as a Basic Right and Obligation of a Moral Society.

So overwhelmingly positive was the response of CHCN leadership and management to our efforts in the area of Organizational Ethics, that an Organizational Ethics Resource Workgroup was formed, and this group serves as a clearinghouse for information on organizational ethics. It further assists the CHCN Office of Mission Leadership as they plan educational sessions for CHCN member institutions and agencies and finally it helps in identifying and exploring organizational ethical issues common to multiple CHCN members. In the spring of 1999 an organizational ethics baseline survey was completed for all CHCN institutions and agencies, providing us with an overview of how organizational ethics are understood and practiced within CHCN and how our Network might continue to move forward with education and training in this area.

Perhaps the most significant recent achievement in this area was the development of a two day Leadership Formation Program. Top leaders and managers from each of our member institutions and agencies have committed themselves to participating in this collaborative educational program and it will cover the following topics:

– Catholic Teachings and Principles.

– Organizational Ethical Principles.

– Social Justice Teachings of the Church.

– Leadership Opportunities and Challenges Facing the Catholic Manager of the 21st Century.

This Leadership Formation Program is just one of many concrete examples of how the CHCN Mission Leadership Plan has been vitalized and actualized. Through their participation, our leaders and mangers will receive the support they critically need, as well as have the opportunity to communally share in their spiritual membership of our Church's healing ministry. It is but one way in which a Catholic healthcare network can move towards fulfilling what our Holy Father has called us to: a Gospel of Life and a Gospel of Love.

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President of the "Catholic Health-Care Network"
New York – USA

Note

[1] Medicare, a healthcare entitlement program created in 1965, is a federal program which provides comprehensive health care for all those over the age of 65 or who are permanently disabled. The program is funded and administered by the federal government, and represented the first major intervention of the federal government into health care. Since its inception, the federal government has significantly increased its involvement in and control over healthcare in the United States. Medicaid, the sister program to Medicare, was enacted in 1966 and was designed to provide comprehensive healthcare benefits for the poor, regardless of age. Medicaid is a program which is funded by the federal government and the state governments, and has grown to be a major expenditure for both local and national governments.

[2] Excerpt from the Certificate of Incorporation of the Catholic Health Care Network as authorized by the State of New York, USA, April 6, 1996.

The New Evangelisation for the Third Millennium and Catholic Health-Care Institutions

Premiss: a Question which is not Rhetorical

"I am led to ask: those people who leave our hospitals, our places of care, fortunate because healed by the skill and generosity of medical doctors, by nurses etc., with what feelings to they leave? Glorifying God?". This rather provocative question, which however is not rhetorical in character, was posed by Cardinal Tettamanzi during his paper on "Church and Health" in which he argued that the episode of the healing of the paralysed man (Lk 5:17-26) was a model for therapeutic co-operation and collaboration. In commenting on the "essentially liturgical" conclusion to be drawn from the episode both for the man who was saved and healed *(he went home glorifying God)* and for those who took part in the event *(all of them were amazed and praised God),* Cardinal Tettamanzi posed the question which I have already quoted and added that "to bring about a glorification of the Lord" is not only the high-point of the health-care ministry but also, the Cardinal continued expressing himself in lay terminology, the high-point of medicine.[1] His question is also certainly valid, and in a special way, for those people who manage health-care institutions which root their action in the word of Christ and his example.

At this point it could be too easy, and would run the risk of being somewhat rhetorical, to ask oneself if it is "the glory of God" which, as those responsible for Catholic health-care institutions, we are really concerned with, and to pose the question if this is the criterion to which we really refer in thinking about the choices which we have to make.

1. The Language of Care and Relationships

In his book entitled *"L'irrilevanza e la rilevanza del messaggio cristiano per l'umanità d'oggi"* ("the irrelevance and the relevance of the Christian message for contemporary mankind"), a work which contains his lectures on this subject, Paul Tillich asks himself if the Christian message is "relevant" today, that is to say whether it provides answers to the existential questions posed by contemporary mankind, to its passionate search for a life full of meaning, and to its longing for a "message which is capable of healing". "We must not undervalue this fact", writes this theologian, "because the power to heal forms a part of salvation. *Saved,* literally, means *healed"*.[2]

It is interesting that this theologian perceives in the ability to heal a "proof" that the Christian message is still "relevant" even for the troubled humanity of today's world. Healing is not salvation and salvation cannot be defined by a single concept or by a single image. When Holy Scripture refers to salvation it employs a whole series of images in order to describe this reality from a whole host of different points of view. However, it remains indisputable that in Jesus the *healing* action is a constant of his days and the *healing* encounters mark his teaching and his journeying. He, the salvific Word of the Father, describes himself and makes himself understood through a thousand actions of healing.

The biblical conception of salvation derives its meaning from an experience of liberation "and it is precisely in this liberation that the feeling is experienced that such healing comes from God",[3] and this conception recognises, from within the faith, that it is a gift, a grace, and a call, the human language of God's salvific initiative which reaches us through Jesus Christ, the only Word which revealed in fullness His salvation.

The concept-image of *healing* can be, therefore, and this is especially true today, "relevant" when speaking about *salvation* and the experience of healing (and about health lived out in the richness and varied "harmonising" of its different dimensions along the whole journey of life and the various personal experiences which characterise that journey) as being a "place" to receive the Good News of the love of God, the *already and not yet* of His salvation. Therapeutic and pastoral action, like the spoken and meaningful word in the actions of service and care, becomes "relevant" for contemporary humanity, and thus eternal but always new gospel, if it demonstrates that it is able to "discern" in the request for health the implicit nostalgia for salvation and knows how to be a sign and language of this salvation *of the world beyond* in the answers and responses involving healing.

Healing, in its various accepted meanings of treating, taking care of, helping, accompanying, re-establishing relationships and reconciliation, becomes the declaration and the "presence" of a salvation which continually "speaks" in the human but which always remains "humanly unsayable" and transcendent, and of a Kingdom (space of life and love with God) which, while it expands its horizons, also sees its boundaries grow more distant in its Homeland.

In his book entitled *"Mondo Sanitario Terra del Vangelo"* ("the health-care world: terrain of the Gospel"), Jean-Marie

Tillard writes, among other things, that "far from being a simple segment of the mystery of man, the universe of health comes to include human nature in its most fundamental area, that of life", and that to commit oneself to the health-care world thus means to commit onself to one of the central "places of humanity, a crossroads of human dramas and the fundamental questions which such dramas generate".[4]

For the Christian community, a re-reading of its message in terms of "healing" (and the rediscovery of the *healing* dimension of its preaching and its action in the unfolding of its relationships with the various sick and wounded people which it encounters on its path) can be not only a matter of dutiful obedience to the example and commandment of the Lord, who passed by (and still today passes by) helping and healing, but a "relevant" way on which a new evangelisation should lay special emphasis in order to attune to the deepest aspirations of contemporary humanity, a "new" way of *telling parables* which can be understood more easily. It is intersting that for spirituality as well the most urgent of today's tasks is that of bringing or at least sowing "healing", thereby becoming in today's wounded world a "therapeutic proposal", a road of redemption and of salvation.[5]

"Human language", declares John Paul II in *Fides et Ratio*, "embodies the language of God"(n.94). He who in Jesus spoke His *healing Word* agreed to live in our tents and to be *narrated* in our therapeutic relationships, in our actions of treatment, and in our *healing words* – the hermeneutic places of His Love. The contribution of "news" which Catholic health-care institutions can make to evangelisation cannot but be rooted in a strong recovery of the healing dimensions of their action (in preaching, in treating, in celebrating, and in their expression of communion).[6]

Notwithstanding its widespread employment, the word "evangelisation" is not easy to define. The Apostolic Exhortation of Paul VI, *Evangelii Nuntiandi*, recognised that "no partial and fragmentary definition can describe the rich, complex and dynamic reality which is evangelisation without running the risk of impoverishing it or even of mutilating it" (n.17). It is a complex process made up of various elements which can seem to be contradictory and even mutually exclusive but which instead are complementary and mutually enriching: "renewal of humanity, witness, explicit preaching, adhesion of the heart, entrance into community, the welcoming of signs, and initiatives of apostolate" (n.24). Evangelisation cannot, therefore, be understood without linking it to other terms which in turn are used as synonyms when an attempt is made to describe the totality of ecclesial practice – mission, witness, apostolate, pastoral care and charity.[7]

Jesus was the first evangeliser, he who proclaimed "the good news of the kingdom of God"(LK 4:43), and he is this Good News. And it was to his disciples, who were the first to hear it, that he gave the task of proclaiming this Good News, in their turn, to the whole world, in actions and in words. If today, after two thousand years of the history of the Church, a need is felt to speak about a *new* evangelisation, then it is clear that it is not the contents of the *news* that must be renewed – given that this was given definitively in Christ, eternal Word and the always new word of the Father – but how it is announced in its entirety, in all the dimensions of ecclesial practice, by means of a language that knows how to respond to the anxiety of the heart and through a form of witness that knows how to interest people in the entirety of their individual and socio-cultural experience. The aspect of news in the evangelisation which takes place in the health-care environment, and in particular in the structures which describe themselves as being "Catholic" and thereby *confirm* that they are a strong expression of ecclesial action, is today, in my opinion, in understanding how that news must be embodied in a message of healing entrusted not so much to words but which, rather, can be decoded from the relationships and actions of care and treatment, and which, in addition, is visible in those structures.

The *request for care and treatment* expresses an expectation which is wider that mere technical provision: "it is a search, that is to say, by the suffering person, for his or her own identity",[8] a search for his or her self-recognition as a person. It therefore has boundaries whose breadth and width corresponds to what the suffering person perceives he or she lacks, and not least his or her dignity. It is possible to speak about health and illness because they are subjects which are related to each other, and the context within which the discussion of the right to health has a meaning and appears practicable is, as D'Agostino puts it, "the context of our relational identity: that which each individual acquires in relation to others, through others and with others, and in which our personal physical-biological history acquires its anthropological value".[9]

The health and illness of other people are thus an appeal to engage in an alliance and are elements which require "sharing". The therapeutic practice is an *alliance*. Illness, like health, affect the person in his or her entirety and for this reason involves a *great alliance* of factors. *Therapy*, too, is the fruit of a successful mosaic of professional skills and capacities, of a pact based upon a relationship, of a great alliance between people and above all else between a sick person and those who take care of him or her.[10] Catholic institutions become evangelising if they become spaces in which, in the therapeutic relationships, these alliances are possible, and speak "in signs" of the alliance with a God whose presence, whatever may take place, is not lacking: they therefore become places of meaningful and per-

sonalising relationships within the desert of the illness.

2. Stones and Journeying

But to speak about God and of the relationship with Him is not so much a matter of blocks of stones but rather of people – the alive stone blocks of the only church of God, witnesses to her action, and, in Him, "transmitters" of the healing love of the Father. But "only the whole set of gifts makes the whole body of the Lord epiphanic. In the building every stone needs the others (1 Pt 2:5); in the body every limb needs the others in order to make the whole body grow and to work for the common good (1 Cor 12:7)".[11]

In his first letter Peter refers to living stones around the chosen stone which is Christ himself (1 Pt 2:1-10). As Elena Bosetti writes: "the quality of *being alive* which is used both for Christ and for the disciples is in net contrast with the very idea of a stone to which habitually are attributed characteristics of being material and heaviness. To describe the stone as *living* is thus an intentional correction which refers to the resurrection and draws attention to the shift from the realistic level of material construction to the ecclesiological level".[12] In allowing ourselves to be transported by the Word of God, we become immersed in an image in movement. There is a drawing near of the various stones to the alive stone (the Lord) not in order to build a static house made once for ever but to give life to a dynamic community journeying in history, to structures which are not the definitive place of our dwelling between ourselves and God, languages which cannot capture the richness of his Word, but "tents", places which host our and others *pilgrimaging towards the house of the Father,* which "involves the innermost part of every person, extending then to the believing community to reach the whole of mankind" *(Tertio Millennio Adveniente* n. 49).

In *Gaudium et Spes,* Vatican Council II reminds us that today "mankind is passing from a rather static conception of order to a more dynamic and evolutionary conception. This favours the rise of a formidable complex of new problems which stimulates analyses and new syntheses"(n.5). And a theologian comments how the Council: "without in the least drawing away from the inevitable Christological reference of "yesterday, today, always", welcomes this entrance of man into a new horizon of interpretation and projection of himself and his history in which there prevails over rigid reference to unchanging points of reference or to rigid social structures which are codified once and for all, the dynamic of a free and responsible search for projects and structures which are more responsive to the ever growing vocation of man himself".[13]

"Jesus Christ is the same yesterday and today and down the centuries" (Heb 13:8). He is the already given Word which today, however, needs our "new" translations, specific elements in our expressions, our words, changes in our therapeutic relations and in the structures where these relations find their space for expression. It is precisely the wealth of the possible expressions of *healing* which must re-express in an always new way and in the Spirit which continually renews us, the wealth of the Word of the Father.

We are living stones in movement which are always ready to act; able to engage in "change" if our minds continue to be awake; capable in the various worlds of health and health care of perceiving the signs of the times which are in constant flux and contain prophetic signs which when read in relation to God communicate the possible evolution of our history. On this point the same letter by Peter (1:13) suggests a special mental attitude to us: *gird the loins of the mind.* "A long garment is a problem when one has to walk, or work, or fight. So we gird our loins. In our case our loins are those of the mind – it must be employed so that we can meet the Lord who comes, always being vigilant",[14] ready to perceive the sound of his passing, the signs of his Word before he knocks and asks us to come in, able to tune in to the newness of his voice which constantly asks us to convert and to change.

An exodus-like dimension must permeate our lives, our way of relating to each other, and our health-care institutions: a readiness to go forward, to focus in an always new and different way on our work at the side of the sick person, to construct communities, homes and hospitals, that is to say pieces of the Church where Christ, the cornerstone, still today can be present in order to "re-say" the redemptive profundity of his healing. We should be open to welcome in his eternal today the newness of our tomorrow.

At the side of the sick person, with our loins girded in order to serve him or her better, we will express what we are as priests, members of religious orders and of the laity together, in the offering of our lives, the worship which is pleasing to God. The sick person and our relationship with him or her, the health-care structure or service in which this takes place,

should become the "theological place" where in the mutual encounter we live our faith and proclaim it to each other. In such a context the healing contents will promote *health* which is truly human and thus *overall*, an open and *nostalgic* sign of "salvation which is existence achieved in its integrity and its fullness", a gift that we receive from Christ and at the same time a vocation which invites us to be "ministers to each other of health-giving grace" which expresses itself in the various forms of healing and health, always, however, "rising above them and rejecting the idea that they are the final and global configurations of the destiny of men".(15) The Christian is troubled because he is born from on high and it is to this homeland that he must return. The structures in which he works necessarily maintain the unsettled character of this exodus and journeying.

To the request for health, in the variety of its expressions and the diversity of the problems and difficulties which it raises, the ecclesial community is called to respond as a healing community, an effective sign (sacrament) of an overall salvation carried out by the Lord Jesus through the power of his Spirit of healing.

One of the most important challenges which the Christian community must accept and to which it is called to respond, and this so that the Gospel which it preaches can constantly express its "newness", is certainly that of *inculturalisation*, that is to say a real cultural "incarnation" of its preaching. For this reason, the *here and now* of its speaking and its acting should be the place where the process of "teo-logare", that is to say the experiencing of the presence of God and his speaking, has its own expressive form which enrich theology as a whole because they *reveal* the richness of his *Word*. It is also the "place" where Christians must create new prophetic "signs" through a *praxis* which in healing speaks about God and proposes readable models to people who are indifferent in religious terms or who do not believe in God.[16]

Ecclesial action, and this is the case of its specific *healing* role as well, cannot be anything else, therefore, than "in" and "through" the *flesh* of a specific culture. A "new evangelisation" cannot be carried out in our institutions and through them if one does not understand at the deepest level the health-care culture into which one wishes to become integrated and of which one is, at least in part, an expression. Health, and the culture which in various ways today expresses its meaning, are not only a "place" where God makes impelling invitations to us to read the present.

To evangelise in the health-care field, re-saying the healing "news" of the Word, means "reaching and almost overwhelming through the force of the Gospel those criteria of judegement, the determining values, the points of interest, the lines of thought, the sources of inspiration, and the models of life of humanity which are in contrast with the Word of God and with the plan of salvation"(EN n.19). It also means to contest by prophetic and alternative methods the lack of respect for the completeness of the request for health of the people whom we

are committed to treating and looking after. An *incultured evangelisation*, thanks to ecclesial action which in our institutions must express the completeness of the language of healing, "translates at the same time the absolutely new character of Revelation in Jesus Christ and the need for conversion which springs from the encounter with the only Saviour: "Behold! I render all things new!"(Ap 21:5).[17] This is a task entrusted by Christ to the whole of his Church. The various categories of professionals who work in the field of health and health care, as individuals but above all else in their characteristic of being an ecclesial community, must bear witness to the rich potentialities and expressive and communicative (and thus evangelising) forms of this gift, which is given to them by Christ, of healing.

3. Instructive Images

"A sign of hope". This is the expression used by Cardinal Bernadin in his pastoral letter on Catholic health-care institutions. As he puts it, illness is a kind of human exile, of not feeling at home, a sense of being cut off from the previous form of life, a feeling of being immersed in chaos. The distinctive vocation of Catholic health-care institutions is not that of healing in a way that is better than other such institutions or with greater effectiveness, but of giving "reason for hope" to those who are sick through the relationships of treatment and care which exist. Work within the health-care environment is "a ministry of the entire community of faith, the Church" and is something which is thus essential for the Church herself and cannot be delegated to others. They are a place where religious congregations can find new ways of co-operating, a more "Catholic" perspective which is thus able to rise above local interests and work for the common good. In addition, bishops can thereby express their "collegiality" in a better way beyond the

boundaries of their dioceses.[18] Catholic health-care institutions express "the ministry of healing of Christ in a specific way within the local Church".[19]

"Healing" cannot be such if it is not placed within relationships where the "human" dignity of the sick person is recognised in all the contexts, and at all the moments, of the period of care and treatment. Furthermore, the humanisation of medicine and of the relationship of treatment can become an "evangelising" moment in the field of health, a more easily understood *new mode of evangelisation.*[20] The experience of illness (and of the pain which is one of its especially meaningful keys of comprehension) is an experience of "fragmentation"[21] and of fracture at the various levels of communication (in relation to our own bodies, in relation to ourselves, to others, and to God).

The humanisation of which the Church is the bearer in her pastoral action, and which finds its basis in the Christology and anthropology which derives from that action, must be expressed, as Ignazio Sanna observes, as a "unifying humanisation".[22] A unitary vision of the person which respects his or her biological, psychological and relational dimensions, and which recognises a constituitive role in his or her openness to the transcendent, is indeed fundamental for a defence of the dignity of the person from his or her beginnings in the maternal womb. It is an authentic therapeutic response, and the "taking care of" which springs from this becomes "gospel" which heals. But the process of humanisation does not achieve its goals if greater attention is not paid to the health-care worker and to a recognition of the entirety of what it means for him or her to be a person.[23]

The Gospel preached by the Church in this field becomes transformed into promotion and a social task: "it is not enough to remember principles", as *Octogesima Adveniens* observes, "to affirm intentions, to emphasis strident injustices, and offer up prophetic denunciations: these words will not have real weight if they are not accompanied by a more energetic awareness of responsibilities and by effective action" (n.49). It is a duty of the pastoral ministry of the Chuch and of her Catholic and thus universal configuration to ensure "that human, economic and technological resources" are at the service of the human person and of all people all over the world so that "the health of those who do not have a voice is promoted in its entirety and so that the health-care world is not left to be constrained by the dynamics of profit but instead permeated by the logic of solidarity and charity".[24]

The Church is called, therefore, to *critical vigilance.* "This involves taking on human hopes and to assess them in the light of the resurrection of the Lord who on the one hand supports every authentic work of liberation and human advance and on the other is opposed to every absolutisation of earthly goals".[25] But the Church must also keep this vigilance alive within her. "Certain socio-assistance choices and the institutions which spring from them, which were understandable in a past with a different social and cultural context, are by now obsolete and in contrast with a new human sensitivity".[26] Conversion is not only a "constant" duty of the person but also a duty of the community and a "structural" undertaking.

The Incarnation is not only a truth of faith that involves the mind and requires consent in words. It also requires a relational approach, a style that God proposes to us and which permeates our actions and our self-expression. We are called to *say together our profession of faith* (our Creed) *through our different professions.* In the health-care context, as well, "the whole of human relational life is integrated into the salvific ministry of grace entrusted to the Church and by her to the evangelising mission of Christians, and not only the inter-subjective relations but also the social and political interactions".[27]

But the Church is also called to give the first example of this. "The practical and theoretical task which Christians have before them is thus that of building "images" and "signs" in which the merciful irruption of the kingdom of God is manifested, in which that eschatological unity which is the deepest desire of history itself is foreshadowed".[28] Catholic health-care institutions and the services which they can express can become a new preaching if *instructive images* become this "merciful irruption of the kingdom of God" in a world which listens ever rarely to its words.

The interest and concern of the Church in relation to the sick, the disabled and the dying has a long history of "incarnation" in hospitals and in various types of institutions dedicated to health care, and more specifically "Catholic" health-care structures. These are some of the signs and images that the Church proposes to the whole of society as a "contribution" to care and treatment and as a model of that care and treatment. But these institutions are undergoing a whole series of transformations caused by factors within the religious communi-

ties which administer them and by local socio-economic elements. These various factors threaten to throw their purpose into crisis or to corrupt their Catholic identity, which is based first and foremost upon the commitment of their staff to "see health care as a ministry".[29] This is an identity which expresses itself in the type of healing relations that prevail within such institutions and which becomes continually renewed and rebuilt through these relations. The kind of gospel which one breathes within these institutions (above all the gospel of life, and especially of fragile life, and of its dignity) defines its Catholic identity and is transformed into a universal message.[30]

Conclusion: Proclaiming the Trinity which Dwells within us

As a saved and healing community, the Church can express herself both at a universal and at a specific level as a salvific-healing community. It is indeed in her being a community that the Church expresses in pregnant fashion her being as an "icon of the Trinity", thereby revealing and communicating the salvation of the Trinity through new relations and a style of communion which should be ever more expressive. The model of service, that is to say of *diakonia*, which the Church is called upon to express today in the world of health and health care as a sign of the Kingdom, and especially in her institutions, is the model of "ecclesial communion". It is the trinitarian model of communion and reciprocity in which each person is a partner in a relation in which he or she is healing and healed, Christ- Samaritan and Christ-the sick person, a space for authentic evangelisation because it involves the communicative entirety of he or she who gives and he or she who receives. If Christ redeemed the human person "he has also therefore redeemed the relationship between persons". It is thus evident that it is "the quality of the relations of ecclesial *koinonia* and *diakonia* which demonstrate the authentic Christological figure of faith", and the place where this is manifested is our personal and social history.[31]

"The request for health", as the Italian Church emphasised during the world day of the sick of 1999, "expresses the nostalgia for the infinite and for salvation that the Father has placed within the inner world of each and every one of us and which only the return to Him can fully satisfy".[32] The response to this request must find those incarnations which are the signs of his Word.

In the therapeutic relations in which request and response meet each other there is always the presence of the Spirit and of his love wherever this happens. The request for health (which in the sick person expresses itself in all its profundity), and the community which assumes responsibility for this request and takes care of the sick person, can both become *tents in which God the Trinity wishes to dwells*, expressive spaces of therapeutic relationships whose comprehension, although employing different kinds of languages, will, by the work of the Spirit of love, be universal.

If we want to provide the "new evangelisation" with authentic contents, Pagola reminds us, then one of our first commitments must be "to rediscover the therapeutic dimension of evangelisation".[33] But we must above all else, in my opinion, recover the evangelising force present in our healing because as an ecclesial community (and Catholic health-care institutions must be a specific and "qualified" expression of that community) we have been sent to "evangelise by healing", following the example of He who was not only a *messenger* of this but also the great *message.*

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Notes

[1] D.TETTAMANZI, 'Chiesa e Salute', in AA.VV., *Progettualità Ecclesiale nel Mondo della Salute*, acts of the third conference held by the national consulting body on the health-care ministry of the Italian Episcopal Conference 23-25 April 1995 (edited by I.Monticelli), Salcom, Brezzo di Bedero, VA, 1995), p. 93.

[2] P.TILLICH, *L'Irrilevanza e la Rilevanza del Messaggio Cristiano per l'Umanità Oggi* (Queriniana, Brescia, 1998), pp. 41 and 61 (or the English edition of 1996).

[3] D.TRACY, 'Salvare del Male. La Salvezza e il Male Oggi', in *Concilium* (1998), 1, p. 156.

[4] J.M.R.TILLARD, *Mondo Sanitario Terra del Vangelo. Salute e Malattia al Vaglio della Coscienza Cristiana* (EDB, Bologna, n.y.).

[5] B.SECONDIN, 'Come e Perché Coltivare la Spiritualità nel Cuore della Modernità in Crisi', in *Consacrazione e Servizio* (1999), 5, p. 37.

[6] Cf L.SANDRIN, 'La Chiesa, Comunità Sanante', in Pontificio Consiglio della Pastorale per gli Operatori Sanitari, conference on "Chiesa e Salute nel Mondo. Attese e Speranze alle Soglie dell'Anno 2000", held at Rome 6-8 November 1997, the acts of which are to be found in *Dolentium Hominum* (1998), 37, pp. 69-74 published by the same Pontifical Council. Cf also L.Sandrin, 'Los Agentes de Pastoral de la Salud.

Una Reflexiòn Teològical-Pastoral', in *Camillianum* (1998), 9.

[7] F.V.ANTHONY, 'Evangelisation: Growing Understanding of a Complex Process' in *Salesianum* (1999), 61, p. 18. On the same subject see also M.Midali 'Modelli di Pastorale e Nuova Evangelizzazione' in P.Vanzan (ed.), *La Teologia Pastorale* (A.V.E., Rome, 1993), pp. 21-116 and S.Pontor, 'Il Primato dell'Evangelizzazione nella Teologia Pastorale Oggi', in *Camillianum* (1998), 9, pp. 9-26.

[8] P.CATTORINI, 'Allianza Terapeutica', in G.Cinà, E.Locci, C.Rocchetta and L.Sandrin (eds.), *Dizionario di Teologia Pastorale Sanitaria* (Camilliane, Turin, 1997), pp. 30-37.

[9] F.D'AGOSTINO, 'La Persona e il Diritto alla Salute', in Pontificio Consiglio della Pastorale per gli Operatori Sanitari, conference on "Chiesa e Salute nel Mondo. Attese e Speranze alle Soglie dell'Anno 2000", held at Rome 6-8 November 1997, the acts of which are to be found in *Dolentium Hominum* (1998), 37, pp. 28-29 published by the same Pontifical Council.

[10] Consulta Nazionale CEI per la Pastorale della Sanità, *Il Mosaico Terapeutico* (Camilliane, Turin, 1996).

[11] Pontifica Opera per le Vocazioni Ecclesiastiche, *Nuove Vocazioni per una Nuova Europe* (Libreria Editrice Vaticana, Vatican City, 1997), p. 47.

[12] E.BOSETTI, *Per un Cammino di Spiritualtà Ecumenica. La Prima Lettera di Pietro* (Centro Pro Unione, Rome, 1994), p. 84.

[13] P.CODA, 'L'Antropologia Trinitaria. Una Chiave di Lettura della "Gaudium et Spes"' in *Nuova Umanità* (1988, 56, p. 25.

[14] E.BOSETTI, *Per un Cammino di Spiritualtà Ecumenica. La Prima Lettera di Pietro* (Centro Pro Unione, Rome, 1994), p. 84.

[15] Y.CONGAR, *Un Popolo Messianico. La Chiesa, Sacramento di Salvezza. Salvezza e Liberazione* (Queriniana, Brescia, 1982), pp. 128, 72, 127.

[16] R.FISICHELLA, *Quando la Fede Pensa* (Piemme, Casale Monferrato, Alessandria, 1997), p. 190.

[17] Pontificio Consiglio della Cultura, *Per una Pastorale della Cultura* (Vatican City, 1999).

[18] J.BERNADIN, *A Sign of Hope. A Pastoral Letter on Healthcare* (CHA of US, St.Louis, MO, 1995).

[19] National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (Washington D.C., 1995), p. 4.

[20] Cf A.BRUSCO, *Umanità per gli Ospedali. Prospettive Pastorali* (Salcom, Brezzo di Bedero, VA, 1983); AA.VV., *Per un Ospedale più Umano* (Paoline, Cinisello Balsamo, Milan, 1985); A.Pangrazzi, 'I Volti dell'Umanizzazione e della Disumanizzazione negli Ospedali' in *Camillianum* (1995), 6, pp. 269-284; P.Marchesi, 'Umanizzazione Sanitaria' in G.Cinà, E.Locci, C.Rocchetta and L.Sandrin (eds.), *Dizionario di Teologia Pastorale Sanitaria* (Camilliane, Turin, 1997), pp. 1327-1340.

[21] R.ROLANDO THIELE, *Psicologia. Nuove Rendenze nell'Assistenza al Malato di Cancro* (Il Mulino, Bologna, 1988).

[22] I.SANNA, '"Dalla sua Pienezza noi tutti Ricevuto". La Cristologia e la Prmozione Umana. Fondomento o Garanzia?' in P.Coda (ed.), *L'Unico e i Molti. La Salvezza in Gesù Cristo e la Sfida del Pluralismo* (Pontificia Università Lateranense, Mursia, Rome, 1997), pp. 184-185.

[23] M.A.ANNUNZIATA, 'L'Umanizzazione della Medicina' in G.Morasso (ed.), *Cancro: Curare i Bisogni del Malato. La Assistenza in fase Avanzata di Malattia* (Il Pensiero Scientifico, Rome, 1988), p. 225.

[24] JOHN PAUL II, speech to the conference entitled "Chiesa e Salute nel Mondo. Attese e Speranze alle Soglie dell'Anno 2000" of the Pontificio Consiglio della Pastorale per gli Operatori Sanitari, held in Rome 6-8 November 1997, the acts of which were published in the same ministry's *Dolentium Hominum* (1998), 37, n.2.

[25] B.FORTE, *La Chiesa della Trinità.Saggio sul Mistero della Chiesa, Communione e Missione* (San Paolo, Cinisello Balsamo, Milan, 1995), p. 355. See chapter IV of *Gaudium et Spes* on the mission of the Church in the contemporary world. And see also I.Ellacurìa, *Conversione alla Chiesa al Regno di Dio* (Queriniana, Brescia, 1992).

[26] Pontificio Consiglio per i Laici, *La Dignità dell'Anziano e la sua Missione nella Chiesa e nel Mondo* (Vatican City, 1998), p. 26.

[27] M.COZZOLI, *Chiesa, Vangelo e Società. Natura e Metodo della Dottrina Sociale della Chiesa* (San Paolo, Cinisello Balsamo, Milan, 1995), pp. 62 and 71-80. See also H.Carrier, *Dottrina Sociale. Nuovo Approcio all'Insegnamento Sociale della Chiesa* (San Paolo, Cinisello Balsamo, Milan, 1993).

[28] G.RUGGIERI, 'Chiesa e Mondo', in W.Kern, H.J.Pottmeyer and M.Seckler (eds.), *Trattato sulla Chiesa*, vol. 3 (Queriniana, Brescia, 1990), pp. 313-4.

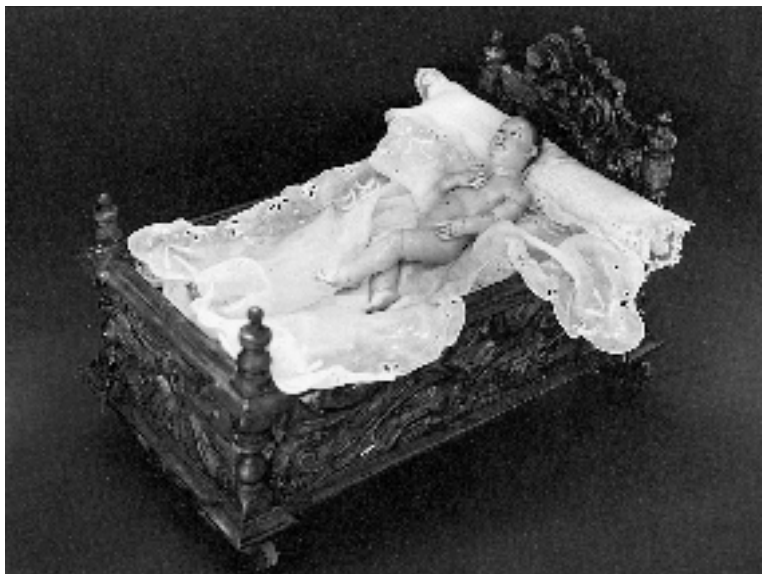
[29] J.BEAL, 'Ospedali Cattolici. In che Misura Saranno Cattolici?' in *Concilium* (1994), 5, pp. 127-129.

[30] Cf also M.F.COLLINS, 'Il Ruolo degli Ospedali nel Nuovo Millennio', in Pontificio Consiglio della Pastorale per gli Operatori Sanitari, conference on "Chiesa e Salute nel Mondo. Attese e Speranze alle Soglie dell'Anno 2000", held at Rome 6-8 November 1997, the acts of which are to be found in *Dolentium Hominum* (1998), 37, published by the same Pontifical Council, see pp. 85-89.

[31] P.CODA, 'Sul Concetto e il Luogo di un'Antropologia Trinitaria', in P.Coda and Z.L'Ubomir (eds.), *Abitando la Trinità. Per un Rinnovamento dell'Ontologia* (Città nuova, Rome, 1998), pp. 128-131.

[32] Ufficio Nazionale CEI per la Pastorale della Sanità, *Domanda di Salute, Nostalgia di Salvezza* (Camilliane, Turin, 1998).

[33] J.A.PAGOLA, *Acciòn Pastoral para una Nueva Evangelization* (Sal Terrae, Santander, 1992), pp. 137-162. Cf J.A.PAGOLA, *Es Bueno Creer. Para una Teologìa de la Esperanza* (San Paolo, Madrid, 1996); J.A.Pagola, 'Evangelizzazione e Mondo della Salute' in G.CINÀ, E.LOCCI, C.ROCCHETTA AND L.SANDRIN (eds.), *Dizionario di Teologia Pastorale Sanitaria* (Camilliane, Turin, 1997), pp. 427-432; B.Haring, 'Proclamare la Salvezza e Guarire i Malati. Verso una Visione più Chiara di una Sintesi fra Evangelizzazione e Diakonia Sanante' in Ospedale Miulli, *Quaderni* 1, (Acquaviva delle Font, Bari, 1984),from the original German publication of 1984.



Conclusions of the World Symposium of the AISAC

1. Groups (Summaries)

1. The English Group

We should begin with prudence and caution, and we should always be aware of what we are doing. We need to employ all the information which is necessary to us, and in particular information about how groups of medical doctors, male and female nurses, and pharmacists already work. We need to see how organisation is achieved bearing in mind the dissimilar realities of the various continents of the world, as for example is the case in Africa. The leadership group will be made up of about nine or ten people. The structures projected must be flexible and this process must always be open to dialogue in line with the various skills and responsibilities of the Catholic hospital community. We must know what kind of organisation we want, draw up the first draft of a project, formulate principles, and make clear what our purpose really is.

2. The French Group

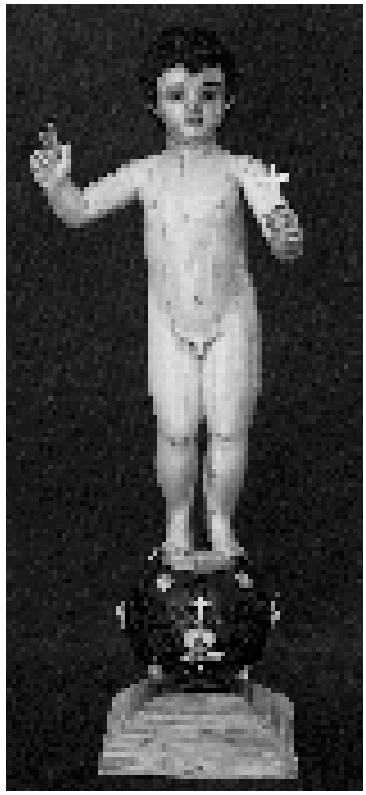
We need to make clear that the AISAC is needed: 1. To take part in an effective way in international organisations. In addition we need: 2. To establish criteria. 3. To achieve the co-ordination of the health-care network. 4. To enter into dialogue about its ethical dimension and general philosophy: a) to help those most in need; b) humanisation. A model for the achievement of co-ordination could be that of the statutes which existed before the AISAC, or of private hospital structures. We need to study the different national, regional and international levels. To conclude, we need to create an initial working group immediately.

3. The Italian Group

It is possible to found the AISAC along the lines of a confederated constitution which is made up of national Catholic hospital institutions. Its responsibilities would be of a spiritual and training kind. This confederal constitution could start with the episcopal conferences in consultation with the conferences of the religious. In doing this we need to know those who are in charge and to identify the national representative committees.

4. The Spanish Group

The creation of an international federation of Catholic health-care centres is considered to be necessary in order to: 1. harmonise shared principles and values. 2. In this way the Church would become more committed to the health-care ministry. 3. There would be greater opportunities for the exchange of resources. 4. Greater information would be made available. 5. There would be an opportunity to take part in international forums. We need to be aware of the fact that in many countries there do not exist, and it is not easy to create, national associations of Catholic health-care institutions, and it is for this reason that the Pontifical Council for Pastoral Assistance to Health Care Workers encourages the episcopal conferences to stimulate activity, and also provides criteria, goals and values to achieve this end. The problems cannot be solved by a policy of closure. What is needed is a solidarity-inspired and communitarian approach, especially if its takes the form of a positive outcome of the year of the Great Jubilee.



2. Conclusions of the President of the Pontifical Council

Of the various objectives indicated by this Symposium, especial emphasis has been placed on the International Association of Catholic Health-Care Associations. During the Symposium four fundamental points have been discussed, and they are: 1. the identity of a Catholic health-care institution. 2. Its economic questions and issues, its relationships with other organisms (WHO), and its effectiveness in the future (telemedicine). 3. The organisational models for this kind of institution. 4. Guidelines for a new evangelisation of Catholic health-care institu-

tions. All these subjects were dealt with at length and in detail, and gave rise to a fruitful and valuable dialogue.

The high quality of the Symposium and its international significance, achieved by having highly qualified representatives from the five continents of the world, was something which stood out. It is to be hoped that the creation of the AISAC will become an effective reality which will bring about a more incisive pastoral presence of the Church in the world of health and health care. It should be borne in mind, as indeed was expressed in various papers, that this organisation will be subject to the organisation which already exists at a national level. For this reason, all those present were encouraged to promote such an organisation in their own countries so that the re-constitution of the AISAC can really take place.

The President presented three proposals which were unanimously approved:

1. To create an international pastoral organisation which will bring together all the Catholic health-care institutions of the world.

2. For the moment the Pontifical Council for Pastoral Assistance to Health Care Workers will have to provide the impetus behind the creation of this international organisation.

3. To establish within the Pontifical Council a group led by Father Marchesi which will have the task of creating this organisation. The group will be made up of representatives from all the continents of the world on the basis of a balance between the industrialised countries and developing countries.

A vote was taken on how often such symposia should be held and it was unanimously decided that such symposia as the one which had just been held should take place every year in the Vatican.

The Symposium ended with a prayer and an expression of thanks to God for the success which had been achieved.

His Excellency JAVIER LOZANO BARRAGÁN,
President of the Pontifical Council for Pastoral Assistance to Health Care Workers, The Holy See