DOLENTIUM HOMINUM

N. 66 – Year XXII – No. 3, 2007

JOURNAL OF THE PONTIFICAL COUNCIL
FOR HEALTH CARE WORKERS
(FOR HEALTH PASTORAL CARE)

Editorial and Business Offices:
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Published three times a year. Subscription rate: € 32 postage included

Printed by Editrice VELAR, Gorle (BG)

Cover: Glass window Rev. Costantino Ruggeri

Poste Italiane s.p.a. Spedizione in Abbonamento Postale - D.L. 353/2003 (conv. In L. 27/02/2004 n° 46) art. 1, comma 2, DCB Roma

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The illustrations in this issue are taken from the book:
Assisi uomini e pietre
by Vittorio Peri and Dante Alimenti (Editrice Velar, Gorle (BG))

Message of the Holy Father Benedict XVI for the Sixteenth World Day of the Sick

11 FEBRUARY 2008

Dear Brothers and Sisters!

1. On 11 February, the memorial of the Blessed Mary Virgin of Lourdes, the World Day of the Sick will be celebrated, a propitious occasion to reflect on the meaning of pain and the Christian duty to take responsibility for it in whatever situation it arises. This year this significant day is connected to two important events for the life of the Church, as one already understands from the theme chosen 'The Eucharist, Lourdes and Pastoral Care for the Sick': the one hundred and fiftieth anniversary of the apparitions of the Immaculate Mary at Lourdes, and the celebration of the International Eucharistic Congress at Quebec in Canada. In this way, a remarkable opportunity to consider the close connection that exists between the Mystery of the Eucharist, the role of Mary in the project of salvation, and the reality of human pain and suffering, is offered to us.

The hundred and fifty years since the apparitions of Lourdes invite us to turn our gaze towards the Holy Virgin, whose Immaculate Conception constitutes the sublime and freely-given gift of God to a woman so that she could fully adhere to divine designs with a steady and unshakable faith, despite the tribulations and the sufferings that she would have to face. For this reason, Mary is a model of total self-abandonment to the will of God: she received in her heart the eternal Word and she conceived it in her virginal womb; she trusted to God and, with her soul pierced by a sword (cf. Lk 2:35), she did not hesitate to share the passion of her Son, renewing on Calvary at the foot of the Cross her 'Yes' of the Annunciation. To reflect upon the Immaculate Conception of Mary is thus to allow oneself to be attracted by the 'Yes' which joined her wonderfully to the mission of Christ, the redeemer of humanity; it is to allow oneself to be taken and led by her hand to pronounce in one's turn '*fiat*' to the will of God, with all one's existence interwoven with joys and sadness, hopes and disappointments, in the awareness that tribulations, pain and suffering make rich the meaning of our pilgrimage on the earth.

2. One cannot contemplate Mary without being attracted by Christ and one cannot look at Christ without immediately perceiving the presence of Mary. There is an indissoluble link between the Mother and the Son, generated in her womb by work of the Holy Spirit, and this link we perceive, in a mysterious way, in the Sacrament of the Eucharist, as the Fathers of the Church and theologians pointed out from the early centuries onwards. 'The flesh born of Mary, coming from the Holy Spirit, is bread descended from heaven', observed St. Hilary of Poitiers. In the Bergomensium Sacramentary of the ninth century we read: 'Her womb made flower a fruit, a bread that has filled us with an angelic gift. Mary restored to salvation what Eve had destroyed by her sin'. And St. Pier Damiani observed: 'That body that the most blessed Virgin generated, nourished in her womb with maternal care, that body I say, without doubt and no other, we now receive from the sacred altar, and we drink its blood as a sacrament of our redemption. This is what the

Catholic faith believes, this the holy Church faithfully teaches'. The link of the Holy Virgin with the Son, the sacrificed Lamb who takes away the sins of the world, is extended to the Church, the mystic Body of Christ. Mary, observes the Servant of God John Paul II, is a 'woman of the Eucharist' in her whole life, as a result of which the Church, seeing Mary as her model, 'is also called to imitate her in her relationship with this most holy mystery' (Encyclical *Ecclesia de Eucharistia*, n. 53). In this perspective one understands even further why in Lourdes the cult of the Blessed Virgin Mary is joined to a strong and constant reference to the Eucharist with daily Celebrations of the Eucharist, with adoration of the Most Holy Sacrament, and with the blessing of the sick, which constitutes one of the strongest moments of the visit of pilgrims to the grotto of Massabielles.

The presence of many sick pilgrims in Lourdes, and of the volunteers who accompany them, helps us to reflect on the maternal and tender care that the Virgin expresses towards human pain and suffering. Associated with the Sacrifice of Christ, Mary, *Mater Dolorosa*, who at the foot of the Cross suffers with her divine Son, is felt to be especially near by the Christian community, which gathers around its suffering members, who bear the signs of the passion of the Lord. Mary suffers with those who are in affliction, with them she hopes, and she is their comfort, supporting them with her maternal help. And is it not perhaps true that the spiritual experience of very many sick people leads us to understand increasingly that 'the Divine Redeemer wishes to penetrate the soul of every sufferer through the heart of his holy Mother, the first and the most exalted of all the redeemed'? (John Paul II, Apostolic Letter, *Salvifici doloris*, n. 26).

3. If Lourdes leads us to reflect upon the maternal love of the Immaculate Virgin for her sick and suffering children, the next International Eucharistic Congress will be an opportunity to worship Jesus Christ present in the Sacrament of the altar, to entrust ourselves to him as Hope that does not disappoint, to receive him as that medicine of immortality which heals the body and the spirit. Jesus Christ redeemed the world through his suffering, his death and his resurrection, and he wanted to remain with us as the 'bread of life' on our earthly pilgrimage. 'The Eucharist, Gift of God for the Life of the World': this is the theme of the Eucharistic Congress and it emphasises how the Eucharist is the gift that the Father makes to the world of His only Son, incarnated and crucified. It is he who gathers us around the Eucharistic table, provoking in his disciples loving care for the suffering and the sick, in whom the Christian community recognises the face of its Lord. As I pointed out in the Post-Synodal Exhortation *Sacramentum caritatis*, 'Our communities, when they celebrate the Eucharist, must become ever more conscious that the sacrifice of Christ is for all, and that the Eucharist thus compels all who believe in him to become "bread that is broken" for others' (n. 88). We are thus encouraged to commit ourselves in the first person to helping our brethren, especially those in difficulty, because the vocation of every Christian is truly that of being, together with Jesus, bread that is broken for the life of the world.

4. It thus appears clear that it is specifically from the Eucharist that pastoral care in health must draw the necessary spiritual strength to come effectively to man's aid and to help him to understand the salvific value of his own suffering. As the Servant of God John Paul II was to write in the already quoted Apostolic Letter *Salvifici doloris*, the Church sees in her suffering brothers and sisters as it were a multiple subject of the supernatural

power of Christ (cf. n. 27). Mysteriously united to Christ, the man who suffers with love and meek self-abandonment to the will of God becomes a living offering for the salvation of the world. My beloved Predecessor also stated that 'The more a person is threatened by sin, the heavier the structures of sin which today's world brings with it, the greater is the eloquence which human suffering possesses in itself. And the more the Church feels the need to have recourse to the value of human sufferings for the salvation of the world' (*ibidem*). If, therefore, at Quebec the mystery of the Eucharist, the gift of God for the life of the world, is contemplated during the World Day of the Sick in an ideal spiritual parallelism, not only will the actual participation of human suffering in the salvific work of God be celebrated, but the valuable fruits promised to those who believe can in a certain sense be enjoyed. Thus pain, received with faith, becomes the door by which to enter the mystery of the redemptive suffering of Jesus and to reach with him the peace and the happiness of his Resurrection.

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5. While I extend my cordial greetings to all sick people and to all those who take care of them in various ways, I invite the diocesan and parish communities to celebrate the next World Day of the Sick by appreciating to the full the happy coinciding of the one hundred and fiftieth anniversary of the apparitions of Our Lady at Lourdes with the International Eucharistic Congress. May it be an occasion to emphasise the importance of the Holy Mass, of the Adoration of the Eucharist and of the cult of the Eucharist, so that chapels in our health-care centres become a beating heart in which Jesus offers himself unceasingly to the Father for the life of humanity! The distribution of the Eucharist to the sick as well, done with decorum and in a spirit of prayer, is true comfort for those who suffer, afflicted by all forms of infirmity.

May the next World Day of the Sick be, in addition, a propitious circumstance to invoke in a special way the maternal protection of Mary over those who are weighed down by illness; health-care workers; and workers in pastoral care in health! I think in particular of priests involved in this field, women and men religious, volunteers and all those who with active dedication are concerned to serve, in body and soul, the sick and those in need. I entrust all to Mary, the Mother of God and our Mother, the Immaculate Conception. May she help everyone in testifying that the only valid response to human pain and suffering is Christ, who in resurrecting defeated death and gave us the life that knows no end. With these feelings, from my heart I impart to everyone my special Apostolic Blessing.

From the Vatican, 11 January 2008,

BENEDICT XVI.

Third World Congress of the AISAC International Federation of Catholic Health Care Institutions

3-5 May 2007
New Hall of the Synod
Vatican City

A Message to Catholic Health Care from the Continental Delegates of the International Federation of Catholic Health Care Institutions AISAC

Introduction

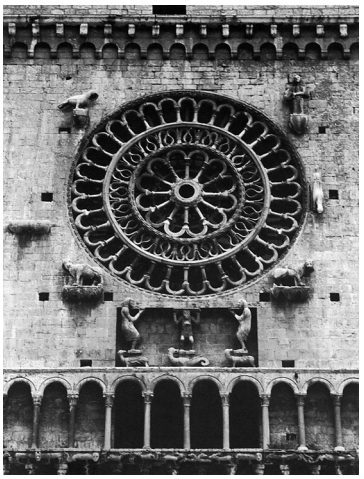
In 1985 there was the First International Congress of Catholic Hospitals and Health Care Institutions, which was held in the Vatican City. The purpose of that Congress was to invite Catholic hospitals and health care institutions of the whole world in order to enhance communication and cooperation between and among them. There was a second congress held in New York ten years later that gathered Catholic health care workers and representatives of Catholic Hospitals. Both of these events were important opportunities for representatives of the Church's healing ministry from across the world to learn from each other and to strengthen the ministry.

More recently His Eminence Javier Cardinal Barragán, President of the Pontifical Council for Health Care Workers, has sought to strengthen international collaboration within Catholic health care by revitalizing the International Federation of Catholic Health Care Institutions. (AISAC) In 1999 delegates from twenty-five nations gathered in the Vatican to discuss the challenges facing Catholic health care. As a result of that meeting, a Board was established to assist the Pontifical Council in advancing the mission of the AISAC. The Board is composed of continental delegates and a chair.

Among its activities the Board assisted the Pontifical Council in the planning of the Pontifical Council's XVII International Conference which reflected on the identity of Catholic hospitals.

In the discussions that have taken place since 2002 it has become clear that there are several challenges that confront the ministry of Catholic health care wherever it is present. More recently His Holiness, Benedict XVI has spoken of the need for an 'aggiornamento' of Catholic health care.

Being aware of the many challenges and in support of the Holy Father's call for 'aggiornamento' the AISAC received permission to convene the Third International Congress of Catholic Health Care. As a background for the convening of the Congress, the AISAC Board prepared this Message to Catholic Health Care.



Message

'Jesus now called the Twelve together and gave them power and authority to overcome all demons and cure diseases. He sent them forth to proclaim the Reign of God and heal the afflicted' (Luke 9:1-2).

For over two millennia the followers of Jesus have gone forth to carry on this healing mission of Jesus. Many have done this as individual believers while others have done it in a more organized manner. Over the centuries women and men religious have had a special concern for the poor and the sick. Whether it was the infirmaries of monasteries and convents or the "hotels" opened for sick pilgrims, the Church's ministry of health pastoral care has adapted to the changing face of those who are sick and to the resources available from medical knowledge. Today the ministry is present across the world. From the rural dispensaries in India to the AIDS clinics in Africa, and on to the tertiary hospitals and community care services in the developed world, the Catholic health care ministry in its many forms is, as John Paul II said, an essential ministry of the Church.

Over a year ago Benedict XVI noted that "it is necessary to give pastoral health care a new impetus. This implies renewal and deepening of the pastoral proposal itself." As delegates representing Catholic health care from each of the earth's continents we have seriously reflected on the Holy Father's call for an "*aggiornamento"* of the ministry. That reflection has led us to note that there are certain common challenges that confront the ministry across the world:

– The public space in which the ministry is conducted has changed dramatically with the result that accountability and transparency are critically important.

– Conflicting priorities and limited financial resources have resulted in inadequate public and private resources to fund the work of the ministry

– The forces of a culture of death that advances the legalization of abortion and euthanasia and of a bioethics devoid of normative truth seek to limit the freedom of the ministry to preserve and protect the dignity of human life.

– The health care needs of the poor and the vulnerable are ever present whether it be because of HIV/AIDS or tuberculosis or malaria or marginalization from health care resources because of lack of insurance.

– The ongoing realignment of the ministry continues with growth coming in some parts of the world and consolidation in other areas.

– The face of those who serve as leaders in the ministry is evolving with the laity sharing ever more responsibility.

How we respond to these and other challenges will determine, in part, the future of the ministry in the first part of the third millennium as well as how we advance the Holy Father's call to renewal.

After several years of dialogue we are convinced that there is much *we can learn from each other about how best to respond to these challenges* and to renew our common ministry. That is why we proposed the convening of an international congress. We have invited leaders from the five continents to share their perspective on the challenges we face and others to describe some of the innovations that have emerged in the ministry. The real work of the congress, however, will take place in the guided discussions that will take place in language groups and in the plenary sessions. This will be a *working and sharing congress* that will draw on the experience and expertise of its participants.

We ask our sisters and brothers in the ministry to pray for the success of this third international congress. It is our hope to share the results of the congress's deliberations with the ministry. Most importantly we pledge to continue working to do what we can to advance the *aggiornamento* of this vital ministry.

Rev. MICHAEL PLACE
Chairman AISAC

The Identity of a Catholic Hospital Beginning with the Eucharist

In this paper I will try to develop three points that are relevant to the identity of a Catholic hospital, namely: the characteristics of a Catholic hospital, its ecclesial character, and some suggestions as to pastoral guidelines.

In the world there are 6,308 Catholic hospitals. In some countries a significant part of health care is provided in these centres. Indeed, there are nations where the whole of the health service is in the hands of the Catholic Church. If all these hospitals were united they would constitute an enormous force for evangelisation. Furthermore, there can be no doubt that at the present time, given secularised globalisation, that these hospitals run the risk of being seen solely as places of philanthropic charity and reference is made to placing them under state management in order to get rid of all the difficulties involved in keeping them going, For that matter, the religious Congregations and Orders responsible for pastoral care in health in these centres by now have very few members, most of whom are elderly, and it will be a difficult matter to replace them with young people.

In this paper I will try to reflect upon Catholic hospitals but also on those lesser health-care centres, such as dispensaries and clinics, which we cannot really call hospitals. Later on I will talk about Catholic hospitals in general and by this I mean every health-care centre of any size so as not to always have to distinguish between them, and this in the awareness that not everything that is said about their condition can be applied literally to all of them. Everything must be understood in the broad sense with reference to hospitals in themselves and in an appropriate way to other health-care centres.

Emphasis will not be placed on the term 'hospitals' but on what defines them, that is to say on the term 'Catholic', and I will ask what is needed for a centre of this kind to be really defined as being Catholic. Is a Catholic hospital, in its present state, a valid instrument for evangelisation? And to be more precise, what is its identity?

To these and other questions it will be possible to provide an answer after clarifying the concept of 'Catholic' in relation to health-care centres: what do we mean by a Catholic health-care centre or hospital?

To begin with I will say that there are two pre-conditions for a health-care centre to be called Catholic, namely that it accepts the Magisterium of the Church in this field and that it is recognised as such by the competent ecclesiastical authority (Canons 216, 300 and 312 of the C.I.C.).

I. THE CHARACTERISTICS OF A CATHOLIC HOSPITAL

1. Bishops' Conferences

Various Bishops' Conferences have addressed themselves to answering the question of what a Catholic hospital is and they have outlined its characteristics. Here I will mention in summarising form the opinion of some of these bodies.

In the view of the *Catholic Bishops' Conference of Uganda*, a Catholic hospital is a hospital in which justice and fairness prevail, which stands out for its efficiency and the quality of its services, which is very near to the mission of the Church, which is aligned with the priorities of national health-care policy, which shares the goals of participation, and which is always open to ongoing improvements (Uganda Episcopal Conference Medical Bureau, *Investing in Faithfulness to the Mission*, 26-28 Nov. 2003, 19).

For the Bishops of the Italian Bishops' Conference, a Catholic hospital must be characterised by overall care for the patient who is introduced into a new life of grace, by the training of its workers in pastoral care in health, by the presence of new spheres and challenges – for example in the field of biogenetics, by the development of a new ministry of health, by great humanisation, and, lastly, by management that is totally transparent and up to the job.

For the *Bishops of the Spanish Bishops' Conference*, a Catholic hospital sees the patient as the central point of its work and it always recognises that he has the right to decide about his treatment. It always respects him in particular at his innermost level. It works to ensure that terminal patients can die in peace and respects their dignity and their right to life until the end. It must recognise the religious freedom of its members, it must support its staff in all senses, and it must attend in particular to the poor and the marginalised and protect life from its beginning until its natural end.

The Catholic Bishops' Conference of the United States of America lists as characteristics of a Catholic hospital: being a living Gospel for everyone, respecting patients and their families, attending in particular to the poor and the marginalised, taking the needs of research very seriously and having centres for research, imposing cooperation between all the members of its personnel and knowing how to treat its workers in a just way in conformity with what Canon law requires of Catholic hospitals, being in contact with the parishes from which the patients who have been admitted come, training the workers in pastoral care in health that work in it in the right way, and privileging the administration of the sacraments and in particular the Eucharist, the anointing of the sick, and Viaticum.[1]

2. Other authors

For Massimo Petrini, in his article 'Ospedale cattolico' ('Catholic Hospitals') in the *Dizionario di teologia pastorale sanitaria* ('Dictionary of the Theology of Pastoral Care in Health'), there are four criteria to be employed for a hospital to be able to define itself as Catholic: a preferential option for the poor, care for the person as a whole, the universal commitment of the ecclesial community, and being an expression of the ecclesial community. The document of the National Council of the Bishops' Conference of Italy on pastoral care in health, *La pastorale della salute nella Chiesa italiana* ('Pastoral Care in Health in the Italian Church') defines a Catholic hospital as having the following characteristics: overall care for the patient, the defence and promotion of unborn life, the training of staff at a Christian and professional level, a prophetic presence in the new areas of medicine, quality and efficiency in the ministry of spiritual accompanying, the safeguarding of the humanity of care and services, the promotion of a health-care culture based on Christian values, and a healthy transparency at the level of management and administration.[2]

Eduardo Schillebeckx states that a Catholic hospital is one in which charity is practiced through organised medicine.[3]

H.E. Msgr. José Luis Redrado states that a Catholic hospital is technically competent, integrated into a health-care network with suitable planning and co-ordination, in which the patient is treated as a person, humanly and in an overall way, including his religious dimension, open to society and recognised by the ecclesiastical authority as such. He states that the Commission for Hospitals of the Catholic Church in Spain established the following points: primary care for sick people, their right to a free decision, respect for their innermost beings, the right to die in peace, the right to religious freedom, the fulfilment of the heath-care staff, care for the marginalised, and respect for human life.[4]

I will now try to incorporate all these characteristics in the reflections that I will now present.

II. THE ECCLESIAL CHARACTER OF A CATHOLIC HOSPITAL

1. Fundamental elements

From what has been stated hitherto, we can conclude that for a hospital to be called Catholic the first thing that it needs to have as a primary motivation is the development within it of the practice of charity towards the sick. This means that in each hospital we should find three indispensable elements, namely: *1) service to the sick; 2) institutionalised relationships between those that provide these services and the patients themselves, with these relationships being something special; 3) the management of the hospital itself*. When these three elements – services, institutional relationships and management – are based upon a Christian approach, that is to say upon the Gospel Message and upon Christian charity, faith and hope – that is to say the theological virtues – then that hospital may say that it is Christian. In addition, if the Gospel Message is present, and thus Christian charity, as it is practiced, lived and taught in the Catholic Church, then we will have a Catholic hospital.[5]

2. The ecclesial mission and Catholic hospitals

In fact, a Catholic hospital bases its identity on the mission to heal the sick which was received from Christ within the Church (Lk 9:1-2).

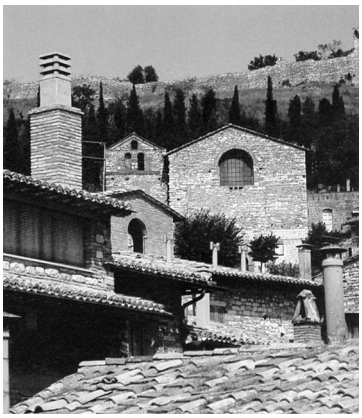
The Church has carried out this mission in history in different ways according to various circumstances and places. At the beginning this was a matter almost of an exclusive and private service. With time the Church helped to ensure that this service was understood as being something that was owed to citizens out of justice and in fact in many countries it was adopted as such by the state. The Church is happy at the fact that out of charity in today's world and in numerous countries it was understood that these are duties involving justice since charity does not annul justice but, rather, presupposes it. This previous ecclesial practice helped to ensure that many states began to understand these institutional health services as a humanisation of the sick person.[6]

3. The Holy Spirit and Catholic hospitals

However, we should remember that the Church founded and continues to found its hospitals not only as mere humanisation of the sick but as charity towards them. In the past, and still today, it has been motivated to provide this service by the love of God infused in it by the Holy Spirit. Naturally, this love involves love for neighbour, even though this last follows on from love for God, the Holy Spirit himself. It is the Holy Spirit that inspired the Church in the past and inspires it in the past so that it founds and supports hospitals which it creates out of charity and justice because the first implies the second but goes beyond it.[7]

4. The ecclesial call and Catholic hospitals

In exploring the above we discover that this action of charity is centred in the very essence of the Church. Indeed, its motivation is written into the ecclesial call itself which congregates the Church and makes it such. The Holy Spirit makes the Church understand that Christ is present in a special way in the sick and, amongst these, in the poorest and least protected. It calls the ecclesial community to extend its range of action and to increase its community links with the sick themselves, so that the ecclesial mission is carried out amongst these poor people and the Word of God which unites them and saves them reaches them, giving them overall health, which is health of the body and the soul, the health of the whole person. The Word of God that unites people is an essential point in the Church. In this way, the creation and the maintenance of hospitals belongs to the permanent constitution of the Church, understanding this in a particular way beginning with the sacrament of the Eucharist, which is the foundation, in its turn, of the Church itself.



5. Bishops, the Eucharist and Catholic hospitals

In this context, in the light of the completeness of the doctrine that Pope Benedict XVI expounds in his apostolic exhortation *Sacramentum Caritatis*, the Eucharist comes to be the inner force of a hospital, the true curative force, both of the patients and of the whole environment that surrounds them. In his address that he gave to the seventh plenary assembly of this Pontifical Assembly, when referring to this exhortation, which he enjoined us to make our own and to apply in the field of pastoral care in health, the Pope said 'It is precisely from the Eucharist that health pastoral care can continuously draw the strength to relieve human beings effectively and to promote them as befits their proper dignity. In hospitals and clinics, the Chapel is the vibrant heart where Jesus ceaselessly offers himself to the Heavenly Father for the life of humanity. The Eucharist, distributed to the sick in a dignified and prayerful way, is the vital sap that comforts them and instils in their souls the inner light with which to live the condition of sickness and suffering with faith and hope'.[8] Indeed, a Catholic hospital is understood when understanding the constitution itself of the Church which is fulfilled in the call that is its foundation. Given that today his call is expressed to the full by a bishop in the Eucharist, it is not possible to understand a Catholic hospital without reference to its tie with the bishop and in concrete terms with the celebration of the Eucharist because it is here that the Spirit unites the never-to-be repeated action of Christ healing the sick with the today of history in which the sick are healed as a sign of the advent of the kingdom of God. The bishop, the Eucharist and the hospital are substantially related. For this reason, in antiquity the hospitals of the bishop were built near to cathedrals and they had the function of being a sounding box of the call of the Eucharist that the bishop made from his chair to call men of all times and thus to make the Church. [9]

The bishop, as a pastor, is in a unique position to animate in the faithful the great responsibility to be found in the healing ministry of the Church. As a teacher he upholds the moral and religious identity of its apostolic action and as a priest he actuates it in the very ministry that he celebrates. In this way he belongs to the apostolic Tradition of the ministry of the healing of the sick; it is he who, with his personality, lives and actuates the apostolic succession and makes present Christ, the sole call to salvation, in the sick,

and creates a Catholic hospital.[10]

The forms and ways in which this Tradition is expressed have numerous variants which flow from the mystery of the Eucharist which is made present by the Spirit and his gifts. Amongst these stands out the wonder of the advances of medical science and technology and organisational and administrative efficiency. The capacity to manipulate human nature, within the limits that build man and do not destroy him, is a gift that is offered to us today to solve so many problems that previously never arose. It is from these bases that certain practical guidelines can be traced so that we can speak about Catholic hospitals today.

6. Sacramental pastoral care and Catholic hospitals

The first guideline that we encounter in the constitution of a Catholic hospital is the pastoral one. In a Catholic hospital it is obvious that, as was observed above, the Eucharist must occupy an important position and this sacramental pastoral care as well – without any form of ritualism and rich in an evangelising power. The chaplain of the hospital, as the representative of the bishop, must know that from the Eucharist flows all the being of a Catholic hospital, as the effect of the charity of the Holy Spirit. It is the freely-given love of God that constitutes the foundation of a Catholic hospital and its realisation is the Eucharist. From the Eucharist derive, in their turn, the other sacraments for the sick and in a special way the Eucharist itself as viaticum and the anointing of the sick, the presence of the saving mystery of God who calls the sick person to full health.

7. The chaplain of a Catholic hospital

It is obvious that to be a chaplain of a Catholic hospital the approval of the bishop is necessary because the chaplain is his representative. The pastoral workers also need this approval as well as a specific training. Viaticum, the anointing of the sick, penitence, baptism, confirmation in emergency cases, and marriage, require a very special colouring as special calls in the Church which, from the hospital context, are to be understood in a way that is different from normal parish life but which must always be linked to the parish.[11]

8. Holy Scripture

In this context, Holy Scripture is the aware explanation of the call that God makes in Christ in the hospital world and which is understood in the special circumstances of the patient through the gift of the Holy Spirit. It must be presented as Gospel, that is to say as the good news of God that saves and restores health. An adequate and personalised catechesis is required according to the circumstances of the patients themselves. The sick person should be cared for in all his dimensions, that is to say as a physical, mental, social, spiritual and transcendent person created in the image of God, redeemed by Christ, and called to eternity. Thus the Church is made in hospitals and beginning with hospitals.

III. SOME GUIDELINES FOR PASTORAL CARE IN HEALTH IN CATHOLIC HOSPITALS

Beginning with the dignity of the patient as a privileged child of God I will now try to list certain guidelines for pastoral care in health for Catholic hospitals in line with these points: humanisation, training, unborn life, the terminal stage of life, economics, and co-operation between hospitals.

1. Humanisation

As a first requirement of charity towards the sick the health care workers – chaplains, medical doctors, men and women nurses, pharmacists, other paramedical staff and administrators – should treat the patient as a person and with special care given his condition of being ill. To counteract the depersonalisation that we often witness in the sector of public health it is necessary, in particular, for the Church to behave towards patients in the most personalist way possible. Those who work in the field of health must 'personalise' the way in which patients are treated without ever seeing them as mere numbers or clinical cases. A patient is a person with special problems which grow worse much more than is the case in healthy life, specifically because of the illness and the foreign and often hostile environment that he encounters.

Charity, which is what motivates hospital work, must ensure that a total empathy with the patient is generated so that the ministry of health is practiced in a literal way, suffering together with the patient and identifying with him so that he does not allow himself to be defeated by his illness but rather to free himself from it. The example of the Good Samaritan is the model to follow in behaviour here.

The treatment that a health-care worker gives to a patient is the call that God gives to this person in the painful situation that he is living. The health professional practices a true ministry because it is specifically the service of showing this person the call filled with the affection of the Lord who receives him into the community that makes the Church in the family of the hospital.

Because of this call which is received and welcomed, medicine does not end with the scientific and technical approach, it does not become dehumanised, but rather it takes care of the person as such. It gives a preference to those most in need and offers a vision of totality, not confining itself to the physical forms of treat-

ment imposed by the illness but incorporating them into the psychological, spiritual and religious dimension, offering a broad vision that presents the Christian meaning of suffering and the culture of life, and which brings together all the health-care workers in a unity in which priests, religious and lay people take part, each with their own distinct function but where all are part of the same mission of building up the Church, addressing this call to the patients in their deepest personhoods. This mission is also carried out with the family relatives of patients thereby assuring to them in their totality a climate in which patients feel that they are accepted and defended at the level of their rights.[12]

A very important right of patients is that of being informed about their illness and the treatment that will be received. A patient's consent must be obtained when he is able to give it. When this is not possible this is a right that is exercised by his family relatives in the way that they think best. In this way a contribution will be made to creating an authentic health-care culture so that within the hospital context this sick human existence will be experienced in the best way possible. Sufficient information must involve not only medical information but also moral information; the patient must be aware of his obligation to protect his own corporeal and functional integrity.[13]

An organ transplant should never cause substantial damage to the donor and should never take place for economic reasons. The patient must know that he should not be the subject of medical or genetic experiments; therapeutic experiments must never be allowed unless proportionate reasons exists or there is a probability of a successful outcome. A patient is not obliged to subject himself to forms of treatment that do not offer the possibility of a reasonable outcome and that impose disproportionate risks or excessive costs for himself, for his family or for the community; his privacy must always be respected and all instances of abuse must be reported.[14]

In each Catholic hospital an ethics committee should exist in which relevant questions can be discussed, a committee which allows the hospital to be present in a Christian way in the crucial conflicts of medicine and which facilitates relations between all the health-care personnel and between them and the patients.[15]

2. Training

Charity, the principal motivation of a Catholic hospital, requires that the services that are provided in it are the best possible and that the greatest expertise possible is also present. Workers in pastoral care in health, as has already been pointed out, represent Christ, the Good Samaritan, Through this charitable representation, the humanisation to which reference has been made does not remain mere philanthropy but, rather, is transformed into the love for God that is present in one's sick neighbour, thereby filling the health-care worker with concern and tenderness by loving Christ who is present in the sick person. Through this virtue of charity, the relations between all the members of the hospital personnel must always be ones based on friendly cooperation.

A serious training of health-care professionals is required so that they are competent in the full sense of the term. The ministry of health is practiced using medical science and technology. Thus they should be fully mastered. For this reason, such training must be ongoing and this is especially true of medical doctors and nurses. Professional excellence is a requisite that must be bound up with Catholic hospitals. As has already been pointed out in this paper, the healing ministry must find a suitable channel. Thus ongoing training is required because today science, and in particular medical science and technology, are increasingly advancing thanks to continual studies, research and discoveries.[16]

3. Unborn life

By its very nature, a Catholic hospital must bear witness to life. This is a fundamental instrument for establishing the culture of life from the outset. Its fundamental principle is that life is a gift of God. Man receives life from God and it is nothing else but a steward who must give life as God decrees. God has wanted life to be transmitted in that intense act of love that represents the union of a couple within marriage, which is unique and indissoluble. Thus life must be transmitted solely within this special act of love. Each transmission, or what is connected with the transmission, of life that is contrary to this principle must be extraneous to a Catholic hospital. Following the central argument about what pastoral workers in a Catholic hospital accomplish in the call that convokes them, and which makes the Church, it is obvious that because this convocation is a convocation to life any practice of death absolutely contradicts the mission of a Catholic hospital.

As a consequence, a Catholic hospital must never allow the unitive aspect to be separated from the procreative aspect in the conjugal act; it must not allow *in vitro* fertilisation or the destruction of embryos or their deliberate production in numbers that cannot be implanted in a licit way; it must not allow heterologous fertilisation and homologous fertilisation should only be allowed in case of need and when it is not separated from procreation in the conjugal act; it must not allow human cloning or surrogate motherhood; in fertility treatment the couple must be presented with other methods to deal with their problem, for example by having recourse to adoption; in prenatal and obstetric treatment the life of those who are to be born must be respected to the utmost; prenatal diagnosis is allowed from a therapeutic point of view and always on the condition that it does not lead to a procedure involving abortion; genetic experiments are not allowed unless

they have a recognised therapeutic character and are proportionately suited to the positive results that are envisaged; it is evident that contraceptive practices or directly willed and procured sterilisation are not accepted; and genetic research is accepted only if it is directed towards promoting responsible parenthood.[17]

I have presented only some of the most important points that are currently to be observed in the field of unborn life, although I am aware of the fact that because this is one of the fields where the greatest advances are being achieved today the moral questions are vast, and this to such an extent that the need is being imposed of creating a bioethics committee in every Catholic hospital which can bring concrete help in the very difficult questions and issues that are raised every day in the field of biogenetics.

4. Life at the terminal stage

A Catholic hospital must in a special way attend to life at its terminal stage, even though, strictly speaking, this phrase is not exact because one is dealing here only with the ultimate stage of its expression on earth. Human life, in fact, does not terminate because once it is given it exists for ever.

As a consequence, a Catholic hospital must bear very strong witness to resurrection. The way in which it behaves at this stage must be marked by the virtue of hope. It is necessary to ensure that terminal patients and their families are profoundly aware of the fundamental and decisive reality of resurrection. This is the reason why a Catholic hospital exists – otherwise there would be disappointment and frustration. A Catholic hospital is a place of life and not a place of death because physical death is only a vital stage in a period of existence. It is the day of reward and fullness. It is through this climate of faith that a Catholic hospital is achieved and a Catholic centre must strongly distinguish itself from other non-Catholic health centres in which death is hidden or concealed as much as possible.

In Catholic hospitals death is not hidden, it is not seen as a failure but rather as the culmination of all the stages of earthly life, as the maturation of earthly existence, and as the beginning of something that is about to come: 'What no eye has seen, nor ear heard, nor the heart of man conceived, what God has prepared for those who love him' ((1 Cor 2:9).

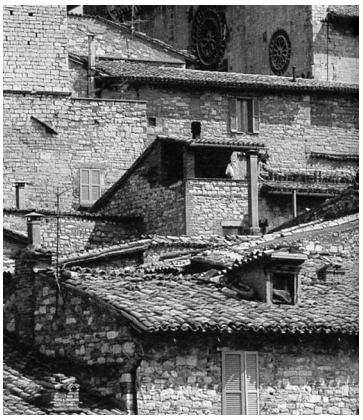
A Catholic hospital, therefore, must not present itself as a station of sadness but rather as a beginning that is full of joy. In today's secularised world, this the witness that must provide a 180 degree turn in the life itself of a hospital. Health is proportional to the stage of life of earthly existence and this culminates in death which, in conformity with the faith of the Church and the ecclesial calling that the Church actuates in hospitals, is seen in the following terms: 'life is not taken away but transformed; and while the dwelling of this earthly exile is destroyed an eternal home is being prepared in heaven' (*Preface to the Departed*). For this reason, for a Catholic hospital there are not the dead but the 'departed' and this because, in line with the etymology of the verb 'to depart', they have in fact terminated their function in the world.

Death, as maturation in Christ, is united to his death through the love of the Spirit, and, in this crucified embrace, with all the trust of the infinite Love of the Spirit, one reaches the fullness of human love in the resurrection, to live for ever in most happy union with God the Father in Christ and, from this Trinitarian mystery, in harmonious union with the whole of mankind and the whole of the creation. This is the witness that an authentic Catholic hospital bears. In the call that Christ makes in a Catholic hospital, the call to life gives to those who adhere to it through the faith the faculty to defeat fear of death.

As a consequence, a Catholic hospital must protect life at its terminal stage by preparing the patient for death with the required spiritual support; it must use suitable means to prolong life so that it completes its function when this is necessary. These means offer a reasonable hope of benefit and thus require that an excessive burden is not placed on the patient or constitute an excessive burden for his family or the community. It is thus necessary to provide ongoing hydration and alimentation; euthanasia must always be forbidden; certainly patients must be kept as far as this is possible out of pain and conscious through the use of 'palliative care', which, although it does not treat in the strict sense, in that a cure is impossible, does alleviate pain; and

it is obvious that exaggerated treatment must be avoided since these are useless forms of therapy and ones that are disproportionate in the context of an imminent death – they do nothing else but prolong the dying process.

It is obvious that sick people have the right to know about the gravity of their state and about the imminence of their deaths so that they can end their role in this life. The ascertainment of death as the total disintegration of personal unity is carried out by the competent medical authority on the basis of the cardio-respiratory functions, meeting today in particular the neurological criterion, that is to say the observation, in line with well identified parameters and ones shared by the international scientific community, of the total and irreversible halting of every brain (brain, cerebellum, and brain stem) activity in the time that is need for assessment (that is to say within at least six hours).



Within the mission that falls to everyone, the donation of organs or human tissues after death is encouraged; in the case of the death of children, this is carried out solely with the consensus of parents or wards; to engage in the donation of organs the principle that a Catholic hospital must adopt is that of the preservation of life and the identity of the person, both of the recipient and of the donor. Autoplastic transplants are licit; as regards heteroplastic transplants, a donation of organs that endangers the life of the human donor, or interferes with the identity of the person (for example the donation of the encephalon or of the gonads), is not licit. It is obvious, given the dignity of the human person, that only donation is accepted. Any economic benefit that derives from this is immoral. With the exclusion of this, the donation of human organs is a great demonstration of charity towards neighbour.[18]

5. Economics

In some places Catholic hospitals are afflicted by two opposing forces. The first is the decrease in the number of religious and the growth in members of the laity of a sense of responsibility for the work in the Church. The second is the dramatic change in the payment of health-care suppliers both as regards governments and insurance companies. The result of this is that various hospitals that were owned by religious institutes have come together to make their process involving purchase or management more effective. In addition, these individual systems and institutes have begun to be directed by lay people and often religious institutes themselves have come together to sponsor one or more health-care centres and have transferred their responsibilities to a different juridical person, leading to the full configurations of lay management.

Another significant movement has been more of a philosophical nature: the most important purpose of a hospital is no longer treating illness – it has expanded to include the preservation of health both at an individual and a collective level. The goal is healthy people and a healthy society. New challenges thus arise for pastoral care in health which require a strengthening the identity of the ministry, management, structures, and the understanding and the provision of health care as a social or public good.

The identity of health-care workers becomes complicated when one has to work with government and with large organisations and one enters into the field of supply and demand. On the other hand, the secular people that are beginning to manage these organisations, which were previously religious, are not trained in the traditional values of the Catholic faith and thus it is not enough to give them only certain directives. What is needed is a life that is identified with Christ who heals and from there an outlining of a new Catholic identity.[19]

As we can see, here in a particular way emerges the economic question. This is an important point that must characterise a Catholic hospital. With regard to the issues raised here as well we should say that a Catholic hospital is not created for commercial ends, that is to say it is not a hospital in which the ultimate end of its functioning is that of earning more money by drawing on every possible advantage. For this reason, a Catholic hospital cannot be a business that is run by basing it in an economic sense on shares. A business of this kind is planned for the highest profit which then has to be distributed amongst the shareholders.

This does not mean, on the other hand, that a Catholic hospital should be a free hospital;[20] rather one should envisage a hospital in which the norm is *the Christian communication of goods*. The patient communicates his goods to the hospital and the hospital communicates to the patient its own goods. Each party does this to the extent that it can afford it. A patient with economic resources does this by covering costs. A patient with less resources does this according to what he can afford, but both have to receive the same health-care service. Indeed, patients with greater resources are exhorted to devote a part of their money to the benefit of those who cannot even cover the indispensable costs of the hospital itself.

When a Catholic hospital receives grants from the state, the economic burden does not fall on that hospital – it is managed according to the relative health-care laws. In this

case, the Christian communication of goods is the spirit that prevails in the relationship between the patient and the hospital because the quotas paid to the state by those having the right to care amount to a communication of goods to the hospital by the patient. The hospital, far from having a cold and irresponsible bureaucratic approach, acts in the spirit of the Christian communication of goods, and for its part gives the care that has been requested in a spirit of love and service to the patient, and not only to obtain the greatest return from the state grant. Special attention must be paid to avoid the depersonalisation of the patient by treating him as one amongst many. Instead, as has already been observed in this paper, he should be drawn near to with all the personalisation possible. One should also avoid corruption and ensure that the services that are offered are the best possible and are not directed towards profit but towards excellence. This applies to all therapies, to all the medical apparatuses, and to the services that are provided as a whole.

6. Co-operation

The field of medicine, like the field of care for health, is growing larger every day. The institutions concerned with this field increasingly notice the need to be inter-related, especially when it comes to belonging to a national or international network of providers of health-care services. It is in these circumstances that the question of the cooperation of a Catholic hospital with other Catholic hospitals or health-care centres presents itself. There are cases when this cooperation seems to be necessary and there are others when it is useful or advisable.

In the cooperation of a Catholic hospital or health-care centres with other non-catholic institutions, the problem often arises of cooperation in the field of moral questions. There are health-care centres whose practices are not compatible with the position of the Church, in particular as regards life at its beginning and its end. To meet these needs for cooperation there applies what Catholic doctrine states as regards cooperation in an action that is morally improper.

First all, all scandal has to be avoided. Even when one is not dealing with a matter of cooperating in an action that is intrinsically bad but rather apparently bad, even though it is in itself acceptable, cooperation is not licit if it gives rise to grave scandal.

We should then establish that no Catholic hospital or health-care centre should cooperate in any morally unacceptable action. Any formal cooperation makes a Catholic institution guilty of the same deplorable action in which it cooperates.

Where such a centre is obliged to cooperate it should do so in a way which means that the cooperation is material and not formal and in line with the norms of a material cooperation which expresses Catholic morality, that is to say that it is absolutely necessary for there to be a proportionally grave reason for cooperating, and that any deplorable intention etc. is excluded.[21]

CONCLUSION

In conclusion we can say that a Catholic hospital forms a part of the Church itself and as such is incorporated into the call by which Christ founds his Church. Its deepest identity is rooted in this call by which Christ creates it. This is a call to health, a call to life, even though by way of the difficult pathway of the cross which means death but which does not obscure the goal of resurrection. To heal the sick is a sign of the Kingdom of God because it is a preamble to the life in abundance which constitutes the happiness that Christ gives us, and which helps us to understand and to respond to the call that constitutes us as a Church.

A Catholic hospital must be based on the theological virtues of faith, hope and charity, and it is founded on the mission that Christ entrusted to his apostles before the Ascension: 'Preach the Gospel and heal the sick…' This mission is born in the Eucharist as its perennial actualisation. The Eucharist has a principal celebrant and this is the bishop in the local Church. Through him, Christ makes himself present in the hospital through the Love of the Holy Spirit, both in the workers of pastoral care in health and in all the health-care personnel and in the patients themselves. Christ makes himself present and gives health to everyone and the definitive form of this health is his Resurrection.

This vision of faith of a Catholic hospital should be made effective as regards the whole of its structure and operation. Special reference should be made to humanisation, the training of health-care workers, the treatment to be given to unborn and terminal human life, economic management, and cooperation with other health-care services.

H. Em. Card. JAVIER LOZANO BARRAGÁN
President of the Pontifical Council for Health Care Workers, the Holy See.

Notes

[1] Cf. NCCB, 'Ethical and religious directives for catholic healthcare services', *Medicina e Morale*, 1996/2, 340-384.

[2] Cf. Camillianum, *Dizionario di teologia pastorale sanitaria* (Edizioni Camilliani), pp. 800-804.

[3] Cf. 'El trabajo sanitario y el Catolicismo', in *El ospedale católico*, Labor hospitalaria (188/XV), 105-110.

[4] Cf. 'Palabras de Bienvenida', *Labor hospitalaria*, *ibid.*, 70-71

[5] Cf. Setién José María, 'Dimensión eclesiológica y principio de subsidiariedad que subyace', *El ospedale católico, Labor hospitalaria* (188/XV) 1983, 93

[6] Cf. Petrini Massimo, 'Ospedale cattolico', in Camillianum, *Dizionario di Teologia pastorale sanitaria* (Edizione Camilliane), pp. 800-801.

[7] Cf. E. Schillebeckx, 'El trabajo sanitario y el Catolicismo', *El ospedale católico*, *Labor hospitalaria* (188/XV), pp. 105-110.

[8] Address of the Holy Father Benedict XVI to the Seventh Plenary Assembly of the Pontifical Council for Health Care

Workers (for Health Pastoral Care), 22 March 2007.

[9] Cf. MASSIMO PETRINI, 'Ospedale cattolico...'

[10] The Bishops' Conference of the United States of America, in its document "Ethical and religious directives for Catholic health care services" (*Medicina e morale* 1996/2 340-384) specifies the three ministries of a bishop in a hospital in a clear way. It states that the bishop, as a pastor, is in a unique position to generate in the faithful a great responsibility in the healing ministry of the Church. As a teacher, he ensures the moral and religious identity of this ministry. As a priest, he provides for care for the sick. These responsibilities, these bishops say, require progressive communication between the bishop and the health-care workers, especially now that we are witnessing a great change in the field of medicine, offering an authorised teaching in the fields of morality and pastoral care, acting thereby as a guide and director, although no answer exists for every dilemma that arises…

[11] Here the Bishops' Conference of the United States of America states that a Catholic hospital must work together with the local parishes, privilege the administration of the sacraments, and in a special way the Eucharist, attend to the administration of the sacrament of penitence, train ministers of the communion according to the prescriptions of the Church, pay special attention to the administration of anointing of the sick, and that all Catholics must receive the holy Viaticum when circumstances so require it. In addition a Catholic hospital must attend to baptism in a situation of urgency and to how priests should on this case administer the sacrament of confirmation (*Ethical and religious*...., pp. 340-384).

[12] Massimo Petrini, in the work quoted above, mentions the position of Rev. Gemelli in the this point and who found this to be one of the strongest characteristics of a Catholic hospital.

[13] The *Charter for Health Care Workers* of the Pontifical Council for Health Care Workers, is very explicit in listing these rights, especially at the moment of death of the patient (cf. Charter for Health Care Workers, Vatican City, 1995, 107-109. Cf. also NCCB, *Ethical*..., pp. 340-384.

[14] *Charter for Health Care Workers,* .pp. 66-73.

[15] Cf Commissione degli ospedali della Chiesa cattolica, 'Configuración del ospedale católico', in *Labor hospitalaria* (188/XV)1983, 72-77

[16] Cf NCCB, *Lc*.

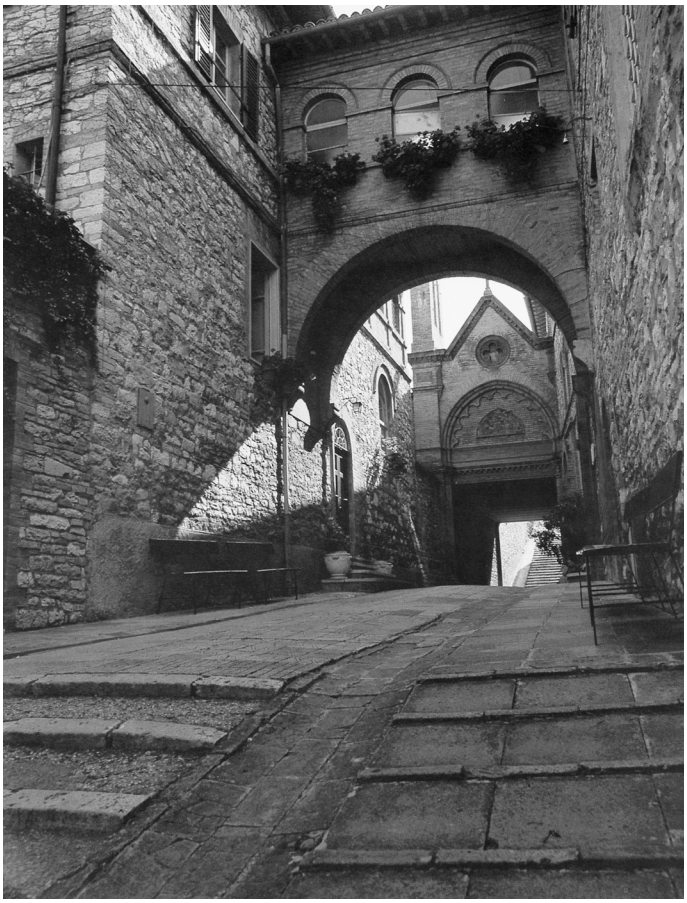
[17] For an analysis of this question see *Charter for Health Care Workers*, .pp. 23-48, and NCCB, *l.c*.

[18] The above mentioned Charter for Health Care Workers devotes the whole of its third part to this point under the heading of 'dying', cf. pp. 95-124. The bishops of the United States of America also consider this point, cf NCCB, *Lc*.

[19] Cf. MICHAEL PLACE, 'Report of the Catholic Health Association of the United States', Pontifical Council for Health Care Workers, Symposium, 25-26 September1998.

[20] Thus Schillebeckx refers to the need to practice retributive justice with all those who work in a Catholic hospital, *El ospedale católico...l.c.*. The Commission for the Hospitals of the Catholic Church makes the same observation, cf. *Labor hospitalaria*, 'Configuración del ospedale católico', pp. 72-77.

[21] This is what is stated by the bishops of the Bishops' Conference of the United States of America in the declaration that has already been quoted in this paper, *Ethical and religious directives*..., *l.c*.



THE CHARACTERISTICS OF CATHOLIC HOSPITALS

I. The Characteristics of the Challenges Facing Catholic Health Care as it Exists in Asia

1. Introduction

1.1 The voice of the Church

Pope John XXIII said that health care was a basic human right that stems directly from the right to life itself. These were the prophetic words spoken by him in 1963 in the encyclical *Pacem in terris*. The Catholic Church in its official catechism, *The Catechism of the Catholic Church*, reaffirms the same teaching: 'Concern for the health of its citizens requires that society helps in the attainment of living conditions that allow them to grow and reach maturity: food and clothing, housing, health care, basic education, employment and social assistance' (n. 2288).

1.2 The voice of international bodies

After Pope John XXIII this voice was taken up by the International Conference on Primary Health Care which was convened by virtually all the member nations of the World Health Organisation (WHO) and UWICEF in Alma-Ata, Kazakhstan, in 1978. The Alma-Ata declaration of 1978 emerged as a major milestone in the field of public health (outside the Church) and identified primary health care as the key to the attainment of the goal of 'health for all'. Twenty years later an international meeting on primary health care, which met in Almaty, Kazakhstan (in the same city of Alma-Ata which had changed its name to Almaty), reaffirmed the same goal.

On 15 April 2005 the United Nations Commission on Human Rights passed a resolution urging state governments to achieve the right to heath and called upon the international community to continue to assist the developing countries in promoting its full realisation. It also encouraged state governments to reorganise the needs of persons with disabilities as well as their families. Gender justice was another focal point in health care. Since my task is to outline the challenges facing health care as it exists in Asia let me go straight away to an enumeration of the challenges.

2. Challenges

– Infectious diseases constitute a major cause of premature death, especially of children under the age 5 and an equal number of young adults annually.

– Since the global eradication of smallpox, 30 new pathogens have been identified, including HIV/AIDS, Hepatitis C and E, new strains of vibrio cholera, etc

– The emergence of drug-resistant pathogens and insecticide resistant vectors have made it difficult to control and treat some infectious diseases. Non-health determinants such as the environment, pollution, malnutrition, poverty, illiteracy and/or ignorance and behavioural attitudes contribute to the persistence of these diseases.

– Diseases such as tuberculosis, leprosy, malaria, filariasis, Japanese encephalitis, nutritional blindness and other deficiencies, HIV/AIDS, sexually transmitted illnesses, and psychoactive substance abuse, are all areas of special concern to us. The adverse effects of these illnesses are not limited to individuals alone. Families and communities face serious problems of economic deprivation, stigma and discrimination. Concerted efforts are required to reach out and provide services to the millions of people who suffer from these illnesses.

– Persons who are classified as terminally ill, such as certain types of cancer patients, HIV/AIDS patients, etc., who are in the dying stage, have the same physical, emotional and spiritual need as everyone else. The health-care system does not cater to such needs.

– Even though health care is a duty, and state governments address the vast population through different centrally sponsored schemes, a lack of funds and facilities as well as of trained personnel has become a chronic problem. The uncommitted and profit-oriented services of the medical personnel are further reasons why poor and low-income families are deprived of proper health care.

– International conflicts in terms of ethnic clashes, religious enmities etc. and natural calamities have caused the displacement of huge numbers of people to refugee camps and congested and unhygienic areas, thereby affecting the health of hundreds of thousands of people. Health care for such a population is often not only not available but even denied, thereby generating misery and human rights problems. Often infectious diseases take a heavy toll. Vulnerable groups such as pregnant and breastfeeding moth-

ers, the differently abled, the elderly and orphans, suffer the most in such situations.

– Deadly diseases such as malaria, Hepatitis C and E devastate the lives of millions of people in Asia. The pharmaceutical companies that invest in research and development do not like to invest money in inventing an effective vaccine to prevent the outbreak of these diseases, especially in particular areas, because these companies think that they will not derive much profit from such a vaccine. Up till now no world pressure has managed to make pharmaceutical companies invest in such a field.

– Do we need ethical criteria to decide whether a certain percentage of a county's gross national product (GNP) is adequate or not for its expenditure on health care? At present we do not have such ethical criteria. Who has the authority to produce such criteria and if they are reliable why has this not been done? Who has the right to enforce such criteria? These are challenging questions that should be answered.

– We need global financial solidarity to improve the efficiency and quality of health care, particularly in low-income countries, in Asia. Often there is economic solidarity to finance economic development projects but not necessarily in health-care institutions, and in particular for the poor and marginalised.

– Fairness is an important consideration in the just distribution of health care. It is based on the principle of non-discrimination.

Unfortunately gender biases exist. Women in developing countries are often in poor health and overburdened with work. They are very tired, most are anaemic, many suffer from malnutrition, parasitism and chronic ill health, because of a lack of personal attention and adequate health care, especially during pregnancy and childbirth. Early marriage, repeated childbearing, ignorance, poverty and manual labour, all have their deleterious effects. It has been estimated that every sixth death of a female infant in India, Bangladesh and Pakistan is due to neglect and discrimination.

The discrimination between the urban and rural population is yet another reason for the disparity in the just allocation of health-care resources. A proliferation of medical equipment and technologies in urban areas has led to excess capacities and the consequent irrational use of these technologies. In developing countries, governmental health services are inaccessible to a large section of the population, especially to those people who live in rural areas.

In the market of health-care delivery, the parties involved, namely doctors and patients, measure and judge their own destinies independently of each other. Each of them buys and sells freely so as to gain maximum personal satisfaction. The efficiency or cost reduction which the market is said to achieve is a value and social goal worth striving for. The great drawback of this model occurs when poor people lack adequate resources to buy health care in the market. The result is that this competitive model does not guarantee minimum standards of care. Other factors such as a scarcity of health-care resources and inadequate information where patients hardly understand the quality or cost of alternative treatments prevents people from making proper choices about the competing providers of health care.

Another challenge we face is the fact that people's responses to illness, health care and health-related behaviour generally are profoundly influenced by what the mass media portrays. Cultures construct personnel experiences of illness and health. A good understanding of such health factors is essential for health educators and the providers of health services. People interested in the media must also be concerned with the role of the media in influencing this so that both fields can benefit from the interaction of these two fields.

Health research in general has underemphasised the role of the popular media in constructing and influencing the experience of illness and in forming expectations of health care.

3. Conclusion

These are but some of the grave challenges facing the health-care system in Asia. Those interested in health care in Asia must seriously address these challenges in order to achieve the overall improvement of health in a holistic sense within the health-care system.

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II. The Challenges for Catholic Hospitals in Europe

Premise

In this paper of mine I have based myself on the training that I have acquired and on the experience and knowledge that I may have about the continent of Europe.

As a Church I believe that with difficulty in our institutions we will be able to conserve the same points of reference that we have had hitherto.

Today in our continent there are needs at the level of health care that are different from those of the times when our founders were alive.

In all the countries of Europe there is a network of health care organised by the state that is rather substantial, whereas our position is that of complementing and supplementing. For this reason, I would like to try to indicate certain of the challenges that are already underway, and others that will arise in the future, connected with the way in which we will be present in the world of health care.

In order to define what a Catholic hospital is we should begin, in my opinion, from points that I see as being basic and which, without being essential, have nonetheless a certain influence.

Catholic Hospitals or Centres

'Are hospitals or centres promoted by the Church to do good to people through care and accompanying, trying to evangelise through witness to charity, together, when this is suitable, with catechistic and sacramental action?'

Specifically because we are in Europe I would like to point out the following:

– *The direction and context of centres*: our opportunities at the level of actuation vary according to whether one is dealing with an important hospital centre, such as a general, specific or intensive-care hospital which is integrated into the health-care network and has public resources for its activities, or another kind of centre such as old people's homes, private clinics, etc. which are normally maintained with their own resources or donations and which have less bearing on the subjects of bioethics that are present in our society.

In the first case, we can organise the health care that we provide by basing ourselves on the positive laws of the state, some of which do not allow a conscientious objection option for institutions and others that do not allow a conscientious objection option for health-care workers. In other cases, we can define with sufficient freedom what we are called upon to do.

– *The range of centres*: the breadth of the health-care mission in centres has its repercussions as well. In every centre a promotional group of believers is present, whether made up of members of the laity or of a religious community, which directs the apostleship that is engaged in within that centre.

Depending on the importance of the centre, there are a large number of Catholic professionals who share the philosophy on health care of the centre, whereas those who do not share it enrich the health-care project with their values even though they share only some of its aspects because they are distant from the Church or belong to other religious confessions.

Then there are many patients and their family relatives who do not share our way of directing our lives beginning with faith in Jesus Christ but who must, however, be understood and respected as regards their way of seeing reality and directing their own existences and in living illness and death.

Elements that Should be Borne in Mind when Looking at the Future

The riches of an approach that begins with the spirit of the founder

Inside Catholic centres or hospitals there is always a body that promotes them: dioceses, parishes, foundations or religious Orders and Congregations. We must always be illuminated by the Word of God, by the Magisterium of the Church, and by the reflections that theologians or thinkers make about reality.

Although we live in an increasingly secular society, there are many people who follow with fervour the spirit of the impulse of a foundation and in the case of religious Orders follow the spirit of the man and woman founder.

Those who work in an institution or other people who are connected with it, volunteers or benefactors, take part after a certain fashion in this spirit.

There is also the possibility of organising the pastoral services with greater freedom: pastoral groups supported by wages, visitors to the sick, a chapel with a timetable for celebrations, concern in the health-care services to call a priest in urgent situations, etc.

Beginning with the values of the institution concerned, the forms of actuation are studied, selected and applied with the consulting of ethical health-care committees and ethical committees on clinical research.

The values that are promoted

The values that Catholic institutions promote are based upon the Gospel. It is true that in relation to specific questions and issues in some centres of reference there is a certain divergence of views amongst

Christians themselves and that at times we find ourselves in a kind of 'no man's land' illuminated by the principles of the Magisterium but actively involved in daily health care. This leads us at times to act in line with conscience when it is believed that it is necessary to have recourse to a benevolent application of principles.

With regard to the experience that I myself have had, I should say that in our centres there are prevailing approaches and human warmth that ensure that the people who are cared for appreciate the style of health care that is practiced. In our hospital the patients and their family relatives are at the centre of attention because of the human treatment that they receive, the various activities that are promoted along these lines, and the presence of figures such as psychologists, social workers, voluntary workers, priests, women religious or other members of the pastoral service, who are always attentive to their spiritual needs and, where this is appropriate, to their religious needs as well.

The evangelisation that is engaged in during numerous moments of the health-care process

The pastoral team, from the moment that patients enter the hospital, tries to understand the situation of the patient and his family relatives. Although there are admissions that last only a few hours or days, and in such situations one can do very little, there are others which are very long because of the nature of the illness.

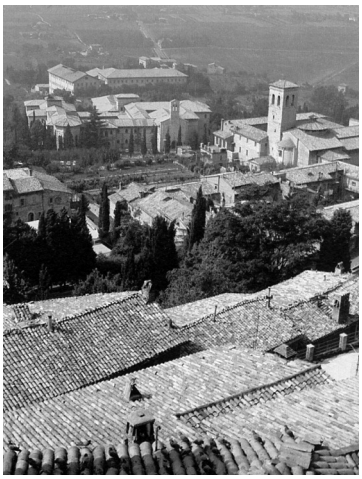
In this case patients are accompanied at the level of their human needs: loneliness, worry, etc., and on, when this is required, to the deeper aspects bearing on the religious dimension which arise spontaneously. There are cases that really stimulate us and provide us with the strength to continue our apostolic dimension with enthusiasm.

Indeed, in order to achieve all of this, the workers have to be well trained at the level of pastoral care in health and bioethics in order to respond as a Church to the needs of our time.

The ability to respect other approaches to life

Although good will is very helpful, it is always necessary to begin with high professional levels in what is engaged in. It is certainly the case that at a technical level the best that is possible must be offered but it is also necessary to promote humanisation and accompany sick people in their questions about their grave illnesses and the drawing near of death.

In pastoral action it is necessary to respect the approaches to life that those who are in front of one have engaged in and to try to respond to the needs that this involves in admissions to hospitals or health-care centres.



The great evangelising sign of charity

We operate in a world in which we must give great emphasis to the theological virtue of charity. Good pastoral action passes by way of evangelisation, the celebration of faith, and witness to charity.

In his encyclical *Deus caritas est*, Benedict XVI reminds us that these three actions complement each other. They must pull each other forward in a normal process.

But the Pope also states that each one has its own meaning. Thus when it is not suitable to engage in evangelisation and the celebration of faith, it is suitable to engage in witness to charity. 'God is love and… God's presence is felt at the very time when the only thing that we do is to love' (*Deus caritas est*, n. 31c). We must always act in awareness of the fact that in loving others we make God present in our lives.

How to ensure that many of the existing centres continue as centres of the Church

In the past the Church had many opportunities to promote many social and health-care initiatives, amongst which we find our Catholic hospitals.

Another challenge that we have before us is that of discerning the most suitable form to be adopted so that our centres can continue to exist. Indeed, what has been pointed out hitherto in this paper has sought to outline a different form by which to continue works in line with what is possible as centres in which the Church is present.

Conclusion

With this brief paper I hope that I have offered certain ideas for reflection. We will have the possibility to complete what has been said, to manage to discern challenges, and thus respond to the characteristics that we think our Catholic centres should have.

We cannot follow the approaches of our world as regards what we see as being far from the Gospel, but we must adapt to the reality of the world in which we are called to live and operate.

I will end with one of the prayers of Jesus to the Father: 'I do not pray that thou shouldst take them out of the world, but that thou shouldst keep them from the evil one. They are not of the world, even as I am not of the world' (Jn 17:15-17).

Bro. PASCUAL PILES FERRANDO OH,
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II. Catholic Healthcare in the Americas: Characteristics, Challenges and Responses

Introduction

It is an honor to be invited to participate in the Third International Congress of the International Federation of Catholic Healthcare Institutions, to meet with others involved in healthcare around the world, to share insights gained through experience, and to reflect on the Congress theme "Aggiornamento of the Catholic Healthcare Ministry." As we gather in Rome during the Easter Season, we celebrate the salvation accomplished by the death and resurrection of Jesus and remember with joy and gratitude that he came to heal the whole person – body, mind and spirit.

Institutional Catholic healthcare participates in the mission and ministry of Jesus who "went all over Galilee teaching in their synagogues, preaching the Good News of the Kingdom and healing all sorts of sickness and diseases" (Mt 4:23). Just as Jesus exercised his ministry within the milieu of his time and culture, those involved in Catholic healthcare today exercise their ministry in the context of the political, economic and social systems where they are located. In my presentation, I will situate Catholic healthcare in the realities of the continent, outline challenges faced by Catholic healthcare providers, and share some creative responses to these challenges.

The Americas

"The Americas are the lands of the Western Hemisphere consisting of the continents of North America and South America with their associated islands and regions. The Americas cover 8.3% of the Earth's total surface area (28% of its land area) and contain about 14% of the human population."[1]

A Snapshot[2]

Area	Population	Land mass	Political/ geographic divisions
Canada	32,819,700	3,854,085 sq mi	10 Provinces 3 Territories
Contiguous United States	301,106,000	3,700,000 sq mi	48 States
Latin America	548,500,000	21,069,000 km	20 Countries, each with internal sub-divisions

Healthcare in Canada, the United States and Latin America

Healthcare in Canada has long been a source of national pride and is a core value in Canadian history and culture. Its origins are Catholic: in 1639 Augustinian Sisters founded the Hotel Dieu in Quebec City, the first Catholic hospital north of Mexico. In 1957, Tommy Douglas, the Premier of Saskatchewan, established Canada's first public hospital insurance plan. The Canadian Health Act of 1984, which has been revised several times, outlines national standards for public healthcare delivery.[3] Known as "medicare," the Canadian system is publicly financed but privately run; it provides universal coverage, and care is free at the point of use. The Canadian system is funded primarily by tax dollars, and the ten provincial governments are responsible for planning and financing the provision of care. Hospitals and hospital systems are predominantly private, non-profit organizations funded by public monies via provincial budgets. Physicians are mostly in private practice and remunerated on a fee-for-service basis by the provincial health plan. The intention is to provide core services to every Canadian.[4] Catholic hospitals contract with provincial governments to provide services consistent with the Health Ethics Guide developed by the Canadian Catholic Health Association and approved by the Canadian Bishops.[5]

The current system in Canada is undergoing change caused in part by "creeping privatization" and the impact of "limitless demand, an aging population and the costly advance of medical technology."[6] One effect of the effort to control costs is longer wait times for services in heavily populated areas. The major challenge in Canada today is to prevent a two-tiered healthcare system from establishing itself to the detriment of the publicly funded system.[7]

In Mexico, there is a system of public medical care, but the government systems are in bankruptcy. In other countries of Latin America there are some national systems financed by taxes, but the reality is that payment for primary care is the responsibility of individuals and families. In urban areas, there are hospitals that are accessed by the rich, including people from outside the country, who can afford to pay for care. This situation leaves rural people, ethnic and racial minorities and the urban poor particularly vulnerable. The World Health Association

reports that 1 of 4 persons in Latin America cannot access primary healthcare, either because there are no facilities available or because the individuals cannot pay.[8] There is no Catholic Health System in Latin America, but there are hospitals built and/or financed by religious congregations and other Catholic organizations, often from outside the countries.

Healthcare in the United States is provided by not-for-profit and for-profit private and public institutions. Most physicians are organized into groups that contract with insurance companies for payment for services. Costs of services–physicians, testing, hospitalization, home care and hospice–are covered by employer-based and/or private insurance programs, individual payment or by state and federal safety-net programs. There are over 600 Catholic hospitals; many of these are in rural areas and they represent 12% of hospitals in the United States. There are about 60 Catholic healthcare systems.[9] Currently, Catholic healthcare facilities are financed through public funds (Medicare/ Medicaid), third-party payers (insurance), and philanthropy.

Healthcare – a Human Right or a Commodity?

While there are clearly differences in the organization of healthcare in Canada, the United States and Latin America, an underlying issue facing each region is the question of whether healthcare is a basic human right or a commodity. The political and economic answer to this question determines what services are provided, for whom, where these services are located, and how they are financed. In all countries, there are challenges related to how costs are shared by government, employers, individuals and providers. In countries lacking a conviction that healthcare is a human right, and without national consensus about how to provide and finance healthcare for everyone, the disparities in access and quality of care continue to grow.

In the United States, 46 million people are uninsured. One in 6 people receive care in Catholic facilities. Reimbursement through government programs continues to decrease while the costs of providing care continue to increase. Catholic healthcare providers have assumed responsibility for many of the uninsured through free-standing and mobile clinics and by expanding their charity care coverage in in-patient facilities. They have committed financial and personnel resources for advocacy efforts to provide insurance coverage, particularly for children. They have been a catalyst for national conversations for healthcare reform.[10]

Through the U.S. Catholic Health Association, Catholic providers have committed themselves to work for "access to healthcare for everyone through legislative solutions and grassroots engagement by CHA members and Catholic partners." This advocacy seeks to ensure the continuation of governmental support for financial safety-net programs for vulnerable populations (children and the elderly). In addition to advocacy, the Association and its members are committed to offering a theological and ethical perspective to the national debate on healthcare reform.[11]

In Mexico, the challenge to all healthcare providers is to get care to the whole population. Thirty percent of the people do not have any kind of medical care; at least 50% of people do not have medical facilities in their cities or towns. Catholic healthcare is almost non-existent; there are only small, isolated hospitals. A major challenge is to find ways to partner with the private system to improve care and make administration more efficient and cost-effective. However, the "system" is characterized by wide-scale corruption, and there is a lack of political will to change the situation.[12] To provide more access, CHRISTUS Health System in the United States has partnered with a Catholic-owned facility in Mexico to provide five hospitals and numerous clinics.[13]

In Tierra Blanca, Usulutan, El Salvador, a pastoral team has improved access to healthcare by developing an extensive health program including a clinic partially funded by local families, who give twenty-five cents a month, and by contributions from non-governmental groups in Canada, Europe and the United States. There is a doctor and a volunteer clinical psychologist on site who provide primary care, vaccinations, and health education. They also help with transportation to the city for hospital care and have money to fund a portion of medical expenses in the city.[14]

There are other realities that

pose some particular challenges to providers of Catholic healthcare in Canada, the United States and Latin America.

Demographics

In Canada and the United States, more people living longer puts a strain on already stretched resources for healthcare. Situations raised in this environment include who determines the type of care the elderly receive, the place of palliative care and hospice in the continuum of care, and the application of Church teaching to end-of-life issues. In Latin America, the high number of children and young people poses challenges related to basic care and how it is best provided and accessed.

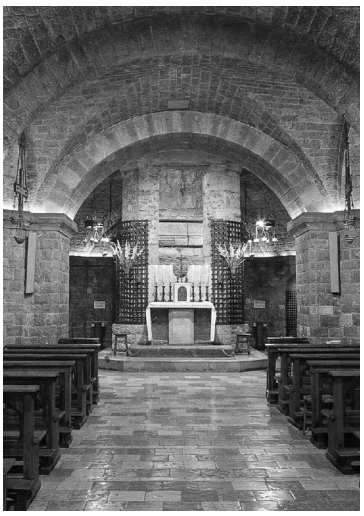
Migration and immigration patterns throughout the Americas challenge healthcare providers to care for people with increased attention to cultural and religious diversity. In the United States and Canada, increasing numbers of undocumented immigrants tax the resources of the healthcare system and accentuate the question of whether healthcare is a basic human right or a commodity.

Technology

In urban areas of all countries, rapidly advancing technology makes demands on economic resources, contributes to an environment of competition among healthcare providers, and sometimes leads to a depersonalization of healthcare. Rural areas suffer from lack of access to technology. Catholic healthcare providers are regularly faced with questions about the implications of the high costs for technology and are also challenged to balance the increasing use of technology while continuing to focus on care of the whole person – body, mind and spirit. In the United States, the demand for technology is not supported by the systems of reimbursement for services.

Clinical Advances

In developed areas, clinical advances have contributed to increased life expectancy and have shifted care from the inpatient setting to the outpatient setting. In underdeveloped areas, people suffer for lack of these clinical advances. Some clinical advances bring with them new ethical dilemmas. Because of clinical advances and societal attitudes, end-of-life issues are of particular concern to Catholic healthcare providers in the United States who are faced with applying the Church's moral tradition in settings where "treatment at all costs" is possible and desired. In these circumstances, Catholic providers have responded by developing facilities-based ethics committees and protocols to facilitate decision-making that brings patients, families, physicians and other professionals together to discern the physical, psychological, spiritual and financial aspects of treatment. At the same time, Pastoral Care departments provide spiritual resources to support the patient and family.



Labor Markets

For Canada and the United States, particularly, the demand for all types of healthcare professionals continues to exceed supply. A particular moral dilemma faced by all healthcare providers is the widespread recruitment of healthcare professionals, especially nurses, from the Philippines and Africa who come into the United States and Canada through agencies that move these recruits through Europe and the British Isles. Most rural doctors in Canada are from Africa. This begs the question of whether North American countries are served by healthcare providers who could be serving in their own countries.

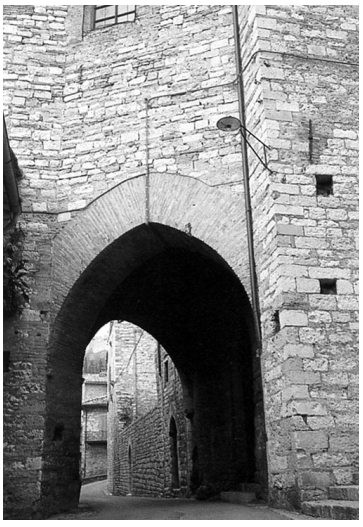
Natural Environment/Ecology

The degradation of the environment – especially of the air and water – is responsible for the degradation of health and the increase of disease. Diarrhea, respiratory infections, perinatal conditions and heart disease can all be linked, at least in part, to environmental conditions. Environmental issues are local and transcend geographic boundaries; e.g., in the Americas pollution from factory and car emissions wafts across the borders of Canada, the United States and Mexico. As members of the global community and as persons committed to the health of the whole community of life, Catholic healthcare providers in the United States and Canada are examining their practices related to the purchase, use and final disposition of all material resources.[15]

The Challenge of Catholic Identity

Beyond all of these challenges of external factors to Catholic healthcare in the Americas, I believe that the most foundational challenge is that of defining and appropriately expressing Catholic identity. As John Allen has observed, the definition of Catholic identity is frustratingly illusive, but there is a growing sense, especially in Canada and the United States, that Catholic healthcare "needs more of it."[16] This challenge is shared today by all Catholic ministries–education, healthcare and social services.

The first aspect of Catholic identity I would like to discuss is how Catholic healthcare relates to the mission of the Church. Frank Monks, M.I., writing in the UISG Bulletin (November, 2006), states that there is a need "to make the Church in general more aware of the centrality of healing in her mission."[17] He says that "the Church has not always shown an understanding of the possibilities for evangelizing offered by the healing of the human body, as the starting point for proclaiming the Good News…. The Church has been solicitous in fulfilling her mandate to go and teach, and to go and baptize. But she has not shown herself too sure as to how to go about implementing her mandate to go and heal."[18] Those individuals and groups engaged in healthcare throughout the history of the Church have extensive experience with how the vulnerability of the sick is an opening for evangelization and pastoral care, not only for the patient but also for the family and larger society. This experience needs to be shared and reflected on more broadly by bishops, lay ministers and Catholic healthcare providers. That some Catholic healthcare providers in the United States



and Canada have been reaching out to parishes to engage more members of the faith community in support of the sick is evidence that there is increased understanding of the Church's responsibility for health and healthcare.

The hierarchical Church has often enough been satisfied that particular religious communities were continuing Christ's compassionate and healing presence through their hospitals and homes for the aging and dying. As the numbers of religious men and women have diminished in Canada and the United States and as various forms of sponsorship (governance) have been developing, the whole Church has had to reassess its relationship to the continuation of Christ's healing ministry and its responsibilities to Catholic healthcare facilities of all kinds.

Another Catholic identity challenge is related to the role of Bishops in Catholic healthcare. Their inexperience about the challenges facing Catholic healthcare in the current social and political environment has led to public statements that cause confusion, to judgments about how particular institutions are applying Catholic teaching, and/or to decisions that were not made in consultation with those closest to the situation. Catholic healthcare sponsors and leaders are working to develop mutual respect for relationships with Bishops that form the basis for on-going conversation, deeper understanding and more consensus about the direction of the ministry.

From another perspective, all those responsible for sponsorship, governance and management of Catholic healthcare must reflect constantly on the ministry in light of the mission of the Church and the marks of Catholic identity. Based on Catholic social teaching, Catholic identity for healthcare:

– Is grounded on respect for the dignity of each person.

– Is holistic, taking into account the whole person–body, mind and spirit.

– Sees itself within the larger community and contributes to the common good.

– Is committed to providing a work life characterized by justice, dignity and collaboration.

– Has a preferential option for the poor.

– Has a special focus on issues related to the beginning and end of life.

In most of the countries of the Americas, the secularization of society and the diminishment of the dignity of the human person are direct challenges, even threats, to the characteristics of Catholic identity outlined above. In some countries, there are legislative assaults on specific Catholic values, particularly around reproduction and abortion. In the United States in the last several years, there have been concerted threats to Catholic identity in the form of challenges to the tax-exempt status of Catholic institutions, attempts to limit the exercise of particularly Catholic ethics, increased scrutiny around organizational practices related to executive compensation, billing and charges, and care for the poor activities. These challenges often seem motivated by an anti-Catholic sentiment that hampers the voice and activity of the Catholic Church in the larger social arena. In Canada, Catholic healthcare providers are faced with demonstrating that they have a right to operate within the system; they must provide value to the system by being excellent providers.[19]

Overall, the challenge to Catholic identity might be framed as a question of how institutions will remain faithful to their roots in the healing mission of Jesus and how to maintain and practice ethical beliefs within pluralistic societies. Another way of reflecting on the challenge to Catholic identity is in terms of ministry and business–do financial and organizational demands overwhelm the charity and compassion that is essential to the ministry?

In the United States a particular challenge to Catholic identity has come through union organizing efforts. At least partially because union membership is down and because the political influence of unions has lessened, Catholic hospitals and systems are experiencing increased labor organizing efforts. These orga-

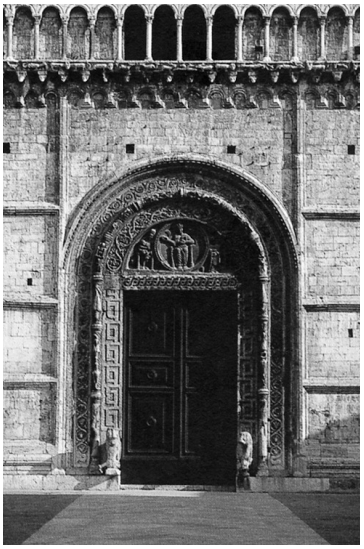
nizing efforts include the worker-led calls for union representation as well as a strategy called the "corporate campaign." One aspect of this campaign involves union representatives approaching healthcare administrators with proposals for agreements and processes that go outside of current federal law governing elections. Other strategies include mobilizing religious leaders, elected officials and others outside the workplace to exert pressure on the employer to agree to union representation.[20] Since unions have been closely identified with the Church's social teaching and because unions have been such a powerful force for advancing the dignity of workers, discerning how to respond to the call for unionization under these circumstances is a challenge to the Catholic identity of many institutions. In this environment, Catholic healthcare leaders have been given the opportunity to re-examine Catholic social teaching and its application in the current social, economic and political circumstances in the United States.

Sponsorship

The decreasing numbers of men and women religious in Canada and the United States have led to major changes in the organization of Catholic healthcare ministry. As membership decreased and the delivery of healthcare in these countries became more complex, religious congregations developed a variety of structures to ensure the Catholic identity of the ministry and its connection to the Church. Some of these structures maintain one religious congregation in the oversight role; others bring together two or more religious congregations who oversee the ministry together. As the idea of sponsorship has developed, other structures have been developed to include lay and religious men and women sharing the responsibility for the ministry.

Canada faced this a bit ahead of the United States; and today, in Canada, most Catholic organizations are out of the hands of religious congregations and are governed by Boards of Public Juridic Person (Church Corporation), some accountable to local Bishops, others to Rome. Most of these Public Juridic Persons are geographically bound, but there are efforts to build relationships and share resources across the country.[21] In the United States, there are many systems comprised of two or more sponsoring congregations, and there are six Vatican-recognized Public Juridic Persons, each organized in a slightly different way.

The development of these



new structures has given greater urgency to the questions of Catholic identity. In addition, other issues facing these organizations include: developing relationships with the hierarchical Church, evolving understanding of sponsorship responsibilities, appropriately maintaining the particular legacy (charism) of the founding group(s) while embracing the language and reality of the healing mission of Jesus, and the formation of sponsors.

The development of these alternative structures of sponsorship and governance represents great detachment on the part of the religious congregations; they have put continuation of Catholic healthcare ahead of their role in it. It also demonstrates great confidence in the laity who are assuming greater and greater responsibility for the Church's mission and ministry.

Formation of the Laity

As described above, the responsibility for the sponsorship and governance of Catholic healthcare institutions in Canada and the United States is increasingly being shared with, and in some instances being entrusted entirely to, lay men and women. This is the result of embracing and implementing the Second Vatican Council's affirmation of the laity's role in the Church's mission and ministry, as well as because of the decline in numbers of men and women religious. The challenge is to be sure there is a critical mass of committed leaders prepared to assume responsibility for the Church's ministry of healthcare. In the present, the need to develop a large number of new lay leaders challenges Catholic sponsors and institutions to provide the financial and programmatic resources for the needed formation programs.

Catholic healthcare systems are working with one another and with institutions of Catholic higher education to develop formation programs that are a gift to the ministry and to the Church. These comprehensive programs of formation include theology, ethics and philosophy, as well as spirituality. These programs foster a sense of vocation, develop an understanding of the charism of the Church and support a personal relationship with Christ. Benedict XVI, in his encyclical letter "Deus Caritas Est," describes the characteristics of the ideal formation. "All those responsible for carrying out the Church's charitable activity" must be motivated by love and guided by faith, they must be "professionally competent and properly trained." Beyond proper motivation and training, they need "a formation of the heart."[22] In the United States and Canada, there is a particular need to train and mentor ethicists for service in

Catholic healthcare because the current generation of ethicists is retiring.

Summing Up

Catholic identity, formation of the laity, healthcare reform, finances and governmental realities, societal attitudes and structures, and environmental issues–these are the challenges, as I see them, to Catholic healthcare in the Americas. Within each of the challenges are signs of new life and seeds of hope. I look forward to exploring them with you during the rest of the Congress.

Sr. KATHERINE GRAY, CSJ
President of CHA, USA

Notes

[1] "The Americas," Wikipedia, Internet Encyclopedia.
[2] Research done by Carmel Anderson, CSJ.
[3] Canadian Healthcare website.
[4] BENEDICT IRVINE AND SHANNON FERGUSON, "Background Briefing: The Canadian Health Care System".
[5] Information provided by Gerard Lewis, President & CEO, Canadian Catholic Health Association; and Michael Shea, CEO, Alberta Catholic Health Corporation.
[6] BENEDICT IRVINE AND SHANNON FERGUSON, "Background Briefing: The Canadian Health Care System" .
[7] Information provided by Gerard Lewis, President & CEO, Canadian Catholic Health Association; and Michael Shea, CEO, Alberta Catholic Health Corporation.
[8] Research done by Mary Therese Sweeney, CSJ.
[9] Catholic Health Association, USA, website.
[10] *Ibid.*
[11] Catholic Health Association, USA, 2007-2009 Strategic Plan.
[12] Information provided by Teresa Stanley, CCVI, CHRISTUS Health System.
[13] *Ibid.*
[14] Information provided by Mary Therese Sweeney, CSJ.
[15] St. Joseph Health System Environmental Trends Report, 2005; and American Hospital Association Environmental Assessment, 2006.
[16] JOHN ALLEN, "Demonstrating Catholic Identity in the World Today"– Talk given at Annual Trustee Conference, St. Joseph Health System, October 2006.
[17] FRANK MONK, MI, "The Church and the Catholic Healthcare World," *UISG Bulletin*, No. 131, 2006, p. 38
[18] *Ibid*, p. 39.
[19] Information provided by Gerard Lewis, President & CEO, Canadian Catholic Health Association; and Michael Shea, CEO, Alberta Catholic Health Corporation.
[20] RICHARD HAUGH, "The New Union Strategy: Turning the Community Against You"– Hospitals and Health Networks, May 2006.
[21] Information provided by Gerard Lewis, President & CEO, Canadian Catholic Health Association; and Michael Shea, CEO, Alberta Catholic Health Corporation.
[22] BENEDICT XVI, "Deus Caritas Est" – 2005, par. 31a).

IV. The Characteristics of the Challenges Facing Catholic HealthCare: The African Situation and Way Forward

The Context in which Healthcare is Delivered in Africa: The African Health Dilemma and the Church's Contribution

Africa today has the poorest health situation in the world, this is a fact that needs not be dilated upon further, and in particular, the health status of the poor and marginalized in Africa is deplorable. The HIV/AIDS pandemic in Africa has caused untold suffering and death which has no comparison in magnitude in the history of the continent.

The challenges facing African countries in achieving an acceptable standard of healthcare for their populations are similar if not the same and many African governments, though accepting and assuming responsibility for the health of their people, have come to the realization that they alone cannot provide the quantity and quality of services required.

The factors dictating the state of health have been identified at national and international fora as primarily socio-economic and political in nature. Nationally, the levels of poverty in Africa makes healthcare unaffordable to most people. The Church's health services are predominantly situated in rural very poor areas. Church-state relationships in the area of health is strained and characterised by competition and mistrust in most African countries, with the state not readily supporting the Church in its efforts to provide healthcare services. Internationally, global level decision-making sets the direction in health and is recognized as having a great impact in determining the direction of healthcare, especially in Africa. Unfortunately Africa and its healthcare providers, including those of the Church, are not effective participants in the global discussions and decision-making processes that invariably affect the continent.

The provision of healthcare in the world in general has become a very complex task requiring highly trained professionals who have to do a lot with very little, effectively, efficiently and equitably. Health sector reforms in many African countries over the past two decades have demanded more efficient management, adherence to national health standards and professional norms as well as improved quality of healthcare from all healthcare providers. The migration of health professionals in Africa to other countries, especially Europe, the United Kingdom and America (the brain-drain) is probably the largest significant challenge affecting the health sector in many African countries. These challenges are not peculiar to government/public healthcare services alone but also particularly apply to private mission healthcare services such as the Church's, which provide services to relatively poor populations in a not-for-profit manner in situations made more difficult by the present world socio-economic order and local economic challenges.

The Catholic Church and other Christian Churches are major providers of healthcare throughout the world. In Africa, the Church's contribution to healthcare is vast and crucial. In a significant number of African countries the Catholic Church provides 15% to 60% of the healthcare available to the general population. The dynamics of the local Church in health has changed drastically over the past two decades as well and is characterized by fewer expatriate religious who are holding on strongly to the ownership and control of health facilities and programs, local religious and lay management teams who have not been exposed to the resources and networks of the founding expatriate congregations and thus are unable to obtain resources to measure up to the high standards set by their predecessors. In addition, there are more local religious, without professional training or capacity, who have been put in charge of the management of health institutions. Where two decades ago there were virtually no local health professionals, now, the brain-drain notwithstanding, there are significantly more local health professionals working in the Church's health institutions who question the authority of unprofessional religious (whether local or expatriate) who are put in charge. With the increase in lay workers TRUST no longer serves as an adequate basis for leadership appointments and assurance of accountability.

In whichever way the issue of healthcare in Africa and the contribution or participation of the Church in meeting these challenges is addressed, there is no doubt that Africa has changed and so has the Church in the context of healthcare. The needs and requirements have changed and a new paradigm must be looked for and developed to enable the Church in an effective and sustainable manner to support Africa in meeting its present and possible future needs.

Strategic Approaches Required for the Church's Health care Delivery in Africa to be Improved and Sustained

The Church in Africa needs

to recognise change, organisational re-structuring and development, enhanced professional practice, development of partnerships and increased transparency in its operations as critical strategic approaches to follow if it is to remain relevant as well as to provide care in a sustainable manner.

Why Change? Fundamentally, the Church, and especially the founding congregations, must recognize and appreciate that things have changed. The international and local health environment has changed. The human resource dynamics of the local Church has changed. The Church in Africa must position itself to be an effective and efficient strategic partner for respective governments in the provision of high quality yet affordable and appropriate healthcare. The Church in Africa must *be mindful of* these changes and accordingly adapt if it is to remain relevant and sustainable into the future in Africa.

Why organizational re-structuring and development? There is a general lack of appropriate functional structures, policies and guidelines upon which services are delivered, unclear lines of communication and ownership, unclear or subjective roles, responsibilities and relationships, and A lack of policies guidelines and professional standards of practice in some countries. As more lay people get involved in the management of Church health services it has become evident that there is insufficient understanding and effective application of existing Church structures, especially by those in management, in the implementation of Church health activities

Why Professional Practice? The achievement of the highest quality of healthcare is subject to the availability not only of equipment and infrastructure but even more of the human resources available to use them effectively. Professional management skills are required now to efficiently manage the health institutions. There are now national professional regulations and standards to be adhered to by all categories of health professionals in all African countries. The provision of healthcare in Africa requires the same level of professionalism and quality as found anywhere in the world, if not more so.

Why Partnerships? The Church in Africa should not be considered 'missionary' but local. It is part and parcel of the community it finds itself in and must find ways to work with, support and be supported by that community. As governments cannot go it alone so the Church in Africa cannot go it alone. The present state of mistrust and competition in countries, a legacy of the missionary history of Church health care, must be removed. Resources abound in countries and across borders and only partnerships can bring them together (local and foreign).

Why Transparency? Church healthcare though categorized as private healthcare is delivered as a public good; the Church owns health institutions in trust for the people, to serve the people. Sustainable partnerships require transparency, trust requires transparency, and effective stewardship requires transparency.

Though the challenges seem insurmountable it is of critical importance that:

1. The Church in Africa, mindful of its mission to continue the healing work of Christ, despite the numerous challenges, remains committed and faithful in providing healthcare.
2. The Church in Africa places health high on its agenda and makes efforts to influence continental discussions, regional deliberations, and national policies to ensure that health remains a human right and not a commodity.
3. The Church in Africa continuously in practice and through advocacy ensures that the provision of healthcare, especially for the poor, marginalized, and rural segments of society, is not compromised.
4. The national Episcopal Conferences are encouraged to establish formal structured health services where they do not exist, and where they are established to further improve them through formal documented processes, procedures, operational guidelines, and, especially, professional staff.
5. The national Episcopal Conferences encourage and facilitate the active development of innovative partnerships with national governments, local and international agencies, ecumenical institutions, and within the local Church itself;
6. The national Episcopal Conferences facilitate and promote the formation of all staff working in the health services of the Church to better understand the Church's philosophy and social teachings as applicable to health in order to maintain the identity of Catholic healthcare.
7. International solidarity between the Church health services throughout the world is supported and strengthened.

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ADAPTABILITY: NEW MODELS

I. Spiritual Care in the Sphere of Assistance

1. A Need of a Spiritual Character

One of the most complex subjects that has to be addressed in contemporary societies is that of the spiritual accompanying of people. At times we have the sensation that we have the conditions available to do this but that the environment that surrounds us, and the speed of daily life, makes this impossible at a practical level. However, accompanying is a necessity above all when difficult circumstances are experienced, during moments of intense fragility in one's life. In such situations, a person feels more than ever the desire to be cared for, and to be accompanied, in an appropriate way.

One of the fundamental challenges with which the pastoral worker is faced in Western societies is that of attending to the spiritual dimensions of a person in an excellent way. Spirituality is connected with the intangible in life, including the complexity of our relationship with ourselves, with other people, and with God. Spirituality bears upon the whole of our being and generates a sort of capacity to appreciate transcendent values: spiritual man asks himself about the meaning and the ultimate purpose of his life, about the relationship that he has with what is greatest about himself, thereby supplementing and transcending the biological and psychological aspects of his own nature.

A spiritual need is intrinsically human but it has different cultural expressions. There is a mosaic of expressions of spiritual needs but beyond these one observes a shared root in human beings, even though human beings are very different at the level of colour, race, language, traditions, worship and rites. This shared root may be seen as the spiritual need that we contemplate in very varied forms at a cultural level. In secular cultures this need for the spiritual can also express itself through what Peter Berger calls invisible religion, that is to say in a way that is opposed to the habitual canons.

A human being, as has already been observed, is an incomplete being who perceives the need for natural and artificial order. But when the human being experiences *infírmitas*, illness, his framework of need changes profoundly.

Illness is not an accidental fact of a biographical cycle nor is it an irrelevant thing. Pedro Laín Entralgo, in his *Antropología Médica para clínicos*, states that illness cannot be reduced to the category of accidents given that this is irrelevant in the structure of the person. Illness, on the other hand, generates a real destructuring of the person. To be sick is not an accidental thing, above all when specific illnesses are experienced. What has to be considered is how the hierarchies of spiritual needs becomes changed as a result of the experience of illness.

There are also needs that are in a latent state but which, as a consequence of illness, then emerge in a forceful way. The need to pray, for example, can remain in a latent state but there can be an experience that means that it comes to the fore in conscious life. This can happen with the need to prayer but also with the need for silence, for symbols or for meaning.

We must thus analyse the way in which already existing latent needs come to the surface as a result of an experience of illness. This process, however, does not take place only with illness. It also takes place with other experiences, such as, for example, the experience of fatherhood. The need to think about oneself and about one's own interests is transformed into a need of a collective character. As a parent I have to think about another being who is vulnerable and who relies in fundamental terms, on me.

During the course of our life cycles we undergo experiences that change our needs, and also needs of a spiritual kind. For this reason, I do not affirm that there is a static framework of needs but rather that there is a dynamic framework in which needs change or are modified according to the experiences that we undergo during the course of a biographical moment.

A man who is in love, for example, has needs that those who are not in love do not perceive. For example, he needs to be in the presence of the woman who is loved, to see her, to feel her, and to be with her. The absence of that person is a painful experience. When a man is in love he feels the need to be with the woman who is loved, and to win her over.

There are needs which were not present in our lives previously but which now appear as consequences of a new experience. In other words, there were there in a latent fashion and they then came to the surface.

A human being is limited. This, however, is not expressed in its totality because he is also able, thanks to his inventiveness, to deal with the framework of his needs, even though he does this provisionally. If we were only limited beings we would hardly have survived the struggle between the species. We have available practical intelligence, which is the ability to foresee needs, to predict them, and *to deal with them* before they arise.

I will now point to twelve needs that we could place in

the spiritual sphere. Here, I mean by spiritual the non-tangible, that need of an intangible character that emerges from a human being as a need that is not directly rooted in the *soma*.

2. The Framework of Spiritual Needs

2.1. The need for meaning

A human being feels the need to give meaning to his life and to his existence. It is not sufficient for him *to be present* or *to subsist* or to remain in being: he has to be in being with meaning. And if he discovers that this presence does not have meaning, that to live does not have meaning, that it is something that is absurd, stupid, or foolish, he may even wish not to be, to become nothing.

This need for meaning is of a spiritual character and can be illuminated in many ways. It can find a response in different traditions, of an immanent or transcendent character, but what assimilates human beings as spiritually needy people is the thirst for meaning.

2.2 The need for reconciliation

A human being feels the need to be reconciled, to close the circle of his existence and to overcome resentment. He needs to treat his resentment and only forgiveness provides a *cure* for this. Indeed, there is no other way of treating resentment other than that of forgiveness, of reconciliation. There is no doubt that this need, which is essentially of a spiritual character, has affective and psychological expressions. It is difficult to obtain interior serenity without the real practice of reconciliation.

This need for reconciliation can take place at an immanent level but it can also occur at a transcendent level. Those who care for the sick must ensure that this takes place, and this means that they must facilitate, where this is possible, a drawing near of people in order to foster processes of reconciliation between them. In sick people who are at the terminal stage of their lives or who are in a critical condition, this need is perceived with greater intensity specifically because, as a consequence of the drawing near of death, the need for reconciliation, the need to deal with questions that hang over them, has greater urgency.

2.3 The need for the recognition of identity

The recognition of, and respect for, one's own identity, is a fundamental need and naturally has psychological and social connotations. The need for our identity not to be prejudiced, not to be crushed, is very present in human beings, but it is expressed when a person notices that processes involving the dissolution of his identity and the life references that configure his existence are at work.

A human being not only needs to know; he also needs to be recognised. He wants the whole of his identity to be recognised, that is to say what he is. When this need is not perceived correctly, he lives his identity in a very violent way. This also applies to collective identities. When a collective identity is not recognised, phenomena are generated that should never have been produced. Indeed, when the identity of the other is despised, that person feels humiliated at a fundamental level.

The need for recognition of an identity implies respect for the characteristics of the other. Identity is always defined by a constellation of aspects, amongst which we may list language, religion, sex, upbringing, and affective ties. To recognise the identity of the other means doing unto him as you would do unto yourself, it means seeing him as a subject with a name and surname, who, is despite everything, a person, a singular entity that is unique and never to be repeated in history. This means that an anonymous relationship, processes of depersonalisation, and the arrival of indifference, do not respect the spiritual need for recognition of identity.

2.4 The need for order

A human being needs order; he needs a cosmos of space and time. We are spatial-temporary beings and disorder has a negative influence on our life structures. There is no doubt that the ways of understanding the meaning of order vary from one person to another, not only at a cultural level but also at a generational level. Every human being perceives the need to live in conformity with his order and when he finds himself in a context in which he can neither express nor live in conformity with this personal cosmos he feels this very intensely.

We need to order the events of life, to order experiences. I am not referring here solely to

the need for physical order, which also influences the person, but also to order of an interior character. We feel the need to order events, priorities, feelings, and memories. Pathology is specifically a form of disorder; it is chaos in all senses. When a person falls ill, this order is disrupted, and for this reason it requires an intervention whose aim is to re-establish this order and not the order of the subject who treats.

This need for order is of a spiritual kind. Indeed, primary needs can be solved but one may still perceive the need to achieve order within oneself. It is very difficult for a person to achieve order again on their own. In general, this requires the intervention of another person; the words and advice of another person to restructure one's own world.

2.5 The need for truth

Plato defined the human being as a being who wants to know truth, who feels the need to know the essence of things. Man wishes to transcend the order of appearances, he feels the impulse to go beyond phenomena, and to understand what things are really.

This need is perceived very intensely when one is dealing with clarifying one's own reality, what each person is in reality. A sick person feels the need for truth even though he is not always ready to receive it, and even less to digest it. A health-care worker must communicate bearable truth, that is to say truth that a sick person can understand and take on board in his subjectivity.

Sometimes a subject does not want to know the truth, and for this reason he protects himself out of fear of what this truth would reveal to him. A sick person has the right to know the truth that concerns him but he also has the right not to be informed, the right to remain unaware. A health worker cannot fall into so-called exaggerated information but at the same time he cannot display indifference towards a sick person. He must try to discover why that sick person does not want to know the truth, what he is afraid of, and how to help him to overcome this fear about the truth.

2.6 The need for freedom

The need for freedom is usually identified with the need for autonomy, although it is broader. The concept of freedom, in fact, covers much more ground than the concept of autonomy. Naturally, without autonomy there can be no freedom, but freedom, from the point of view of liberation, and what St. Augustine termed *libertas*, is a liberation from all the bonds of the ego.

A human being needs to free himself from everything that alienates him and keeps him in a subordinated state. The need to act freely is very limited as a result of experience of illness but the possibility of freeing oneself from certain obsessions or internal fixations is independent of illness. To attend to the spiritual needs of the person means to respond to the need for freedom or, at a more practical level, to the need for liberation. Practice involving caring for someone that is not liberating is not excellent.

2.7 The need for rooting

The need for rooting can be explained as the wish to belong to some kind of community. This is a need for belonging. A human being, as a political and social animal, establishes ties during his life cycle and creates affective ties. When he suffers separation, or the fracture of such ties, he perceives with great force the need for rooting, the need to feel that he is linked to a population, to a community, to a family.

We tend to put down roots and to feel a need to be with our fellows. We are not uprooted beings. This need is not only of a psychological or social character. It is also spiritual because it concerns the deepest and most intangible aspect of human beings.

Human beings feel the need for tooting, especially in contexts that are characterised by individualism and by fragmentation. This need, however, is perceived the most in anonymous contexts, contexts that are empty, in contexts in relation to which a person feels extraneous. In such circumstances a person needs his community more than ever.

2.8 The need to pray

The need to pray is of a spiritual and religious character. It can be described as the need for the eternal You, the need for an existential tie with You, to employ the phrase of Xabier Zubiri.

This is a need that traverses the religions. The scholars of the phenomenology of religions state that one of the transversal aspects of the various manifestations of religion is specifically what we call prayer. This need for interlocution, for openness to an invisible and transcendent You, is produced not only in men who are religious in an institutionalised sense but also in men when they are faced with loneliness and a state of being abandoned. The more intense the experience of the fragility of *homo mendicans*, the more intense the need for You is perceived.

2.9 The need for symbols and rites

Human beings produce symbols, that is to say those artefacts that allow us to say what we can not express in words. Man plays with symbols and uses them in various contexts. The need for symbolic representation, in addition to meeting certain social requirements, is a need of a spiritual character which is expressed above all else when we cannot communicate experiences that are very deep. Thus we need symbols, artefacts and mediations to express what we cannot express orally.

We also feel the need for rites. Man is a ritual animal and feels the need to commemorate and celebrate the key experiences of his life – for example the birth or the death of a loved one. There are fundamental rituals in the world of humans which are not only of a religious character

but also of a non-religious character. We can see this in very secularised societies. The need to ritualise the key experiences of human life is an experience that is connected with the spiritual, even though not necessarily with the religious.

2.10 The need for solitude and silence

Don Miguel de Unamuno, in his extraordinary work *Soledad*, makes a distinction between two types of solitude: that which is looked for and that which is imposed. A human being feels the need to be alone, to flee from society, and to open up parentheses – space and time – of solitude. This need is fundamental for personal balance, the practice of meditation, and the aware and reflective construction of one's own identity.

The need for solitude, to find oneself, leads the subject on a journey without return. To take care of a sick person and to attend to his needs of a spiritual kind means to provide him, if he asks for it, with the experience of solitude. A basic ethical imperative in every practice involving care is to ensure that the other does not suffer imposed solitude.

2.11 The need to do one's duty

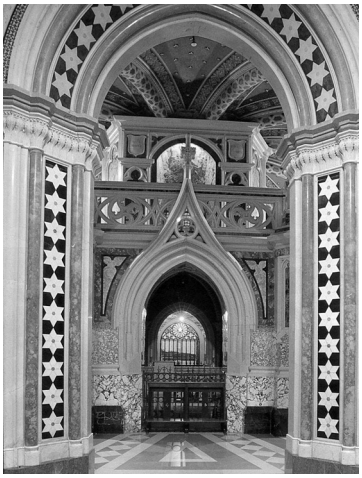
A human being feels the need to do his duty. A person feels internal malaise when he feels that he has not met his obligations. Naturally, the experience of duty is very subjective and each individual lives this experience according to his own nature. But the need to do one's duty is specific to a free subject capable of self-determination and the regulation of his own life.

To take care of somebody means to help that person to think about, and express, his duties. A terminally ill person finds peace if he draws near to his end with the clear awareness that he has performed his duties during his existence. The sick person who feels that he must still do certain things before the final act requires care until he can do them and thus die in peace.

2.12 The need for gratitude

The need for gratitude exists and this may be understood as a need to feel acknowledgement for what has been done. One is dealing here with a need for recognition. Because a human being is fragile he needs gratitude and recognition. We need to be thanked for what we have expressed, for what we have done, and for our work in this world. This is a very human need which bears upon the spiritual plane and the interpersonal plane as well.

It is not easy to meet this need but it is possible when the health-care worker knows who is in front of him and, after listening carefully to his history, is able to appreciate certain elements of his existence and make the sick person see that his life has value, that it deserved to be lived, although only for certain episodes which he, *a priori*, did not consider important.



3. By Way of a Conclusion

This framework of spiritual needs has to be contemplated in an approximate way, as an outline. In my view, the question of spiritual needs should not be seen as a residue of a confessional character that tries to achieve sedimentation in an artificial way in a secularised and secular world but rather as a universal anthropological aspect. Every human being, because he is human, feels spiritual needs that he must address during the course of his life cycle.

This kind of need can be expressed in an explicit way but also in an implicit way. Its expression and intensity vary according to circumstances and the state of development of the person. Spiritual needs, like other needs, change with the times and are not experienced in the same way during the course of a life. This means that a serious study would require their identification during the various moments of a person's existence. It is evident, at an intuitive level, that the spiritual needs of a dying person are not the same as those of a young person at the height of his faculties.

And the spiritual needs of a healthy person are not expressed in the same way as the person who suffers from a mental illness. A human being, because he is limited, is a being who by nature has needs that have to be dealt with during the course of his life. Needs of a spiritual kind form a part of human needs and require, like the others, suitable, competent and professional action on the part of those who dedicate themselves to work involving care. A health-care worker must carefully explore the framework of spiritual needs and respond with sensitivity to each one of them.

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II. How the Catholic Health Care Ministry is Adapting to Meet New Challenges. Ecclesiastical Structures in North America

INTRODUCTION

It is indeed a privilege and an honor to be with you today. I hope that what we will do here will not only be helpful, but also that it will be interesting to you. I wish to build today on some of the proposals I put forward in this very hall in 2002 when I spoke on preserving the Catholic identity of healthcare institutions.[1]

Since I was asked to speak about ecclesiastical structures that have been set up in North America to enable Catholic healthcare systems and institutions to continue the saving mission of Christ, I must recognize that I am in the very fortunate position of having been involved as a consultant in the establishment of the vast majority of the public juridic persons (=PJPs) in the United States and Canada (as well as elsewhere), and so am able to see a number of trends evolving from these new structures.

However, even though public juridic persons have been around for some twenty years in one form or another, they are still a "work in progress" and no one would think for a moment that we have found the last word on the matter. It is quite probable that within a certain number of years we might have to go back to the drawing board to take new circumstances into account. These circumstances could arise from on-going experience, from political and legislative pressure, from changes in Church norms, and so forth.

Nevertheless, my intention today is to consider the current model of the public juridic person that is being used more and more to ensure that sponsorship activities are well supported by appropriate structures.

However, a word first about sponsorship, since its proper functioning is the primary reason for the establishment of new canonical and civil structures.

I. SPONSORSHIP OF CHARITABLE WORKS IN THE CHURCH

A. Certain canonical notions relating to sponsorship[2]

It has generally been held that, for a work to be able to be identified as "Catholic", it must, in one way or another, be related to a juridic person in the Church, whether it be a diocese, a religious institute, one of its provinces, or even one of its established houses (canon 634). While, in general, this statement is obviously true, we must keep in mind that, indeed, there could be situations in which no formal relation to a juridical person is involved and yet the work is considered by a diocesan bishop to be "Catholic". In spite of this possible exception, we can nevertheless operate under the presumption that, indeed, there has to be a canonical sponsor in order for a work to be considered as fully operating within the ambit of the Church's mission.

In general, religious institutes or their component parts have been identified among the principal sponsors of apostolic works, especially in the area of healthcare. At times, though, the work did not have an existence distinct from the local community to which it was related, or at least distinct from that of the institute itself. It did not have separate canonical recognition. This has been a very common feature. But, for this reason, it has been rather difficult to determine which came first: the work, or the community which operated it.

Lately, new entities established specifically for sponsorship purposes have been recognized either by Bishops or by the Holy See. These entities, usually known as "juridic persons" (but sometimes also called "foundations") assume the sponsorship responsibilities previously belonging either to a religious institute (or one of its parts) or directly to a diocese. In some instances, they also assume all the ownership and property rights originally held by the institute or diocese.

As various studies have shown, the term "sponsorship" is relatively new in Church circles. It was originally given wide circulation as part of a threefold approach to healthcare works: ownership, sponsorship, control.[3] With time, the distinctions between these three dimensions have become somewhat blurred.

The term "sponsorship" is not used in the *Code of Canon Law*. In a sense, this is very advantageous because we are not bound by any special parameters. Through the course of time various forms of sponsorship in the Church have been tried and tested. No one form has proven to be correct, with the others being inferior, or even bad. The forms are different, and nothing more.[4]

It is generally accepted that, today, no matter what form or model is used, "sponsorship" entails the use of one's name and the exercise of certain ecclesial and internal responsibilities that arise from this use. It often entails elements of "quality control". To a certain extent, it could be considered somewhat parallel to a franchise. Sponsorship responsibilities are exercised in relation to what the name stands for. In our case, we are referring to works undertaken in the name of Christ, on behalf of the Catholic Church.

B. Qualities to be found in a sponsored work, such as a health care system[5]

When speaking of sponsorship, a clear distinction must be made between "Catholic works" and the "works of Catholics". The former are undertaken "in the name of the Church" (canon 116), with all the guarantees of the Church behind them, while "works of Catholics" are those undertakings of Catholics which might have a direct or an indirect ecclesial relationship, or might be totally secular in their nature.

For a work to be carried out in the name of the Church, a number of special conditions must be met, in addition to the general one of having been duly recognized by the competent ecclesiastical authorities.

1. First of all, it must have a spiritual purpose (see canon 114). Such a purpose can be either a work of piety, a work of the apostolate, or a work of charity. Canon 676 speaks of lay institutes participating in the pastoral mission of the Church through the spiritual and corporal works of mercy, such as caring for the sick.

2. Secondly, a work carried out in the name of the Church must answer a need. Canon 114 even speaks of a "genuinely useful purpose" (when dealing with juridic persons). It could have happened in the past that some Catholic institutions were established, not because there was a real apostolic need, but rather for the simple reason that other groups were carrying out a similar mission.

3. A third condition mentioned in the Code is that the undertaking have sufficient means to achieve its purposes (see canons 114, §3 and 610). We all know that, in many circumstances some works were simply unable to prosper because of lack of funding. On the other hand, we are all well aware that there are many instances of foundresses of religious institutes who made do with almost nothing and, through faith, enabled the works to flourish. The necessary means are not limited to financial assets; a spirit of faith and a willingness to work diligently are also part of the necessary means.

4. Fourthly, works carried out in the name of the Church are expected to have a certain perpetuity.

5. Fifthly, canon 116 refers to tasks or missions that have been "entrusted" to those who are to carry out a work. Those who have been so "entrusted" are to carry out their tasks as good stewards, caring for the work and its assets (see canon 1284, §1).

6. There is a sixth and most important characteristic that we find mentioned in canon 806. While this canon does not apply directly to healthcare institutions – indeed, there is no mention of these in the Code – it applies to educational activities in the Church, and, by analogy (in accordance with canon 19) it could – and perhaps should – be applied to our various hospitals and related institutions. With appropriate adjustments, we could say then that the canon notes that those in charge of a Catholic healthcare work are to ensure, under the supervision of the local Ordinary, that the care given in it is, in its standards, at least as outstanding as that in other similar institutions in the region. In other words, if the name of the Church is to be attached to a specific undertaking, this work must be one of quality.

Indeed, if an activity is not of the highest quality, serious questions should be asked about whether or not it should continue. There is no place for second-rate activities. This does not mean that activities must have the latest technological instruments and facilities, but what it does mean is that the apostolate carried out be of fine quality.

The particular structures we are now going to consider will have as their purpose that of making certain that these sponsorship requirements, and similar ones, are duly met and carefully safeguarded.

II. DISTINGUISHING ELEMENTS FOUND TODAY IN THE VARIOUS MODELS OF JURIDIC PERSONS IN HEALTHCARE IN NORTH AMERICA

For some unknown reason, the *Code of Canon Law* does not indicate who can grant juridic personality to a work or to a system. To date, people have been proceeding by analogy with the provisions of canon 312 on the establishment of public associations of the faithful. There is still some uncertainty, however, at least for outsiders, as to which of the Dicasteries of the Holy See is competent, in a given situation, to grant juridic personality.[6]

I am aware of nine public juridic persons of pontifical right

for healthcare in North America, plus one private juridic person. There are probably many more elsewhere and other requests have been presented recently for consideration. Most of their statutes are relatively similar. Usually, it is the "membership" issue that varies, as well as the relationships with the corresponding secular corporation and with the original sponsor or sponsors. There are also requests being presented for the use of a similar structure for works of education and for the administration of the temporal goods of religious institutes that are in the process of dying.

In the USA: the public juridic persons of pontifical right are *Covenant Health Systems*, *Hope Ministries* (related to *Catholic Health East*), *Catholic Health Care Federation* (related to *Catholic Health Initiatives*), *Catholic Health Ministries* (*Trinity Health*), *Bon Secours Ministries*, *St. Joseph Health Ministry* (related to *St. Joseph of Orange Health System)*. *Peacehealth* is a private juridic person of Pontifical right.

In Canada there are three Pontifical PJPs: *Catholic Health Sponsors of Ontario*, *Catholic Health Partners of New Brunswick*, *Catholic Health Sponsors of Manitoba*.

There are, in addition, a number of diocesan PJPs.[7] These have been set up by individual bishops, or by the bishops of an ecclesiastical province. (It is interesting to note that this provincial model is used frequently in Australia).[8]

A. Early models

1. Sponsorship roles have moved steadily in recent years from stand-alone operations, to two-tiered membership structures, to the establishment of systems, to the recognition of distinct canonical status through public juridic persons (PJPs), with many other variations along the way. It is easy enough to trace some fifteen steps in this process, but it is not necessary to do so here.[9]

2. A number of groups have, for the time being, not found it necessary or appropriate to adopt the PJP model. Although they have received recognition from the Bishops of the places where they are headquartered, their works derive their Catholic identity from the original sponsors who are still actively involved in the apostolate. Among these, we could mention *Ascension Health*, *Catholic Health Partners*, *Catholic Health West*, and so many others that are well known.

3. The first pontifical PJP established for healthcare in the USA was *Catholic Health Care Federation*, associated with *Catholic Health Initiatives*. It was composed of representatives of religious institutes that felt that they might not be able to carry on their apostolic works for much longer, but, nevertheless, wished to maintain Catholic identity and presence. The membership was composed of religious and their representatives.

4. The second PJP was "*Covenant Health Systems*", of Lexington, MA.[10] This was originally the work of one religious institute, the Grey Nuns of Montreal, although the Religious Hospitallers of St. Joseph were in partnership with them for some of the works. In this case, the idea was to establish a PJP that would be identified with the civil board of directors of Covenant, which were mostly lay persons, but with a certain number of religious and priests. At the time, the Grey Nuns retained certain rights, particularly over the appointment of board members for *Covenant*. This was an understanding with the Archdiocese of Boston, which, otherwise, at the time, would have assumed the responsibility itself (the Grey Nuns have since renounced some of their retained rights). *Covenant*, in turn, is a co-sponsor of other systems which do not have distinct canonical recognition.

B. Later models

5. A third Pontifical model was derived for "*Hope Ministries*", with *Catholic Health East*. Instead of giving the civil entity juridic status, a new sponsor was added to provide for the sponsorship of new works coming into the system, and to assume works that one or more of the original sponsoring communities could no longer carry out.[11] With time, it might happen that there will be but one juridic person, but that is certainly not in the works at this moment. The representatives of the new PJP are an integral part of the Sponsors' Council. The civil corporation, "*Catholic Health East*", does not have canonical status as such, but its thirteen or so sponsors each do.

6. A fourth model was "*Catholic Health Ministries*" with "*Trinity Health*".[12] There were two major differences with this model: (1) a majority, but not all, of the members must be Catholic; (2) there was an excellent formation program set up for the preparation of new members of the PJP and this was part of the canonical documentation. More recently, this formation program has become collaborative, with other PJPs participating in it. Careful arrangements are made in the statutes and by-laws for the protection of the rights of the two original sponsoring institutes (Classes "A" and "B").

7. A fifth model, that of *Bon Secours Ministries*, insists that all members be Catholic. However, there is no Sponsors' Council, but rather, the members are of two classes, "A" and "B". The class "A" members would be designated by the original sponsoring group, while the class "B" members would be representatives of other groups wishing to become part of the system. Changes in statutes, etc., in addition to the approval of the members, would require a majority vote of the class "A" members. The members of the canonical PJP would also be the members of the corresponding civil corporation.[13]

8. *St. Joseph Health Ministry*, identified with the Sisters of St. Joseph Health System, Orange, California, builds upon the approved statutes of the

other PJPs and presents a good composite view of what is currently acceptable to the Holy See.[14] One difference noted in these last two cases is that it is not the Holy See which establishes them, but, rather, which grants them juridic status. Likewise, another change in the approved Statutes is that the Members are designated according to the provisions of the By-laws, not the Statutes; more flexibility could result from this.

9. There is also the model of "*PeaceHealth*" which is a private juridic person, operated in conjunction with the Sisters of St. Joseph of Peace.[15] The major difference is that its temporal goods are not ecclesiastical goods, and they are not directly subject to the norms governing alienation. This structure was used to enable a major work, that had been inadvertently alienated, to continue to be recognized as Catholic. The Holy See has recently indicated, however, that it does not consider it appropriate to recognize this model for Australia, since it did not consider that it was fitting to lose the temporal goods still belonging to the various religious institutes there.

10. There are three other pontifical models existing in Canada, besides a certain number of diocesan ones. Perhaps one of the major differences, especially with *"Catholic Health Sponsors of Ontario*", is that the Bishops are a major sponsorship component of the PJP. They are directly involved through the *Catholic Health Association of Ontario* (=CHAO) which groups all the owners and the Bishops of Ontario.[16] Each original sponsor has two seats on the board, but, as an institute wishes to withdraw, its two seats go to the CHAO, so that, eventually, the CHAO would appoint all the members. This calls for a major collaborative effort and has been very interesting to watch. This model does not seem to have been considered in the USA.

11. In some instances, when works were identified exclusively with one diocese, a diocesan PJP has been established.[17] There are presently requests before some Bishops to adopt this model in their diocese. Likewise, there are instances where arrangements are being made with Catholic Charities to assume joint undertakings, so that the PJPs are extending somewhat beyond the direct healthcare field.

12. There are also instances when, instead of using the PJP or Foundation model, an Association of the Faithful was established to operate a Catholic hospital.[18]

III. STRENGTHS OF THE VARIOUS MODELS

As is evident, each model is different, depending on the circumstances surrounding its initial establishment. Each one has its values to be promoted and protected.

1. While *Covenant* has the advantage of having complete unity between the civil and the canonical structures, this means that anyone wishing to serve on *Covenant's* board must be willing to assume the canonical responsibilities also. This calls for a very serious commitment on their part, which, to date, has produced excellent results. The temporal goods owned by the Grey Nuns were not originally turned over to *Covenant*; only later were the alienation procedures completed.

2. The other models in use allow for a direct involvement of the original sponsoring institutes. It was not a question of turning everything, especially the assets, over to the new PJP. However, this implies that the institutes are still in a position to remain actively involved. In spite of this, the Holy See now considers that granting permission to set up a PJP brings with it the required permission to alienate designated assets to the PJP.

3. *Catholic Health Ministries'* provision for the possible membership of persons who were not Catholic gave rise to some concerns. However, to the best of my knowledge, this provision has not yet been put into effect. This PJP has an excellent formation programme for new members, and this is being followed very closely to see how the experience can benefit other groups considering PJP status. Recently, the other PJPs in the USA have joined in with this program to prepare eventual members in the best way possible.

4. *Catholic Health Sponsors of Ontario* brings the Bishops more directly into the work, thus making them an integral part of the PJP. This provides an excellent example of ecclesial collaboration.

IV. RELEVANCE OF JURIDIC PERSONS TO THE SPONSORSHIP AND STRUCTURE OF THE CATHOLIC HEALTH MINISTRY

From what has been noted above, it is evident that the use of juridic persons has many advantages for the future of the Catholic health care ministry.

1. The fact that the juridic person is perpetual, assures continuity. Even if one of the original sponsors ceases to exist (or is amalgamated into another juridical person), the work can continue under Church sponsorship.

2. The fact that the juridic personality is recognized by Church authority gives the work the special status its needs, not only within the Church, but also in society. Of course, in the eyes of many people, the PJP seems to be a "second-class" entity. While we know that this is not correct, we have an uphill battle to wage in regard to on-going credibility.

3. Well-prepared statutes and by-laws can assure that the mission continues in the line of its original philosophy. Even though statutes are more stable in nature, if it is found that they are not working out well, then we should not hesitate to change them. No one likes to undertake this task, but we must keep in mind that the statutes are at the service of the work, and not vice versa.

4. There can be a clear paral-

lel with existing civil or secular structures, which provides for better administration.

5. In the case of a public juridic person, the work is carried on in the name of the Church, thus providing credibility and also security for those who avail themselves of the services offered. But, since the name of the Church is at stake here, we must make certain that those entrusted with the PJP are fully informed and committed to this ministry.

6. Just as religious institutes

provided stability through the years, this new form of involvement, if it is correctly applied, can take up the torch and continue the mission.

7. Lay persons, in virtue of their baptism, can assume their rightful role in the Church's mission, provided they see it as a mission, and not just as employment. This is part of a newer approach; there will be problems along the way – associated with growing pains. However, obstacles and difficulties should not prevent us from moving ahead.

8. There are three particular areas of concern that are apparently being addressed by the Holy See when considering applications for approval of new PJPs: (1) the designation of members of the PJP and their qualifications; (2) the monitoring of the observance of the applicable health care ethics guides; (3) the financial situation of the original sponsoring institutes once they have divested themselves of all or some of their apostolic works, and the alienation of the temporal goods to the new PJP.

V. THINGS CONGREGATIONS SHOULD THINK ABOUT WHEN CONSIDERING A CHANGE OF SPONSORSHIP

In spite of the number of groups that have modified their structures, we are still at the level of "seek and find". Solutions that seem perfect today might, in a few years, for reasons beyond our control, be found inadequate.

However, looking at the experience of others, we can see what are some of the points to keep in mind when considering any changes in structures.

A. Changes of sponsorship

When we are dealing with a change of sponsorship, there are normally five major steps in the process, as decisions are taken. They are not all of equal importance, but, if they are not carefully thought out, there can be difficulties later along the way.

– *The timing*: probably one of the most difficult questions to be asked is: "When is it the appropriate time to begin considering a change in sponsorship?" While there is no one answer to this, it is preferable that changes be considered when we are not in a time of crisis. It is also preferable to do so while we are still really in control, so that we can craft a structure that responds to our aspirations, rather than having one imposed upon us (as is the case these days, in the secular world, with bankruptcy proceedings).

– *The process*: experience seems to show that having a small steering committee is the best way to direct the process. It is not good to have too many people directly involved in considering and designing the various models and possibilities before there is some consensus as to the way the changes should go. Also, it is not absolutely necessary to have the Superior General directly involved in the first stages, since otherwise there is no wiggle room if things don't work out as planned; however, this depends on local needs and circumstances. I would suggest that somehow a civil lawyer and a canonist be involved along the way, if possible, to avoid loss of time and energy later on in the process.

– *The model*: since there is not one model, it will be worthwhile to examine the existing ones to see whether or not some of them have elements that could be helpful for you in the present situation. For instance, will there be identity between the new canonical sponsorship group and the existing civil entity, or will they be totally distinct? Will the model allow for other groups to participate, and, if so, will the originating group have special reserved powers? Will the entire system become a new canonical entity (PJP), or will a new PJP be established to parallel existing ones (as in the case of *Catholic Health East)*?

– *The issues*: probably, what is even more important than the actual structure, is the way in which any change in sponsorship will be announced to the public. This includes relations with the Holy See, with the diocesan bishops of the places where the PJP will be operating. But, perhaps even more importantly, it will be essential to make certain that senior management and other staff understand the process and its implications. If people were to think that they will lose their jobs because of the

changeover, the entire system could suffer a terrible loss of leadership. For the ordinary employees, questions of morale and protection are essential also. There is a further point to be kept in mind: there must be some type of announcement made for the public. How is this to be managed?

– *The life of the PJP; its eventual amalgamation with another PJP, or its dissolution*: another question to be considered is some type of mediation and dissolution processes in case of internal disputes. Not every marriage works out well, in spite of the best intentions of those involved. Therefore, in spite of the desire to have everything run smoothly, it would be good to have some type of "pre-nuptial" agreement, so that misunderstandings can be nipped in the bud, and the temporal goods that belonged originally to the sponsoring institute will not be lost or dilapidated.

B. Points to be kept in mind

Keeping these five steps in mind, we can now, in more detail, mention a number of points (ten general ones) that should not be overlooked in the process.

1. Initial steps

Before any process is undertaken, there must be agreement on the following points:

(1) *Do we want to change*? And if so, are we changing simply because of a few persons? What is the major purpose of the change? Is this the appropriate time to change?

A change in sponsorship is not like the flavor of the month. It is a major commitment, with significant costs in resources, time, and persons. Therefore, it must be for a specific purpose, such as, to provide for continuity in the ministry once "we" are gone, or, to enable more persons to become directly involved in the sponsorship role of the work.

It would not be good to consider changes at a time when the general leadership of the Congregation is about to change, because some type of continuity is needed throughout the whole process, which can last for a year or more.

One way to verify whether is change is being carried out for the right reasons is to draw up a mission statement for the new entity, a statement that contains more than "nice" words.

(2) *What type of structure do we want*? It could happen that some people would want a new structure that would simply perpetuate what presently exists, but with new players. It seems to me that when we are proposing changes, this is a good time to "look beyond the box" and see other possibilities. For instance, are there other institutes out there that are struggling and are not large enough to maintain a presence if they are not helped?

Depending on the answer to this question, the name of the new structure will have to be carefully considered. If the name is too "parochial" or geographically limited, the possibilities for other groups feeling at home are more limited. For instance, "City of Rome Catholic Health Ministry" might be far too restrictive in the present context.

2. *The model*

(3) *What model will be chosen*? For instance, is the new PJP to be pontifical or diocesan? It is co-extensive with the present health system, or is it something on the side, relating to it?

When there are already a number of sponsors, who are PJPs in their own right, it might, in some cases, be opportune to establish a new PJP, which will be one more among the sponsors. This new entity could then assume responsibility for new works coming into the system, but which are not presently sponsored by one of the existing sponsors, as well as for works which the present sponsors feel they can no longer sustain.

Or, there can simply be one new PJP, encompassing the entire system, with the existing sponsors transferring their works and assets to it in due time.

Good flow charts will show the parallels between the existing set-up and the new one.

At the same time as the canonical model is selected, it will be important to determine whether the new PJP will have separate civil existence, or whether it will operate through a corporation which presently exists. Thus, if, for instance, it is decided to make the existing health system a PJP in its own right, there would be no need for new civil structures. The by-laws would simply have to be modified to determine where present sponsorship responsibilities would be exercised in the future (i.e., reserved powers).

If, on the other hand, a new PJP is established, to be added to the existing ones, then it would be essential for it to

have civil recognition, to avoid liability issues flowing to other sponsors, and also to make certain that the ownership of its temporal goods is well respected.

(4) *Who are going to be the members of the new structure*, and how are they to be formed in the traditions of the ministry? Must all members be Catholic? Must they all be religious? Must they all be members of the same Congregation?

If the present sponsoring group wishes to expand beyond present confines, then it will be absolutely essential to foresee some type of formation process for new members. This process could easily take two years, since we cannot presume that those who would be assuming a responsibility "in the name of the Church" are sufficiently aware of the requirements of this position.

Some groups are providing for a wide spectrum of members, with a majority of them being Catholic. Others insist that all members of the new sponsoring group be Catholic, but not necessarily religious. Depending on the answer to these questions, the formation program for new members would be adjusted accordingly. For instance, if only religious could become members, there would be less need to provide detailed background information relating to the Church and its workings, since this can be presumed to some extent.

(5) *Will there be a difference between the members of the new PJP and the original sponsors*? For instance, will there be a sponsors' council?

Since one of the major responsibilities of sponsors in a new PJP is to monitor the application of applicable ethical directives, will this be done directly by the members themselves, or will there be a body representing the initial sponsors who assume this responsibility on the part of the members? Both approaches are correct and satisfactory. But, if there is a sponsors' council, it has to be determined whether or not they are also members of the board, or whether they are an institution working on the side, as it were, distinct from the board, but reporting to it.

(6) *How will the members be selected*? And will there be two classes of membership?

It can happen that the board of a PJP would become a self-perpetuating board. However, this does not guarantee that the Catholicity of the work will be protected in the years ahead.

For this reason, there should be some type of mechanism to verify the preparation of proposed new members and their commitment to the ministry. Among possible solutions: the Sponsors' Council could also have as a duty serving as a nomination committee for the board; or, the diocesan bishop of the place where the headquarters are established could approve any new members on the board before they can be elected to it. Another way is for the original sponsor to retain the right to appoint the members of the board of the PJP, at least for the foreseeable future.

Or, there could be combinations: only the officers of the PJP are subject to approval by the diocesan bishop or the original sponsor, or the sponsors' council, and the other members are elected by the board.

The Holy See has been examining this matter very carefully when new requests are submitted to it for approval, because the whole future of the PJP depends to a great extent on who are its members.

In some groups, rather than having a Sponsors' Council, the original sponsors constitute the "Class A" members, and are appointed by the Congregational authorities. These "Class A" members hold the equivalent of reserved powers, in the sense that any changes in certain items (for example, statutes, by-laws, policies, etc.) require the consent of the majority of the "Class A" members, in addition to a majority vote of all the members.

3. Public relations

(7) *What arrangements are being made to keep the diocesan bishops informed*? Likewise, what arrangements are made to keep senior management and employees informed?

It is absolutely essential that the bishops of the dioceses where the new PJP would operate be kept informed of the process and plans before anything is made public. When requests are made to the Holy See, each of the bishops will have to present a letter of support. It is almost impossible to obtain such a letter if the Bishop (or his healthcare representative) has not been kept informed of developments along the way.

If the Bishop does not agree with the proposal, it will be important to find out if there is any other model that he would be willing to accept. Then, again, no matter what model is accepted, it will have to establish ways in which the diocesan bishop's responsibilities, particularly in the areas of apostolate and ethics, will be exercised. Sometimes, it is good to foresee in advance mediation processes, distinct from those to be used in other instances of disputes, when there would be differences of opinion between the Bishop and the administrators of the PJP.

And, as noted above, the same applies, but in a different way to present senior management and to employees. The future of any work depends on the good will and commitment of those who are involved in the ministry, and, if there is serious uncertainty about their future, the quality of the ministry can be seriously eroded.

In the same vein, the public at large (public officials, donors, the media, etc.) should be aware of what is taking place. The way in which they are informed will depend to a great extent on their present involvement with the works today. If they have little or no involvement or direct interest, the need to keep them informed is not as great as if they were stakeholders in the project.

4. *Financial issues*

(8) *Will the goods belonging*

to the new PJP be ecclesiastical goods? Many health care systems have goods coming from more than one source. Some of the goods are considered in church law to be the property of the original sponsoring congregation; others come from public sources in order to provide health care in "the City of Rome"; other come from goods that have been entrusted to the system, but are not owned by it. For instance, systems often have management contracts with hospitals and similar institutions, but they do not own them.

It will be absolutely essential to have a clear and detailed inventory available before the new PJP is established, in order to make it clear which goods are being transferred to it, and which ones are simply being entrusted to it for administration.

If the goods are ecclesiastical goods, they are subject to the canonical norms concerning administration and alienation. This means that the members of the PJP will have to have some formation into the canonical requirements relating to temporal goods.

(9) *How do we protect the financial interests of the original sponsors*? As anyone involved in the process knows, the assets of many of our Catholic health system are substantial. They are the result of years of hard work on the part of the Sisters or Brothers involved. It might not be fair for a Congregation simply to lose all the assets currently invested in the system. However, much will depend on the financial situation of the Congregation as a whole. If it is well-endowed, it might be able to make a substantial donation to the new PJP. On the other hand, it might need revenues in the years ahead to provide for the Sisters or Brothers.

These points should be clearly addressed before any decision is made in regard to sponsorship. It is too late once the transaction is completed and the assets have been transferred to the new entity. Thus, for instance, any current sponsorship fee could continue to be paid to the original sponsor, or the fee split in two, with one-half going to the Sisters or Brothers and the other half to the PJP to support its activities.

Even though a new PJP would obtain formal Church recognition, nevertheless, unless the decree of establishment (as has been the case in the last two instances of pontifical approval) provides somehow for the eventual alienation of the goods in favor of the new PJP without any additional canonical formalities, an explicit permission from the Holy See would be required to transfer assets to it from the original Congregation (if the value of the assets exceeds the allowed maximum). There is no obligation to turn the assets over to the new PJP, but, if it does not have the means whereby to operate, it is doomed to failure.

5. *Amalgamation and dissolution issues*

(10) *What happens if the project doesn't work out or if it is to be amalgamated with another existing PJP*? The statutes of a PJP have to provide for the distribution of the assets upon dissolution of the work. In this instance, the provisions of the applicable civil law must also be kept in mind.

No one enters an agreement thinking that it will not work out, but reality tells us that, at times, there are changes along the way.

A good document would provide for some type of rights that would revert to the original sponsors (if they wanted to receive them, or were able to do so).

If the temporal goods are not owned by the new PJP, but simply entrusted to it, the situation is quite different from the case where the PJP is the canonical owner of the assets.

What is more probable, rather than dissolution, is that the PJP, with time, would link up with another one, to continue the apostolate, on an even larger scale. The same provisions would apply, but with the appropriate adaptations.

C. Follow-up

Even though those in charge have carefully thought out the issues noted above, this does not mean that the task is completed. There are still things to do along the line.

1. *The annual report to Rome*

At the present time, the Holy See is asking for an annual report of the activities of the PJP. While Bishops have to present a report every five years, and religious institutes must do so each time there is a general chapter, PJPs of pontifical right are asked to do so each year.

The reason for this is quite simple: since we are dealing with a relatively new structure in the Church, it will be important to monitor its activities, to find out what are the strengths in the model, and what are the potential weaknesses.

The Holy See has been willing to take a calculated risk, relying on the baptismal dignity of those involved, but, at the same time, it must be prudent, since in a number of instances, the assets involved are valued in the billions of dollars.

Possibly, with time, this requirement, will be reduced to every two years, or even a longer interval will be allowed.

2. Mediation processes

With any human undertaking, we must recognize that, now and again, there will be misunderstandings. It would be essential to have in place a mechanism for the resolution of disputes, before they blow over into major tragedies.

A distinction must be made, however, between internal disputes, and those involving outside authorities, whether civil or ecclesiastical. Such authorities would not be subject to internal conciliation procedures.

So many of these misunderstandings can be avoided by regular communication. For instance, it is not a bad idea to send the diocesan bishops involved a copy of the annual report sent to the Holy See, or at least a copy of its pertinent parts.

3. Leadership formation

For me, the key to the success of the PJP lies in the quality of its leadership. Therefore, it must become a major priority to see that a worthwhile formation programme for leadership is established and put in place, or that a good existing one is used. This can take different forms, but what counts is that it be adapted to the local situation, while keeping in mind broader Church issues.

4. *Continued involvement of the original sponsors*

In a few instances, once the new PJP was up and running, the original sponsors withdrew. While this might be interpreted as leaving it alone to carry out its mission, it can also be seen as an act of abandonment before the entity reaches its adult stage.

For this reason, the Sponsors' Council, if it exists, can play a significant role in perpetuating the original charism, as well as seeing that the work continues with its true apostolic thrust, and not degenerate into a business undertaking.

Depending on the financial arrangements, to withdraw too quickly might also deprive the PJP of any true capacity for carrying out its mission.

VI. SOME CLOUDS ON THE HORIZON

Structures alone will not ensure that the works of the ministry will be able to continue unchallenged.

In Canada, at the present time, there are very serious concerns for the future of Catholic health care as is it known, because various Provincial Governments (which have responsibility for health care in Canada) have established various forms of regional health authorities, based on geography, and not on the faith-based identity of the institution. This entails, in many instances, an obligation to coordinate procedures and various services with other health care institutions in the same area, as well as establishing uniform policies throughout all the institutions in the same health district. Obviously, Catholic institutions cannot accept *carte blanche* what the civil authorities wish to impose.[19] Since these same authorities provide for most of the financing of the institutions, they have great power of persuasion. It might well happen that there will be little place in the future for Catholic acute care institutions, and that it might be necessary to focus our attention more on hospices, long-term care and on rehabilitation.

A second difficulty in Canada concerns the financing of the juridic persons which have been established, as distinct from the sponsored institutions themselves. Since the sponsored institutions are government financed, they are not free to dispose of funds at will to support external sponsorship structures. This means that the available financial means are quite limited, which, in turn, hampers the operations of the public juridic person as such. The same situation does not present itself in the same way in the United States.

In the United States, however, pressure is growing to unify under one governing board institutions situated in the same geographical area. The State of New York, for instance, has recently mandated geographical coordination.[20] This raises very serious ethical issues. For instance, to what extent can a Catholic institution cooperate directly with a secular institution that carries out proscribed procedures, and, by law, is obliged to offer such procedures? To refuse to cooperate can even entail the loss of an operating licence. It is not an easy matter to draw up internal governance documents that satisfy the Church authorities, the Government departments, the people being served, and even certain special interest pressure groups.

Beginning of life and end of life issues are foremost today in the minds of those responsible for Catholic healthcare institutions. At times, though, they are not as free to make decisions as they would need to be. Where will the Church find itself in the years ahead?

CONCLUSION

This is an exciting period in the life of the Church, with new creations seeing the light of day.

Because a structure is new, this does not mean that it will endure the test of time. There will most probably be adjustments along the way as new situations arise.

What counts most is that the charitable works of the Church are able to continue under a form of sponsorship that enables them to offer quality services that are carried out in the name of the Church as it continues Christ's saving mission.

However, we must recognize that the Church has decid-

ed to take the risk of entrusting its mission to persons other than clerics and religious. It is up to everyone to assure that those now becoming in charge of this mission are duly prepared and supported as they carry out their tasks.

We have to be able to show, with time, that the Holy See was right when it agreed to establish public juridic persons. The actual format and some of the details could change through the years, but the basic principles of ensuring continuity and maintaining quality will have to be maintained.

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Notes

[1] See F.G. MORRISEY, "Improving the Identity of Catholic Health Care Institutions' Structures", in *Dolentium hominum*, 18(2003), No. 52, pp. 128-134.

[2] See ID., "Does Canon Law Speak of Sponsorship of Works?", in *Health Progress*, 88(2007), No. 1, pp. 29-30, 68.

[3] See A. MAIDA and N. CAFARDI, *Church Property, Church Finances, and Church-related Corporations*, St. Louis, CHA of the United States, 1984, xxii-339p. Reprinted 2000: Pittsburgh, Duquesne University School of Law).

[4] See R. SMITH, *et al.*, *Sponsorship in the United States Context. Theory and Praxis*, Alexandria, VA, Canon Law Society of America, 2006, vii-151p.

[5] See ID., "What does Canon Law say about the Quality of Sponsored Works?", in *Health Progress*, 88(2007), No. 2, pp. 10-11.

[6] For instance, in the case of works which were originally founded by religious institutes, but have since been transferred to other sponsors, is CICLSAL still competent to grant juridic personality, or does this now depend on the Congregation for the Clergy? For instance, a letter from CICLSAL, May 21, 1999, Prot. No. R158-1/99 states: "After careful study of the proposal, this Congregation for Institutes of Consecrated Life and Societies of Apostolic Life has concluded that it does not have competency in the matter. [...] The other solution would be to present the petition to the Congregation for Clergy in view of their competency for matters relating to ecclesiastical goods." There is the Pontifical Council for Health Care Workers, but its terms of reference do not refer to the institutions as such, nor to their canonical status. The Pontifical Council for the Laity might also be involved if the work were entirely sponsored by laity.

[7] An example of a diocesan public juridic person for health care is "Providence Health Care", established in the Archdiocese of Vancouver, Canada, June 22, 1999, replacing a previous diocesan juridic person known as "CHARA", and established on October 7, 1994.

[8] For instance, *Catholic Health Care Services* in Australia had its statutes approved by the Bishops of New South Wales and the ACT, November 9, 2000. *St. John of God Australia* had its statutes approved August 13, 2003 by the Bishops of the Ecclesiastical Province of Perth.

[9] See F.G. MORRISEY, "Toward Juridic Personality", in *Health Progress*, 82(2001), pp. 27-31, 51.

[10] The canonical statutes of "Covenant Health Systems" were approved by decree of the Holy See, July 18, 1995, Prot. No. 1299/95.

[11] The canonical statutes of "Hope Ministries" were approved by decree of the Holy See, July 7, 2000, Prot. No. 15051/2000.

[12] The canonical statutes of *Catholic Health Ministries* were approved by CICLSAL, July 14, 2000, Prot. No. 15052/2000.

[13] The canonical statutes of "Bon Secours Ministries" were approved by decree of the Holy See, May 31, 2006, Prot. No. 252-1/2003.

[14] The canonical statutes of "St. Joseph Health Ministry" were approved by decree of the Holy See, November 14, 2006 (Prot. No. 032-1/2006).

[15] The canonical statutes of *PeaceHealth* were approved by CICLSAL, April 29, 1997, Prot. No. 6485/97.

[16] The statutes of *Catholic Health Sponsors of Ontario* were approved by CICLSAL, November 24, 1997, Prot. T.145-1/97.

[17] For instance, *Fontbonne Health Care Society*, established in the Diocese of Peterborough, Ontario, June 1, 1995.

[18] For instance, on August 16, 2000, Archbishop (as he was then) Justin Rigali of St. Louis approved "The St. Anthony's Association of the Christian Faithful" to operate, among other institutions, St. Anthony's Medical Center.

[19] CICLSAL is showing particular interest in this phenomenon. For instance, a letter of March 20, 2007 (Prot. No. B138-2/2006; B138-1/2006), notes: "The subject of health care has been much discussed throughout Canada in the last few years. In fact, this topic has proven to be a primary concern in the most recent general elections. That the government of Canada has sought to exercise more control over health care services is worrisome insofar as the identity of some Catholic health care facilities will be threatened particularly if procedures contrary to normative Catholic ethics are required."

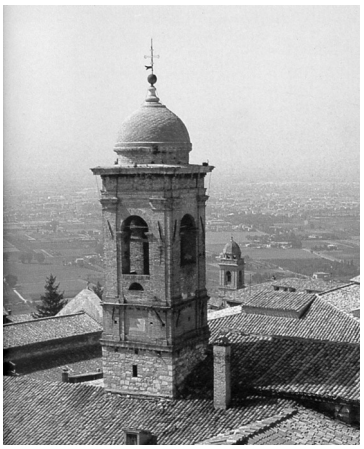
[20] See, for instance, "Some Catholic hospitals pursue suits, some follow recommendations in NY hospital consolidation plan", in *Catholic Health World*, February 15, 2007, p. 3.

III. Do We Understand the Market? Re-defining and Restructuring African Catholic Health Care

Catholic health care worldwide is part of market-driven models of health services. In the developed world financing of health care is either through government funding, private insurance funding or a mix of the two. Meeting health costs from out of pocket payments is not possible. For government funding you need economies with a broad tax base. In the private sector area, you need economies that will support private sector activity as well as an environment that encourages investments by insurance companies who are the suppliers of the health policies to people in the private sector.

With the main financing of health care being provided by governments or health insurance companies, health care services have had to adjust their way of doing business to the criteria established by the financiers. This has meant that even before asking the question of best quality of care, health services have to deal with a whole series of external requirements and regulations which are mandatory for continual receipt of funds. Probably the most important people in the healthcare service organisation are not the world class cardiovascular surgeon and his/her team but the CEO with a small administrative team which makes sure that the health service is compliant in all areas. Compliancy leads to continual funding for the health services and the fulfilment of the mission of the health service.

Catholic health care in Africa is also part of a market-driven model of health care but has not been able to adjust to the present market realities. Catholic health care in Africa has historically been dependent on a market model of major financing by overseas religious organisations and out of pocket payments by patients. This model is no longer sustainable because overseas religious organisations have less members and the source of revenue through members is no longer there. These same Catholic religious organisations are dependent on governments and insurances companies for financing their health services at the cheapest price possible. Also the impact of secularism has caused a decrease in active lay Catholic participation in the churches of the North which has caused a decreasing source of funding. Because the normal way of sourcing their funds has decreased, international Catholic donor groups are now seeking funds from governments as a way to support health care in Africa. These government grants are normally in targeted areas. This direct funding from governments to Catholic donors has also brought with it a whole series of compliance issues which the African Catholic health services need to adhere to.



As overseas donations to health care have decreased, local churches in Africa have been trying to fund health care through out of pocket payments, insurance/government subsidies where available or all three. However government subsidies to Catholic health services has been limited as can be seen from the fact that only 6% of all Global Fund disbursements world wide have been allocated to Faith Based Organizations.[1] Workers' health insurance coverage is basically only within urban areas amongst some, not all, employed people, whereas the largest percent of the population of most African countries are rural.

The following data on people living below the poverty line, life expectancy and *per capita* health expenditures and public/private expenditures for health helps to demonstrate the difficulties in financing health care.

Country	Life Expectancy	Living Below Poverty Line[2]	Per capita $ Health Expenditure	Public/ Private % of Health Expenditure[3]
Kenya	47 years	50%	$20.00	46% / 54%
Malawi	41 years	55%	$13.00	30% / 70%
Tanzania	45 years	36%	$12.00	55% / 45%
Zambia	40 years	86%	$21.00	51% / 49%
Cameroon	48 years	51%	$37.00	29% / 71%
Nigeria	47 years	51%	$22.00	25% / 75%

Thus health care, in most parts of Sub Sahara Africa, is being done in the private sector of which the Church is one of the major suppliers of care. It is highly dependent on cash payments in a continent where the average *per capita* health expenditure estimate by the World Bank is $36.40.[4]

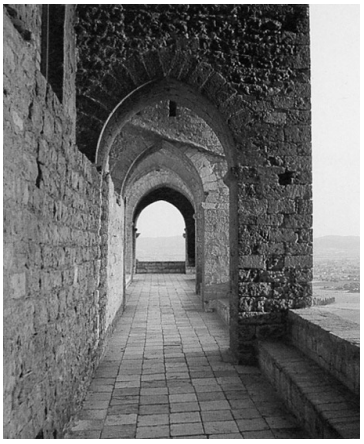
The Church in Africa is thus faced with the challenge of how do we respond to the Gospel message of caring for the poor and how can we be sustainable and still care for the poor?

This challenge calls for a redefinition of how the healthcare systems are structured and managed as well as a better understanding of the market economies both national and international that the health services must relate to.

Diocesan and national Church health systems can no longer function under the viewpoint of a priest, brother, sister, or bishop that what we are doing is good and does not need to be reviewed by others.

A strategic plan needs to be developed at the local level which first of all calls for an evaluation of all health services in the areas of service delivery, staffing, costing of service, sources of revenue, financial and administrative capacity, formation and mission of the health service and future plans. This type of evaluation will not only assist in beginning the process of strengthening the health services but also identifying those health services that need to be closed.

Two key areas in which Catholic health services in Africa have been criticised are their weaknesses in financial management and monitoring and evaluation systems. These weaknesses are often sighted by both Catholic donors and secular donors in funding proposals from Catholic health systems. Capacity building in these two areas is crucial for on-going external support for Catholic health care. The Global Fund, PEPFAR, EEU, DIFID etc. are all demanding a higher level of documentation in these areas. Failure of African Catholic health care services to address these issues now will ultimately relegate them to the periphery of international secular financial support as well as the international Catholic donors. The international donors have been using the Catholic donor community as a vehicle in some areas to fund some aspects of Catholic health care services.



Catholic health services must also shift their focus from being care providers to being competitors in sourcing funding and offering health care. The concept of economic competition is not something that Church people are used to thinking in but it is essential. St. Paul in 1 Corinthians 12 speaks about the gifts we have received and how our gifts are used for the whole. Economic competition is one of the gifts. Economic competition in itself is not evil but should lead to lower pricing and accessing of services. Economic competition also infers that there is a market strategy for presenting why I should chose one product over another. As Catholic health services in Africa have we really worked at marketing in our individual countries why Catholic health care services are needed and the value of these services to people and the larger society? Maybe we need to return to our roots and spend some time in our local African markets observing how the hawkers try to attract buyers to their products and persuade people to buy their items instead of the items being sold by others. Marketing and economic competition is part of African culture and not just a European concept.

What then are some of the key marketing points for Catholic health care in Africa? Catholic health care reaches out to the people living in the rural areas, where the largest percent of the population lives, through rural dispensaries, health centres and a few hospitals. Catholic health care has not remained just in the cities and towns. Many of these dispensaries and health centres support the family through ante-natal care, safe delivery programmes and post-delivery child welfare clinics with immunisation services. HIV/AIDS and TB services can be integrated into these health institutions with the value added on that these services will be provided closer to the patient. At the present time top level HIV/AIDS services are largely only being offered in hospital environments which are removed from the people. In the urban areas Catholic health care has reached out to slum populations and lower income populations through clinics and community-based care programmes. Lastly, Catholic health care has as its foundation's Christ commandment to love and care for the other.

If we look at our description of African Catholic health care and the Millennium Development Goals (MDG) as stated in the World Health Organisation 2006 report, Catholic health care is strategically placed to implement the MDG. Key health goals under the MDG are to reduce child mortality, improve maternal health and combat HIV/AIDS and other diseases such as tuberculosis and malaria. As part of meeting these goals there was also the call for shifting to a community-based and patient care paradigm as well as developing 'piggy-backing services' which can be integrat-

ed into on-going services instead of developing separate services.[5]

Thus we have a good product to market which meets major international health goals but we are quiet about it. There are three key factors which are causing this quietness. Firstly, there is an unhealthy understanding of humility which causes us to be quiet about who we are and what we do. Secondly, there is a lack of skills in programme writing and project proposals that hinders people from communicating our services and lastly there is a long term history of health care services in Africa being defined individually instead of corporately.

To rectify our unhealthy understanding of humility we only need to turn to the Gospels for direction. In Luke's Gospel Christ says 'No one lights a lamp and covers it with a bowl or puts it under a bed. Instead he puts it on the lamp-stand, so that people will see the light as they come in' (Lk 8:16-18).[6] Why then are we hiding the message of Catholic healthcare services?

With respect to the lack of skills in programme writing and communications, international agencies have already positively identified this weakness and have developed skill development tools with faith-based organisations in mind. The World Bank in 2005 offered a programme called 'Enhancing the capacity of FBO to access funding from global initiatives on HIV/AIDS'.[7] The United States government through the Executive Order 13199 of 29 January 2001, established the White House Office of Faith-Based and Community Initiatives (White House OFBCI), which seeks to coordinate a national effort to expand opportunities for faith-based (FBO) and community-based (CBO) organisations. As an outcome of this executive order organisations have been funded to assist FBO in programme proposal writing and reporting. Our international Catholic donors are also a resource to be tapped. The donors have to show sustainability activities for some of their funding and this is one area where sustainability applies.

Finally, to change the mindset of personal or community driven health services to a corporate response means addressing the issues of power and control. Fear of losing control of health services has led to resistance to broader collaboration. The concept of corporate response should flow from the idea of how the corporate response empowers the individual health services in their mission and not how I can control your finances, hiring policies and service delivery models. An individual health service does not have the time and probably not the expertise to be relating to the national government over health policies issues. The same applies for understanding all the nuances of health economics and sources of funding both national and international. In many parts of Africa this is being done through the health desk of the Episcopal Conferences. Would it not be more effective for these activities be done through a national Catholic Health Association? National Catholic Health Associations should not have the issues of power and control since the reasons for their existence is the individual Catholic health services who are the corporate members. The members approve the leadership and the leadership is accountable to the members. If the leadership of the health association does not produce they can be removed. Thus you have effective power sharing and accountability. However it is very difficult, if not impossible, for local health services to remove an ineffective bishop who is chair of the health office at the Episcopal Conference. The same applies for an ineffective health coordinator at the Conference level.

The final outcome of this broad based analysis and restructuring will be strong, professional African Catholic health services which can negotiate from strengths and not weaknesses with national governments and international donors on funding issues. They will understand the dynamics of the market place and be viewed as key players in the health service market. Catholic health care in Africa

would thus be viewed in the same category as the international NGOs who receive a large percent of international funds for supporting health services in Africa. It will also be fulfilling what Pope Benedict XVI stated in *Deus Caritas Est* when we integrate the two key components of health care, professional competence and heartfelt concern. 'Those who work for the Church's charitable organizations must be distinguished by the fact that they do not merely meet the needs of the moment, but they dedicate themselves to others with heartfelt concern, enabling them to experience the richness of humanity'.[8]

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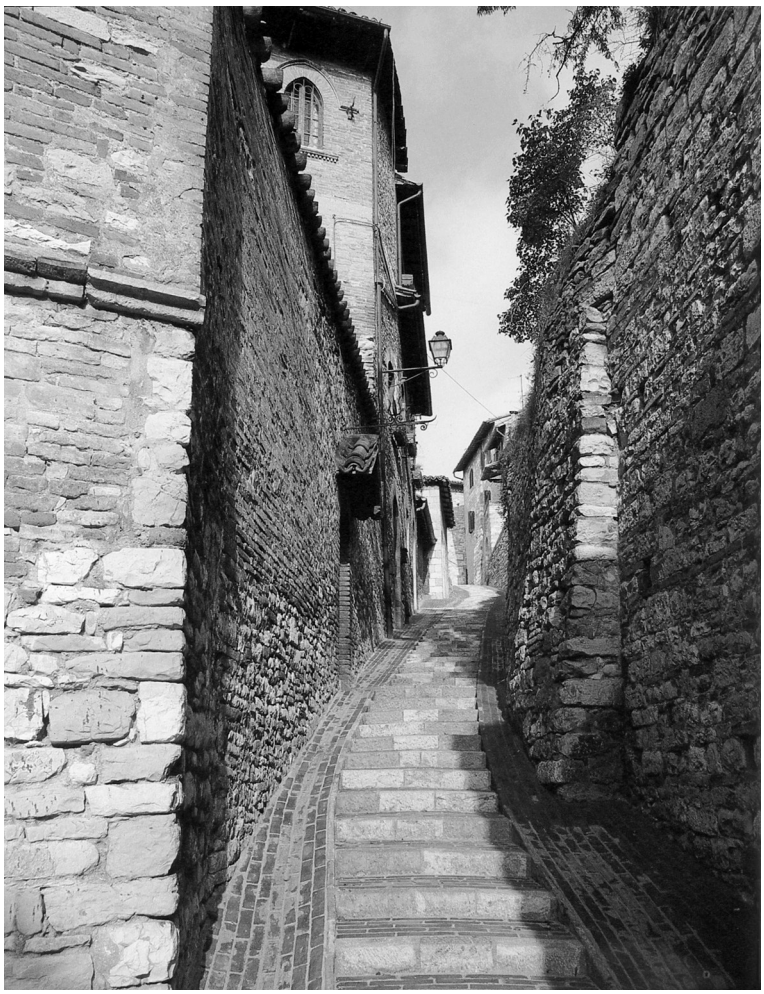
Managing Director Eastern Deanery Aids Relief Program, Nairobi, Kenya.

Notes

[1] MICHAEL SWAN, *Catholic Register*, Toronto Canada, 24 August 2006.
[2] CIA World Handbook 2007.
[3] World Bank 2006 HNP Thematic Data Stats.
[4] *Ibid.*
[5] *World Health Report 2006*, WHO, Geneva, Switzerland.
[6] *The Jerusalem Bible*, Darton, Longman & Todd (London, 1968).
[7] The World Bank.
[8] POPE BENEDICT XVI, *Deus Caritas Est* (Vatican City, 25 December 2005).



IV. Primary Health Care: an Alternative Model

The state of health-care services is a matter of serious concern in most parts of the world. For most of the low- and middle-income sections of the low- and middle-income countries. i.e. the majority of mankind, the issues are primarily those relating to access to what are perceived as good quality basic services. For the better-off across the globe, the issues are mostly those of escalating costs and over-medicalisation. Inappropriate models of development and the organisation of services, as well as the alienation of health-care providers from secular people, have been widely identified as constituting the reasons for the present state of the health services.

A Breakthrough in Global Health Rights

In 1978 a potential breakthrough in global health rights took place at an international conference organised by the World Health Organisation (WHO) and UNICEF in Alma Ata, USSR (now Almaty in Kazakhstan). In the so-called 'Alma Ata Declaration,' 134 countries subscribed to the goal of 'Health for All by the Year 2000.'. They upheld the World Health Organisation's broad definition of health as 'a state of complete physical, mental, and social well-being'.

To achieve 'health for all', the world's nations, together with WHO, UNICEF and major funding organisations, pledged to work towards meeting people's basic health needs through a comprehensive, remarkably progressive approach called 'primary health care' (PHC). Principles and methods were garnered from the barefoot doctors' methodology in China and from the experiences of small, struggling community based health programmes in the Philippines, Latin America and elsewhere.

Health care services are not only about technologies and good management. The Alma-Ata Declaration on Primary Health Care stated desirable health care to be that which is available, accessible, affordable and acceptable in communities, given their specific social, economic and cultural contexts. Lack of access by large sections of the urban poor, rural and tribal populations to basic health care is a glaring issue, and health sector reforms have worsened the situation in the name of improving 'efficiency' and the quality of health services.

Social and Political Implications

Perhaps the most politically-charged aspect of PHC as it was proposed at Alma-Ata was its all-inclusive equity-oriented approach. The Declaration stresses the need for a comprehensive strategy that not only provides basic health services for all, but also addresses the pervasive underlying social, economic, and political causes of poor health. It links health to a strongly participatory strategy that has since become known as 'people-centred development'.

Resistance to Primary Health Care

Sadly, the year 2000 has come and gone, and the goal of health for all in some ways seems farther off than ever before from being achieved.

While a few health indicators have improved modestly since 1978, for billions of the poorest people their health and quality of life have actually deteriorated. This is partly because of decreasing access to costly health services. But it is also because the world's neediest people have been increasingly marginalised by the dominant model of economic development.

As was foreseen, the comprehensive, social-change-fostering concept of primary health care has been resisted by powerful decision-makers at national and international levels. Historically, from the late 1970s to the present, this resistance can be seen in terms of four interrelated assaults.

Four Assaults on Primary Health Care

Selective primary health care – this was introduced in the late 1970s. The comprehensive approach to PHC with its emphasis on equity and its call for a model of socio-economic development conducive to health for all was quickly undermined by experts at the Johns Hopkins School of Public Health who claimed it was too complex and too costly. Instead, they advocated selective primary health care, focusing on a few 'cost-effective', top-down technological fixes 'targeting' high risks groups. UNICEF quickly adopted this selective approach, which in practice focused mainly on oral rehydration therapy and immunisation. While these so-called 'twin engines' of the Child Survival Revolution did succeed in somewhat reducing child mortality, they did discouragingly little to reduce poverty, hunger, or chil-

dren's quality of life. For this, a comprehensive approach is needed that confronts the root causes.

Structural adjustment programmes – these were introduced in the early 1980s. In the 1960s and 1970s the governments and banks of the North loaned a vast amount of money to poor countries in the South to promote a model of development that replaced rural peasants and urban workers with fossil fuel consuming machines. This brought large profits for foreign investors and massive joblessness and increased poverty for the many. When poor countries began to default on their loans, the World Bank and IMF stepped in with bailout loans. These were tied to structural adjustment programmes (SAPs). These required debt-burdened countries to reduce public spending, including that on health and education, to free up money to keep serving their debts to the northern banks. Whereas the Alma Ata Declaration had called for increased government spending on health, SAPs pressured poor countries to reduce and privatise public services.

The World Bank's take-over of third-world health policy –this took place in the 1990s. Prior to the 1990s, the World Bank invested almost nothing in health. But in the 1990s the Bank discovered that poor health reduced worker productivity, thus impeding economic growth (in big industry). So over a few years the Bank increased its investment in health to the point that, by the late 1990s, it was spending on the health sector three times as much as the entire WHO budget. In terms of guiding third world health policy, this has relegated WHO to second place, not only because of the Bank's greater spending but because it can tie its health reform 'recommendations' to urgently needed (or strongly desired) loans. In its 1993 World Development Report, entitled 'Investing in Health', the Bank spelt out its health policy recommendations. These are essentially a free market version of selective health care.

The McDonaldisation of WHO and UNICEF – this took place in the first decade of the new century. Partly because of a shortage of funds, and partly because of the influence of corporate gifts, in the last few years both WHO and UNICEF have entered into an increasing number of 'partnerships' with transnational corporations, including drug and junk food companies. An example is UNICEF's rent plan with the fast-food giant, McDonalds. In its promotion McDonalds will include UNICEF public health messages and boost sales of Big Macs by announcing that part of the purchase price will go to UNICEF. In Nigeria, UNICEF has made a similar agreement with Coca Cola. Compromises with industries that promote products conducive to obesity, heart disease, stroke, and diabetes are not conducive to health for all. The Alma Ata Declaration called for a combating of the underlying social and structural causes of poor health. In contrary fashion, these new partnerships of UNICEF and WHO with transnational corporations further entrenched and legitimised the forces that put healthy profits before people.

How Can we Get Back on the Road Towards Health for All?

It is even clearer today than twenty-eight years ago that the main determinants of health are social, economic, and political in character. Resources exist to provide adequate food and basic health services to everyone. A small fraction of what is spent on arms could provide the necessary health care and food for all those people on earth who now lack them. What is necessary is the political will. The Alma Ata Declaration insisted on putting health – or rather the decisions that determine health – back in the hands of people and communities.

Progress and Reversals in the Implementation of PHC

The implementation of PHC has been rendered difficult by misinterpretation and the changed context. Misinterpretation was even rooted in the Alma Ata document in which PHC was defined as both a 'level of care' and an 'approach': these two different meanings have persisted and perpetuated divergent perceptions and approaches. Thus, in some developed countries and sectors PHC has often been interpreted as

the primary medical care provided by general doctors, and in developing countries as a cheap, low technology option for poor people. Even in countries which embraced PHC as the key to health for all (HFA), conservative changes in the 1980s in the political and economic context bedevilled its implementation.

There have, however, been significant successes. especially in the 1980s, in implementing PHC, although mainly in the development and extension of particular health programmes rather than in the facilitation of social development though the promotion of an inter-sectorial approach and community participation.

The greatest successes in PHC implementation in developing countries have been at the level of its more medically-related elements. For example, in the 1980s coverage of growing children with the six basic vaccinations increased dramatically from below 40% worldwide to reach over 70% by 1990. Similarly, access to oral rehydration therapy (ORT) for treatment of diarrhoea expanded over the same decade as did improved access to water and sanitation in some parts of the world.

However, the control of both communicable and noncomunicable diseases has proved elusive. In particular, HIV/AIDS, TB and malaria are affecting rapidly increasing numbers of (especially poor) people worldwide. HIV, which now affects over 40 million people, three-quarters of them in sub-Saharan Africa (SSA), has led to declines in life expectancy in a number of countries. The control of these three diseases and of chronic diseases, which affect increasingly large numbers of poor people, is complex and clearly requires improved living and working conditions, well-functioning health systems, and strong intersectorial coordination and community mobilisation.

It is clear that progress towards health for all has been uneven. The gains already achieved are under threat from a complex and accelerating process of globalisation and neo-liberal economic policies which are impacting negatively on the livelihoods and health of an increasing percentage of the world's population and of the large majority of people in developing countries. Although the global PHC initiative has been successful in disseminating a number of effective technologies and programmes that have substantially reduced the impact of certain (mostly infectious) diseases, its intersectorial focus and social mobilising roles – which are the keys to its sustainability – have been neglected, not only at the level of words but also at the level of implementation.

Comprehensive PHC

The time is long overdue for an energetic translation of policies into actions. The main actions should centre around the development of well-managed and comprehensive programmes involving the health sector, other sectors and communities. The process needs to be structured into well-functioning district health systems (DHS) which require, in most countries, to be considerably strengthened, particularly at the household, community and primary levels. Here comprehensive health worker schemes should be seriously considered. The DHS has been promoted as the unit within which the implementation of primary health care by the health and health-related sectors (public and private) and communities can be best organised and coordinated. District management structures were envisaged as a focus for the decentralisation of political power and resources, increased democracy, and fairness.

Despite efforts over the past ten years or more, there are few countries where district health systems are functioning fully and effectively. There are a number of linked reasons for this: these are related ultimately to the lack of capacity – human and financial – of health services at local levels and an unfavourable broader political and economic environment.

In short, the development of health systems has been uneven and constrained by fiscal austerity, which in many countries has adversely affected the quantity and quality of human and material resources and logistical support. Efficiency imperatives which have spurred health-sector reform and alternative financing approaches in both industrialised and developing countries have sometimes generated significant innovation but have also often aggravated dysfunctionality and unfairness, particularly in the health systems of developing countries.

The successful development of decentralised health systems will require targeted investment in infrastructure, personnel and management and information systems. A key primary step is the capacity development of district personnel through training and guided health systems research. Such human resource development must be practice-based and problem-oriented, and draw upon, and simultaneously re-orientate, educational institutions and professional bodies.

Clearly, the implementation and sustaining of comprehensive PHC requires inputs and skills that demand resources, expertise and experience that are not sufficiently present in the health sector in many countries. Here partnerships with NGOs and expertise in various aspects of community development is crucial.

Primary Health Care in Asian Countries

At independence the Central Asian countries inherited

massive, inefficient healthcare systems that they are no longer able to support financially. In their current form, the region's public health, service delivery, health finance and medical education systems are unable to address a range of problems that are causing falling life expectancy in the region. Central Asian countries are experiencing heavy burdens of chronic, especially cardiovascular, disease; relatively high infant mortality; high rates of abortion; re-emerging diseases like tuberculosis, syphilis, and malaria; and new diseases, especially HIV/AIDS. At the same time, physicians have not been well prepared to provide high quality evidence-based services that effectively treat the most common and urgent conditions that their people are facing.

Resources that could be used to improve facilities, purchase modern equipment, and further train doctors are instead wasted on many outdated treatments that fail to help patients, and which, in some cases, cause harm. Preventive care measures are poorly funded, and few people understand their own role in, and responsibility for, taking care of their own health. Most Central Asians cannot afford essential medicines. Not surprisingly, these and other factors have led to a serious decline in the population's health. Infant mortality is higher and life-expectancy lower than they were before independence.

Accepting the Role of Primary Health Care

Twenty-eight years after Alma-Ata, it has to be admitted that there are still far too many people who do not have access to basic health care. But there can be no doubt of the enormous impact that primary health care has had the world over. Nations, communities and individuals are far more aware of the need for better nutrition, a clean water supply and adequate sanitation, social support, immunisation, and a healthy environment – and they are more willing to act to provide these things.

Globally, governments are searching for ways to improve equity, efficiency, effectiveness and responsiveness in their health systems. At present, there is no agreement on optimum structures, contents, and ways of delivering cost-effective services to achieve health gains for the population. However, in recent years there has been an acceptance of the important role of primary health care in helping to achieve these aims and in providing cost-effective healthcare to the general population. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development, in a spirit of self-reliance and self-determination.

Reasons for Poor PHC in India

In India, although there are many reasons for poor PHC performance, almost all of them stem from the weak stewardship of the sector, which produces a poor incentive framework. The World Health Organisation (WHO) specifically points out that to some extent the deterioration in health status is attributed to inadequacies in PHC implementation, neglecting the wider factors that have been responsible for this deterioration such as a lack of political commitment, an inadequate allocation of financial resources to PHCs, and the stagnation of inter-sectorial strategies and community participation. The fifties and the sixties really witnessed a considerable shift towards 'health for all' especially in the developing countries. The main problems have been a bureaucratic approach to healthcare provision, a lack of accountability and responsiveness to the general public and an incongruence between available funding and commitments.

The Bhore Committee recommended a decentralised primary health care approach to make health accessible to the marginalised and the underprivileged. At the dawn of independence this was adopted as the basis for India's health care policy. But the actual implementation of this policy was beset with major problems and in the process it became over medicalised, over Westernised, over centralised, and over professionalised and bureaucratised. The focus of people's health in people's hands was overlooked and people's health ended up in the hands of specialists. The strength and resilience of Indian systems of medicine and the social, cultural and economic factors were also ignored. It goes without saying that today the public health system is in disarray and characterised by inadequate capacity in the field, organisational fragmentation and disjointed decision-making. This has failed to mobilise the people to play a vital role in their own health and health-care situations. After sixty years of independence, access to health still remains a cutting-edge issue in India. Health is a function not only of medical care, but of the overall integrated development of society – cultural, economic, spiritual and educational factors, genetic endowment, environmental exposure, lifestyles, social and political influences, income and available medical care. And thus health is a multifaceted phenomenon.

A Rigid Structure

The current PHC structure is extremely rigid, making it unable to respond effectively to local realities and needs. For instance, the number of

ANMs per PHC is the same throughout the country despite the fact that some states have twice the fertility level of others. Moreover, political interference in the location of health facilities often results in an irrational distribution of PHCs and sub-centres. Government health departments focus on implementing government norms, paying salaries, and ensuring that minimum facilities are available, rather than measuring health system performances or health outcomes. Furthermore, the public health system is managed and overseen by district health officers. Although they are qualified doctors, they have barely any training in public health management. Strengthening the capacity for public health management at the district and *taluk* level is crucial to improving public sector performance.

Community Involvement

The principle adopted in Alma-Ata defined community involvement as a process whereby individuals, families and communities assume responsibility for their own health and welfare and develop the capacity to contribute to their own and the community's development. Many countries have successfully learned this principle through various innovations for community action for health. Almost all countries consider this a political necessity and also an important and effective mechanism for the planning, implementation and evaluation of health development at the local level. For effective community action, certain prerequisites are necessary, such as local leadership, decentralisation, appropriate technology, sustainable mechanisms for partnerships, etc. Successful community health development programmes such as the 'Integrated Health Package Programme' (*Po Pelayanan Terpadu* or *Posyandu*) in Indonesia; the 'Village Health Volunteer Schemes' and the 'Integrated Basic Minimum Needs' (BMN) programme in Thailand; and the Community Health Care Programme using a large force of health volunteers in Myanmar, are at the crossroads due to changes in health care management with private-public partnership and decentralisation.

The Catholic Health Association of India (CHAI), one of the world's largest non-governmental organisations in the health sector, with nearly 3,200 member institutions, which include big, medium and small hospitals, health centres and diocesan social service societies, was established in 1943. The members of the association are located in various parts of the country – urban, semi-urban, rural and tribal settlements – and are predominantly engaged in providing curative care, thereby extending health-care facilities to the poor and marginalised. The health centres, which form a majority of the CHAI membership, deliver mainly curative and promotional health services.

Future Thrusts

Achieving universal access to health through national and international networking, and through the process of capacity building and advocacy.

Addressing communicable diseases and related issues through specific interventions of awareness, capacity-building, advocacy and networking.

Assisting in promoting indigenous systems of medicine to enable and empower people to manage health problems as well as to work towards becoming an accrediting institution in integrated systems of medicine.

The Comprehensive Community Health Care Model

The most important need today is for existing centralised and bureaucratic large urban hospitals to be replaced by an alternative model of health care. Rooted in the community, this alternative model would provide adequate, efficient and equitable referral services, integrate promotional, preventive and curative aspects and combine the valuable elements in our culture and tradition with the best elements of the Western system. It is also more economical and cost-effective. The new system of health-care services would be strongly based in the community so that the people can be actively involved in planning and implementing programmes for their own health care. Adequate and appropriate health care can be provided to the entire population at about half the existing expenditure through inter-sectorial collaboration. There have been successful models in the field that have proved that 70-80% of the health needs of the people can be met by the

people themselves. One such model is the comprehensive rural health project, *Jamkhed* (CRHP, *Maharastra*).

Studying various such models, especially CRHP, the Catholic Health Association of India, Secunderabad, India, developed the Comprehensive Community Health Programme which aims to ensure universal access to health for all, and especially for those in the lowest strata of the society. The programme is being implemented at the national level envisaging its eventual mainstreaming.

The Process

Personnel are identified from various health centres and dispensaries (community health coordinators) from different parts of the county and are trained. They in turn reach ten villages within their vicinity and identify and train an active group to become change agents, thereby empowering people. They enable the community to identify problems, seek solutions, network with the local agencies, and lobby with the Panchayati Raj institutions.

The training is focused on the preventive, promotional and curative aspects of health, equipping them to meet 80% of the health needs of the community. The training areas include human and veterinary health, information on Panchayati Raj and related subjects, rural banking, non-formal education, and rural technology.

Resultant Scenario

The process facilitates the participation of the people of an entire community, enabling and empowering them to take responsibility for their health and development, thereby ensuring universal access to health for all, and especially the poor.

The Feasibility of the Programme

The social, technical, managerial and economic feasibility of the model is as follows: employment of local personnel at every level to the extent that is feasible, and training them within this system. This reduces the cost of salaries, training, travel and housing since all such staff are recruited within their locality and community. Mobilising local community support for most functions, e.g. preventive, promotional and curative, with emphasis on the non-medical functions.

All personnel are utilised in a multi-purpose manner as far as this is feasible.

The concept of primary health care as advocated in the Alma Ata Declaration – with its emphasis on equity, strong popular participation, and addressing the underlying social, economic, and political causes of poor health – is as valid today as it was twenty-five years ago. And it is even more urgently needed.

Sr. Dr. VIJAYA SHARMA
Directive Member CHAI, India

(The author acknowledges references to David Sanders, David Werner, Fr. Sebastian Ousepparampil, USAID, and Health Action).

V. Models of Public/Private Management

In the systems of health of the future the role of hospitals will suffer from transcendent changes due in part to phenomena that are known about (ageing, epidemics of chronic illnesses, migratory movements, the expansion of technology etc.) and in part to other important emergent processes[1] which in my view should include:

The Economy

In the management of hospitals the pressure of costs, the impact of the economy in health policies, the consideration that so many times illness by a large measure is due to poverty, is a reality that nobody can ignore. This is totally dependent on the international global situation. I would like to ask you to remember that in September 2000 the governments of the world made compromises with the objectives of the new millennium in the economic, social and environmental fields. In addition, the World Bank has stated that there is a need for greater economic growth in order to move towards the objectives of 2000, especially in developing nations.[2]

The only way by which the poor can improve their state of affairs, in their view, is said to be through encouraging growth. Yes… the world economy is growing but in an unbalanced way, in line with a disintegrated model in the social field and one of predation in the ecological, one that is not inspired with solidarity in relation to those who suffer from privations and in relation to future generations.[3]

The United Nations and Jeffrey Sachs are inclined, in order to defeat poverty, to increase aid for development from the top down (public institutions). Mohammad Yunnus (the Nobel prize for peace) and James Austin (Harvard University) are for an opposite approach and say 'that charity and aid perpetuate poverty'. Official aid for development has been very much discredited and its defects are: a low level of control by the donors of the final destination of such aid, waste, bureaucracy, and the stimulation of the corrupt and dictators.

The new paradigm of the fight against poverty and under-development is to stress activities that begin from the social base.

The not very systemised and decentralised methods of thousands of concrete initiatives are those that can achieve positive results where arrogant centralising planning has always failed.[4] The special political and social situation of Latin America, where changes of a political, economic and structural kind are constantly produced, makes it difficult to describe a homogenous situation.

The State

The role of the state in a globalised world, with the various changes in economic structures and social values, should be reconsidered on the basis of its function in social protection and the distribution of opportunities to its fellow citizens, accompanied by the creation of new health policies. The implementation by governments of new policies of fairness, regulation and financial stability in the coverage of public services has been changed[5] by trying to involve the citizens in the management and protection of their health through the employment of a system of facilitation and bestowal.[6]

The action of the direct management of services is progressively transferred through different channels of the state towards civil society and private initiatives, with an attempt to maintain a high priority for the transformation and decentralisation of the national health systems accompanied by the development of regional, local or council systems.

The Concept of Health

It is necessary to elaborate a more complex way of thinking about the process of health/illness where the historical, social, employment and ecological aspects are taken into consideration.

The concept of health. Medical semiotics and medicine with its symbols allow us to perceive illness and pain as real and accessible to human consciousness and action, and not only, therefore, as the portrayals of a physical subject or a physiological state: they are an essential part of the self.[7] The definition of a hospital, where the meaning of pain finds a fair response, is that a hospital is not only 'an institution that provides accommodation, food and constant nursing care for its patients who are subjected to diagnosis and treatment by health professionals'.[8]

The Definition of Hospitality

A new definition of fundamental rights such as the right to health,[9] coined by men who are experts in humanity and far from philosophical or political positions, which seeks to explain reality with values such as solidarity. All of this helps in the search for mixed markets for the meeting of public needs and helps governments to find hybrid solutions for the management of public services, for example the impulse to initiatives involving public/private capital: (agreements of cooperation between the State and the Church as a private body that provides health services), private hospitals that through agreements become public services managed by private interests, and public hospitals that through agreements of cooperation are managed by private interests, etc. All of this could be the new model to follow in addressing the development of services.

In the recent past when one

spoke about health policies in Latin America it was said: 'it is not possible to follow a pure rational process, thinking that a Ministry or a technical team outlines policies, plans and programmes with the hypothetical participation of a community that does not exist, because one is dealing above all else with organisations of social struggle that have very little about them of the community or culture and use the phenomenon of health as a permanent struggle for so many other suspended claims'.[10]

The Autonomy of Citizens

The development of human knowledge and awareness of individual rights compels the creation of expertise in health services that hospitals cannot ignore. Thus realities such as bad health care, bad treatment, waiting lists and a lack of information are elements that will increase in the future, forcing the creation of new models of organisation and management.

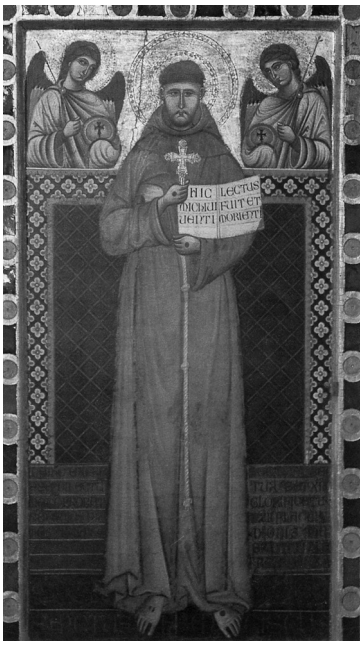
We are in times when a medical doctor is not the person who keeps all information and knowledge to himself. Today the patient is informed and has to hand the resources to have the information that he wants. The information society obliges the medical doctor and the system to be updated and to change their concepts and procedures in the relationship between the medical doctor and the patient. The citizen wants more useful information and thus all the models of management are directed towards the person and not the medical doctor or the institution.

The Change in Clinical Practice

The use of medicine and medical practice in the prevention and care of health in the cultural sphere of membership are tasks of the new health professional. This has adjusted clinical practice towards an effective use of available resources, efficacy and safety in procedures, informed consent, and clinical research applied to the objectives of the system and not to commercial or personal interests.[11]

Technological Development

Biotechnology, genetics, miniaturisation robotics, telemedicine, new vaccines, and the constant search for new therapies for pathologies that until recently were incurable[12] all make us reflect on how the model should change. New professionals, anthropologists, sociologists, physicists, mathematicians, community experts, and care givers are some of the professionals who work in health care and who certainly will be those who will most push for change, together with society and social control, which are becoming stronger every day.



The Transformation of Management

The transformation and decentralisation of health systems are based upon the development of local health systems and administrative solutions where a number of focuses are sought.

Hospitals are beginning to use new models of management that go from a re-reading of the overall scenario of the new management of hospitals to principles for the reform of the health system, from the role of hospitals in the system to the theoretical, methodological and operational aspects of quality in care to processes of support for hospital clinical management, and from the management to change to the use of new models at the level of medical insurance.[13] All of these are subjects which, when the social private sphere is not afraid to employ them, with an approach of being clear in the way of thinking about health, with a sense of why one works in health and of the value that a patient has for the charism of a religious, with the transparency of financial management and the maximisation of costs etc., mean that bodies of the social private sphere become partners that are even more privileged of the public sector.

The Managament of Pharmaceuticals

The improvement of the management of the market in pharmaceuticals (supply, promotion, essential pharmaceuticals), the system of supply (selection, purchase, distribution), prescribing (distribution, compliance, use, management) are all subjects of a very great importance within care. Any health-care worker knows about shortages of this kind but also of the abuse that citizens very often are subjected to because they cannot do without these products.

Conclusion

In my view, models of public/private management presuppose: not very systematised and decentralised systems that come from thousands of concrete initiatives which take into consideration the aspects that have been cited above: the economy, the role of the state, clear concepts of the meaning of pain, suffering, illness and death, the autonomy of citizens, changes in clinical practice, technological development, the transformation of management, and the manage-

ment of pharmaceuticals. They find in front of them: the financing of plans for care of shared risk with the possibility of models of management in integrated systems, and mixed solutions, with the creation of strategic alliances between levels and suppliers of public and private services and with the capacity to proportion complete and integrated care plans, plans for primary, clinical, home and also pharmaceutical care, moving towards a change in care with financing being based on territorial responsibilities.

On the other hand, the manager of the moment of the public sector who only wants results cannot dispense with the, at times centuries-old history, of work in religious hospitals that are managed well, that have the possibility of engaging in dialogue with national, regional or council administrations without fear, with the courage that can only be felt by someone who does not speak for themselves but for other people, for those who have no voice – the patients, and he cannot dispense either with the popular symbolism that very well connects the symbolic elements of pain, illness and suffering with good professionals and good hospitals that demonstrate above all else so much humanity in receiving suffering.

Dr. DANIEL CABEZAS
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The Fatebenefratelli Hospital,
the Tiberine Island,
Rome.

Notes

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[2] *C.Berzoza, Rector of the Complutense University;, Koldo Unceta, Professor of International Economics at the P. Vaschi University, 2007.*

[3] *C. Berzoza* et al...

[4] *V. Poul Serradell, Professor of Economics IESE, 2007.*

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[6] The State in a Changing World, World Development Report 1997, *Washington, The World Bank*.

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[10] *J. Torrez Goitia (the former Minister of Health of Bolivia).*

[11] *J.M. Fernandez and J. Varela, 2002.*

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Ensuring the Sustainability and Effectiveness of Catholic Health Care

My task is to address the very broad topic of the sustainability of Catholic health care. I do not propose to speak about the funding of Catholic health care, although some may think that this is the main point of sustainability. Rather I wish to go to the heart of the sustainability issue, that of how the ministry remains true to its calling. More importantly, the issue of who takes responsibility for ensuring the ministry remains authentic. It is this issue of responsibility for the ministry that seems most debatable as organisational structures become more complex, with civil and corporate duties existing alongside canonical requirements.

Put simply, exercising responsibility involves having the ability to respond. It calls for an appreciation of the fact that the best interests of the ministry are served by a broadly acknowledged locus of authority whereby processes of accountability are established to monitor the effectiveness of the organisational expression of the ministry.

The common understanding of sustainability is to keep something or someone alive. In the context of Catholic health care, it relates to how an organization or service continues to have the motivation, energy and resolve to deliver the healing mission of Jesus.

Put another way, sustainability refers to the durability of an organization as challenges test the effectiveness and capability of its service. An organisation's durability is determined to a large degree by its ethos and culture. How an organization is led and the degree of shared commitment its employees hold for the vision of the organization determine its capacity for innovation, adaptation and endurance.

Therefore, any analysis of sustainability fundamentally rests on an appreciation of an organization's culture and the life that engenders the passion of its service.

In Catholic health care, the founding story of the ministry is the Gospel. Particular religious institutes and congregations have responded to the Gospel call to participate in the healing ministry of Jesus. In all cases they have nurtured and strengthened their ministries with a careful and deliberate formation of staff, the reclaiming of their mission in challenging times and the integration of like-minded and committed lay people into the healing ministry.

This has been a concerted strategy to keep the ministry alive and sustained. It requires careful and prudent stewardship.

For the purposes of this presentation I would like to supply you with a working definition of stewardship since it is not a concept that is clearly delineated in canon law, yet it is a responsibility that those with authority in the Church must embrace.

Stewardship is a particular canonical responsibility best expressed as supervising a ministry's effectiveness in the light of its purpose and mission. This is more simply expressed as a responsibility to keep true to what the ministry is about. Stewardship involves maintaining an authentic identity of the ministry.

For some organizations there may be a definite expression of the ministry that characterises the service. For example, providing palliative care and support for the dying. Others may have a more general focus in providing excellent hospital care or supported accommodation for the frail elderly. Others again may quite specifically focus on HIV/AIDS programs and services in poor communities.

The point of stewardship, though, is to keep the essence of the mission at the forefront of the deliberations, planning decisions, strategic considerations and staff training within the organization.

Strong and effective stewardship requires particular competencies and support structures. Without these the sustainability of the ministry is at risk.

At a minimum the stewardship of an organization requires the following competencies to be made available to it:

– Discernment skills to provide direction and strategic counsel.

– A sound general knowledge of health care and its developmental aspects.

– A capacity for theological reflection with reference to the mission and vision of the ministry.

– A disposition to integrate a faith perspective into the circumstances in which the service functions.

– An understanding of Catholic ethics and spirituality and their application in contemporary health-care settings.

Stewardship is a shared responsibility and these competencies are usually found within a team of people; less commonly should they be asked of an individual alone.

This implies that the stewards are well formed and educated people, dedicated to the Gospel and faithful to the integrity of the ministry. It is as much a vocation in health care as is the role of the committed doctor, nurse and administrator.

As religious begin do diminish in number in some countries, their roles will fall to lay people and a sound education process will be vital to form suitable stewards.

At the same time, effective support structures are needed to assist the stewardship task:

– A dedicated faith community to provide spiritual and emotional support to those with stewardship responsibilities.

– Expertise in ethics, theology and health service delivery to inform decision making.

– A collaborative network of other Catholic stewards to gain from the benefits of other experience.

– An on-going education and formation program to improve the skills and competencies of the stewards.

One very important aspect of stewardship is the ability to articulate the essence of the ministry so that others can gain insight, inspiration and direction for their work. This is a demanding responsibility, but an essential one.

In a general sense the Catholic vision of health care is both a work of mercy and a work of charity. The healing ministry of Jesus and thus the mission of Catholic health care is to fully engage with human frailty and illness. St. Thomas Aquinas describes it as the 'heartfelt sympathy for another's distress, impelling us to succour them if we can.'

This is the essence of what needs to be sustained.

It is fundamental to the distinctive nature of a Catholic health ministry. It is not a business and it is not a government health program. Rather it is a tangible expression of God's love in action.

By anyone's standard this is a weighty responsibility.

Not only does it require a significant degree of education and formation of senior staff, boards and others to understand the Gospel imperatives involved in health care, it also requires serious supervision so that those being served are treated with a dignity and respect consistent with the values that underpin the corporate works of mercy and charity.

This means in effect that effective stewardship needs to remain close to the ministry and involved in its governance enough to satisfy the canonical responsibilities.

It is important to note that this is not a withdrawal from the 'cut and thrust' of the ministry, rather it is a strategic positioning to effect the responsibilities of stewardship.

In practical terms the stewards or trustees of the ministry need to remain informed, educated and in positions of discernment over the direction and performance of the ministry.

This implies supervision of both the ethics and the spirituality of the ministry.

Thus stewardship involves a series of tasks that contribute to a framework of sustainability of the ministry.

1. Nurturing a distinctive Catholic culture of service delivery – ensuring that sacramental and liturgical features of the ministry are integrated into the normal course of events and are used to signify the character of the ministry.

2. Engaging in a theology of health care – the context of health care is often heavily influenced by the funding of the service. Whether it be through markets or through funded programs, there needs to be an on-going theological reflection within that context.

3. Addressing the secularisation of health care – the essence of Catholic health care is maximising the dignity of people, not the commodification of their health care needs. Catholic ethics is based on a natural law tradition, not utilitarianism, and resource allocation and strategic planning need to be advanced accordingly.

4. Formation and education – people charged with leadership responsibilities in the ministry require more than the technical expertise of delivering health care services, they need the intellectual content associated with sustaining Catholic identity.

5. Building a Church presence – as health care systems change and threaten the existence of smaller less resourced services, there is an imperative to keep the Church's presence in the system alive. This may mean the collaboration, even merging, of existing services to maintain a strong entity for the future.

6. Being prophets for the less well off – the Church's responsibility is also to act for justice in health care and to agitate for a better distribution of health benefits and outcomes for the less well-off. The institutional presence of the Church in health care can lend significant advocacy for

those with little or no voice in the public debate.

7. Succession planning – a responsible approach to stewardship and leadership generally is to plan for the next generation of leaders. This implies a strategy and a preparedness to resource the identification and development of future leaders, stewards and trustees.

8. Just workplaces – the pressure on escalating health costs can lead management to unfairly reimburse employees. A just workplace recognises the worth and value of employees.

9. New ministry opportunities - the ethical distribution of scarce health resources requires discernment over the best use of those resources. It also means resisting duplication of services when other areas of unmet need remain unaddressed.

10. Application of performance assessment of agreed mission outcomes – as the context of the health ministry becomes complex and commercialised, the distinctiveness of a mission-driven service needs a fine tuned evaluation. This is best approached through a process where agreed results are sought and assessed. These results can relate to organisational as well as staff level activities.

I am very conscious that I have not yet alluded to the most vibrant of strategies to sustain the ministry. A prayerful approach and a faith-filled perspective are the bedrocks on which all ministry is sustained. History shows that challenges to Catholic health services have best been negotiated through responses that find their motivation and even confidence in the strength of the Holy Spirit.

Thus the future of Catholic health care lies in the promptings of the Spirit and in the courage of those enticed to follow.

FRANCIS SULLIVAN, CEO
Catholic Health Australia

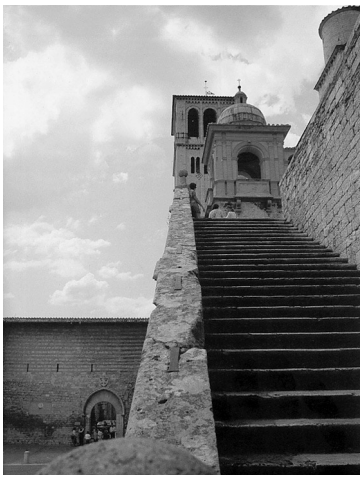
THE SIGNS OF HOPE FOR A FUTURE SUSTAINABILITY OF THE MINISTRY

I. The Signs of Hope for a Future Sustainability of the Ministry as Seen in Asia

1. Introduction

Due to several discoveries in medical science and the concerted efforts of governments to implement improvements in the general health conditions of people as recommended and mandated by international bodies, today we are experiencing great gains in health outcomes. These gains are partly the result of the improvements in income level and the improvements in health-enhancing social policies such as clean water, sanitation systems, nutrition and housing. Improving ways to finance health care and protect the vulnerable population against the cost of illness have been crucial to this success story.

But we also witnessing today a crisis in access to, and the affordability of, health care as the gap between rich and the poor widens. In several middle- and low-income economies in the world there is a trend towards privatised health care which leaves out a vast proportion of the country's population who live at a subsistence level. Those who have the capacity to buy health care from the market do so from their resources and even try to manipulate the health-care system of the government to obtain for themselves direct benefits. Those who live a hand-to-mouth existence are forced to make a direct payment often with a heavy burden of debt or the sale of assets to access health care from the market. The network of health services becomes structured in such a way that it is top-heavy, over centralised, highly curative in its approach, urban-and-elite oriented, expensive, and dependency-creating. In short, the key barriers to good health care are not lack of technology and sophisticated equipment but inequity in health-care systems and the poverty of the masses. The share of the world's population protected against the catastrophic cost of illness only rose significantly during the last decades of the twentieth century.



2. Signs of Hope for the Future

In the context of high costs for health care where the poor are practically excluded, community-based health financing is a sign of hope of the times. This has different shades and meanings as well as different type of schemes whereby lower-income groups in Asian countries largely benefit. We describe some of the schemes here below. The following is taken from the book *Health Financing for Poor People- Resource Mobilization and Risk Sharing*, edited by Alexander S.Preker and Guy Carrin and published by the World Bank (Washington D.C), World Health Organization (Geneva), and International Labour Office (Geneva), 2004.

2.1 Community-based health financing

Community initiatives have recently been started to bridge the gap in social protection between people covered by formal schemes and those with no protection at all against costs of illness that demand economic means beyond their capacity. Today there is the term 'community financing' or 'community-based health financing' which has evolved as a generic expression to cover a large variety of forms of financing community health. Alexander S. Preker and Guy Carrin (*op.cit.* .p. 9) list the following components as community-based health financing. 'Community-based health care financing reflects most of these concepts. One common feature of the definitions is the predominant role of collective action in raising, pooling, allocating or purchasing and supervising the management of health-financing arrangements, even when there is interface with government programs and services in terms of subsidies, supplemental insurance coverage, or access to public provider networks. Some community-fi-

nancing schemes cover common geographic entities, while others are based on profession affiliations, religion, or some other joint activity.

A second common feature relates to the beneficiaries of these schemes, who tend to be populations with no other financial protection or access to collective financing arrangements to cover the cost of health care.

A third common feature is the voluntary nature of these schemes and the tradition of self-help and social mobilization embraced by the poor in many low-income countries…

The growth of community-based health financing arrangements rests on developments in three related areas.

– Microfinance (microcredits, microsavings, microinsurance, financial intermediation).

– Social capital (community, network, institutional, and societal links).

– Mainstream theories (welfare or society, public finance, social policy, and health policy)…

On the one hand different authors use the term community financing in different ways. On the other hand, similar-more-specific-terms are often used to describe similar financing arrangements. Microinsurance, community health funds, mutual health organizations, rural health insurance, revolving drug funds, and community involvement in user fee management have all been referred to as community-based financing. Yet each of these risk-sharing arrangements has different objectives, policies and management, organizational and institutional characteristics, and different strengths and weaknesses'.

2.2 Community-based health insurance

Community-based health insurance is based on risk sharing options. In the words of Kent Ranson and Akash Acharya (*Health Action*, published by the Catholic Hospital Association of India, March 2003 p. 12f), risk-sharing occurs when the payments one makes into the health-care system do not correlate (at least not entirely) with the risk of falling ill or requiring health-care services. Risk would be shared, for example, if all people made payments into the health-care system according to their wealth (i.e. their 'ability to pay') and were provided, in return, with health-care services in proportion to their level of medical need. Risk-sharing is intended to result in the redistribution of resources from those who are healthy towards those who are ill and in need of health care…

Community-based health insurance refers to insurance schemes, typically targeted at poorer populations, in which the targeted community is involved in: defining contribution level and collecting mechanisms; defining the content of the benefit package; and/or allocating the scheme's financial resources.

2.3 Some specific community- financing scheme in Asia

China's Cooperative Medical System (CMS)

In China, about 800 million people live in rural areas and most of them are engaged in farming. The tradition was that health care for China's rural population was organized and financed through the Cooperative Medical System, an integrated part of the overall system of collective agricultural production and social services. Village health stations served an average of 500 to 1,000 residents. These were staffed by part-time village doctors whose training consisted of three to six months basic medical education after junior middle school. Their role was to provide basic preventive care (for example, immunization, prenatal consultation) and simple curative services (treating common illnesses and injuries).

At the peak of the CMS, 90 percent of the rural population was covered by its schemes. Health services, financed through the CMS, relied on prepayment plans. Most of the villages funded the CMS from three sources:

– *Compulsory prepayment by residents*. Depending on the benefit structure of the plan and the local community's economic status, 0.5 to 3 percent of a peasant family's annual income (4 to 8 yuan) was to be paid into the fund as premiums.

– *Village contributions*. Each village contributed a certain portion of its income from collective agricultural production or rural enterprises to a welfare fund, and a portion of this fund was used to finance health care.

– *Government subsidies*.

Subsidies from higher level governments funded the compensation of health workers and capital investments

China achieved remarkable improvements for its rural population.

Bangladesh: community sponsored insurance

In Bangladesh, community participation in health care is increasing. NGOs and the private sector actively organize and finance health-care delivery. Community health insurance schemes have emerged as a mechanism for paying providers and mobilizing resources. Examples in Bangladesh include the Grameen Health Program (GHP), the *Gonoshasthaya Kendra* (GK) health care system, and the Dhaka community hospital insurance program.

– The Grameen Health Program (GHP)

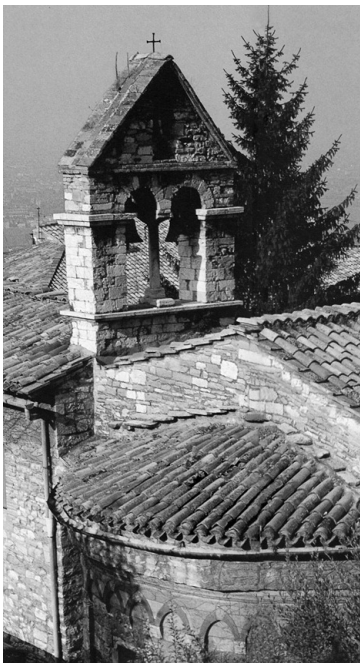
The Grameen Bank, which is internationally known as a successful group-based credit program, provides credit to the rural poor, particularly women, who own less than a half acre of land or whose assets do not exceed the value of one acre of land. At present, *Grameen* has 2.3 million members and covers almost half the villages in the country through 1,167 branches. It started health programs in 1993.

The *Grameen* Health Program was established to provide basic health-care services to its members as well as non-members living in the same operational area and to provide insurance to cover the cost of basic care. The GHP thus functions as an insurer as well as a health-care provider.

Each centre is staffed with a doctor who acts as the centre doctor and with a paramedic, a lab technician and office manager. Each centre is attached to a Grameen Bank Branch. It provides outpatients services, routine pathology, and basic drugs. Health workers provide door-to-door services on health education and health promotion.

– The Gonoshasthaya Kendra (GK) Health Care System

This is an NGO-run local health-care system. It initiated a community insurance scheme to increase the poor's access to health care. GK subscribers pay a premium for a package of benefits including primary health care and some portion of hospital care.



– The Dhaka Community Hospital (DCH) Insurance Program

This offers quality health-care services at low cost, so most of the poor people can afford them. In its system the DCH attempts to integrate the provision of primary, secondary and tertiary care. The DCH itself operates on a fee-for-service basis and provides walk-in services at fixed rates which are lower than those of equivalent private, for-profit hospitals. The DCH offers a special program called 'After Payment', which allows patients who cannot pay at the time of treatment to pay the medical bill in instalments after treatment. The patient's community guarantees payment. The 'After Payment' program is very small, only two to three cases per clinic per year. Since communities take the responsibility for making sure the fees are paid, no default has so far occurred. The DCH is self-reliant and receives no funds from the government or donors.

The Thai health card

The population of Thailand is estimated to be 59 million, of whom 31.5 percent are urban, hence the ratio of urban to rural population is about 1:2.

The health card program was implemented in 1983 as a voluntary scheme, primarily to promote maternal and child health. Purchase of the card meant prepayment of a certain fixed premium, capitation to the provider, in return for free services for one year. Proceeds from the card sale went into the health card fund and were managed by a village committee The program's primary objective at inception was to improve health among rural populations, with an emphasis on primary health care, including health education, environmental health, maternal and child health, and the provision of essential drugs. The system incorporated a referral system from primary care to tertiary care. The program was also intended to involve local villagers in self-help as well as in managing the health card fund.

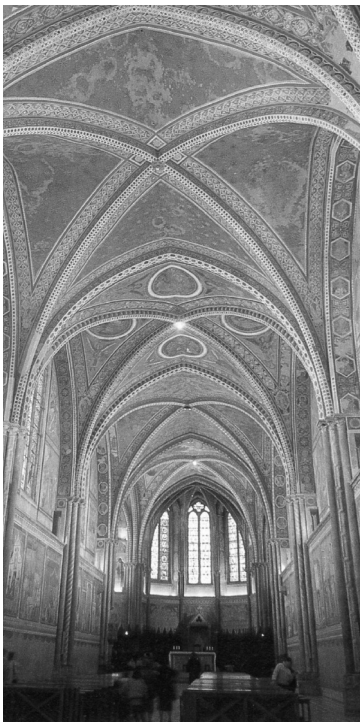
In 1994 free health cards were given to community leaders and village health volunteers to provide free health care for their families. The voluntary cardholders consumed more health care than other types of cardholders. The compulsory community leader cards and health volunteer cards provided better risk pooling and compensated for the deficit in operating the voluntary health cards. Considering costs per card in relation to population coverage, provinces with low coverage of health cards were more likely to face higher utilization rates and health expenditure per card than provinces

with a high population coverage. Therefore, the health card fund provided on average only a 50 percent subsidy to the regional and general hospitals while providing a 80 percent subsidy to the community hospitals and the full cost to health centres.

Initially, individuals with a monthly income below 1,000 Baht (20 Euros) were eligible. Now, health card eligibility extends to families with monthly incomes lower than 2,800 Baht (56 Euros) per month and individuals with monthly incomes below 2,000 Baht (40 Euros), primarily farmers and informal sector workers at the community level. The cards entitle holders to free medical care at all government health facilities operated by the Ministry for Public Health, the Bangkok Metropolitan Administration, the Red Cross Society, Pattaya City, and the municipalities. Each card is valid for three years. The government provides block grants to health facilities based on the expected distribution of the eligible population and past records.

Indonesia's Dana Sehat and Health Care Scheme

Indonesia has the world's fourth largest population, around 210 million people living on 5 major islands and 30 groups of small islands. The urban-to-rural ratio is 30:70. Since the early 1970s, the Ministry for Public Health (MPH) has encouraged the *Dana Sehat* (the village health fund) program. The objective of this program has been to improve the coverage of health services in Indonesia by accelerating community participation in financing and maintaining its own health. In 2000, the total membership of *Dana Sehat* was 23 million people, about 11 percent of the total population. The *Dana Sehat*, a voluntary community-based, prepaid health care program, is commonest in the rural areas of Indonesia. The prime movers are health centres, local government, and NGOs such as cooperatives and *pesantrens* (Muslim teaching units). The people covered are primarily farmers, fishermen, and students.



Microcredit linked health insurance schemes – NGO managed health insurance schemes - INDIA.

In India every State has several such schemes run by NGOs. I will describe here one such programme: the SEWA health insurance programme

'In India, SEWA is a trade union of 215,000 female workers in the informal sector. It organizes them at the household level toward the goals of full employment and self-reliance. Full employment includes social security, which in turn incorporates insurance. SEWA's experience has revealed that women's efforts to escape from poverty through enhanced employment opportunities and increased income were repeatedly frustrated by crises such as sickness, a breadwinner's death, and accidental damage to, or destruction of, their homes and work equipment. Too often maternity also becomes a crisis for a woman, especially if she is poor, malnourished, and living in a remote area. One SEWA study observed that women identified sickness of themselves or their family members as the major stress events in their lives. Sickness was also a major cause of indebtedness among women.

From the start, the health insurance program was linked to SEWA's primary health care program, which includes occupational health services. Thus insured members also have access to preventive and curative health care with health education. Health insurance accounts for most of the claims and for 50 percent of the premiums paid out to the insurance program by SEWA members. The SEWA Bank introduced the scheme in March 1992, with an initial enrolment of 7,000 women from Ahmedabad city. Later extended to cover rural women from nine districts of Gujarat, it now has 30,000 women enrolled, half of them rural dwellers.

Health insurance is an integral part of the SEWA's insurance program. The main motivation for initiating a women's health insurance scheme was the recognition that maintaining active, health-seeking behaviour is vital for ensuring a good quality of life and women tend to place a low priority on their own health-care needs.

The SEWA health insurance program includes maternity coverage, hospitalization coverage for a wide range of diseases, and coverage for occupational illnesses and diseases specific to women. It covers diseases not covered by the GIC's Mediclaim plan and also provides life and assets insurance for the women and for her husband or, in the case of widowhood or separation, for other household members. Administrative procedures under the plan are simplified.

The SEWA health insurance scheme functions in coordination with the Life Insurance Corporation of India (LIC) and the New India Assurance Company (NIAC). SEWA has an integrated

package to address women's basic needs. The claimants are needy health-benefits seekers, and as the insurance is an additional benefit, the beneficiaries willingly pay the premium. Most of the insurers opt for a fixed deposit of Rs.500 (Euro 9.5) or Rs.700 (Euro 13) (depending upon the type of coverage) and the SEWA Bank's large membership and assets have enabled it to provide this insurance coverage at low premiums'.

An example of national and international health financing with the cooperation of the Church - INDIA

The Global Fund: The United Nations General Assembly Special Session on AIDS in June 2001 concluded with a commitment to create a fund to prevent and treat AIDS, TB and malaria. A permanent secretariat was established in January 2002 in Geneva, and just three months later the Global Fund Board approved the first round of grants to thirty-six countries. As a partnership between governments, civil society, private sector, faith-based organizations and affected communities, the Global Fund represents an innovative approach to international health financing.

– The formation of a consortium for GFTAM Round VI and the selection of PR and SR

The Country Coordinating Mechanism (CCM) of the Global Fund for TB, AIDS and Malaria (GFTAM) and the National AIDS Control Organization (NACO) of the Government of India approved the proposal submitted by the Catholic Church network in August 2006. As they finalized the country proposal, the CCM and the NACO requested the Catholic Church to form a consortium in which the Population Foundation of India (PFI) was to be the Principle Recipient (PR) (since they were sub-recipient in previous two rounds of the GFTAM), and the Health Commission of the Catholic Bishops' Conference of India (CBCI-HC) was asked to be the Sub Recipient (SR). Together with the CBCI Health Commission, Caritas India will be the implementing partner and Constella Futures will provide the technical support.

– *Objectives*

The main objectives of the proposal submitted to the Global Fund-Round VI by the consortium are:

1. to ensure access to treatment for opportunistic infection (OI) and to improve drug adherence by establishing community care centres (CCC) for PLHA.

2. To integrate HIV/care and support services into existing outreach activity and build capacities and facilitate community-based care.

– The functions of the CCCs are as follows:

– The provision of OI treatment.

– After initial diagnosis and initiation of anti-retroviral therapy (ART), the provision of five day in-patient care and counselling on drug adherence, nutrition and behaviour support etc.

– The identification of the patient and follow-up for adherence through house visits.

– Advocacy for early testing and counselling at the VCCTC through outreach programs.

The National AIDS Control Program (NACP III) of the Government of India has estimated a total requirement of 350 community care centres across the country. Against this requirement, at present there are already 122 functioning CCCs.

The CBCI Health Commission and the members of the consortium have the task of setting up forty-five such community care centres in five States in north India, such as Bihar, West Bengal, Orissa, Chattisgarh and Gujarat. The project will be implemented in consultation with the bishops of each diocese, and in collaboration with the diocesan social service societies, Regional Fora of Caritas India, the Health Commission of the Regional Bishops' Council and the respective CHAI units.

Out of these forty-five community care centres, twenty-five will be established in the first year and the remaining twenty will be established in the following year.

In the project area, the Catholic Church's network has 85 hospitals, 136 functional community-based health centres. Of these 221 health-care facilities, spread out in 18 dioceses, 105 are in category 'A' districts and 116 are in category 'B' districts,

as per the assessment of HIV prevalence reported by NACO. The facility of these existing health-care centres of the Church will be enhanced so as to achieve the project's objectives.

– *Budget*

A total budget of Indian Rupees 46,47,37,506/- (Euros 8,768,632) has been approved for this programme for the five-year period. A CCC is supported for five years as per the NACO guidelines, which approximately comes to around Rs.1,950,000 (Euros 36,793) and Rs.1,500,000 (Euros 28,302) each in the subsequent years. It has a provision for a part-time doctor, two nurses and other paramedical staff and an office staff. It also takes care of the medicine and nutritional support of the beneficiaries. No financial burden will weigh on the institution for admitting and caring for ten infected persons at a given time in the centre.

3. Conclusion

Every dark cloud has a silver lining when lightning appears. Similarly, at a time when people of good will and particularly the Catholic Church are concerned about health care for the poor and the marginalized, who do not enjoy proper health care in their own countries, the above community-based health programmes serve as great signs of hope to those deprived of proper health care. This is particularly true of those who suffer from deadly diseases such TB, AIDS and malaria.

H.E. Msgr. YVON AMBROISE
Bishop of Tuticorin, India

II. Signs of Hope for the Sustainability of the Ministry

Observations

I assume that you as well have had the experience that I have had. Given that this conference offers me the opportunity to do so, I would like to share my experience with you here.

I believe that we have had a good meeting. I believe that it has been well organised and led, that it has been practical and that it has given us the opportunity to work in an active way. Despite the limitations due to the fact that we speak different languages, we have met many interesting people and we have met others that we already knew about, all of whom are actively concerned and committed in relation to how we should continue to work in the world as Catholic hospitals.

The reflections that have been presented are to be appreciated. All of them begin with an experience and have led us to engage in an analytical reflection on our reality. As a group, the number of those present was sufficient and allowed us to work well, even though the great diversity that existed prevented us from exploring certain subjects.

We have really been catholic, in the etymological sense of the word – universal. The dialogues with people who belong to different realities with different visions according to the context of their responsibilities and on the basis of the experiences that each one of them has had in their lives, have enriched us.

I believe that we recommence satisfied – and I am satisfied – at what we have achieved, independently of the fact that we must explore further certain elements. We have given ourselves the task of doing this over the next five years.

I would like to point out here certain concrete signs of hope:

Called to be evangelisers beginning with service to the suffering

We have observed once again that as a Church we are present in the world of health and health care to be an evangelising sign. We thank the Lord for the gift of our vocation. We feel proud that we can be near to people who suffer and we want to do this like Jesus Christ with our actions and, when this is suitable, with our words.

We ask the Lord at this moment to increase our faith and to be able to transmit it to those people that our ministry leads us to meet. We ask him to increase our hope so that in being near to the sick and their families we can be witnesses. We ask him to help us to work with charity so that we can be witnesses to his life and his resurrection.

This requires that we work with quality, that we grow as people so as to be able to humanise, training ourselves in professional contexts and in philosophical and theological contexts, in order to create the climate that our institutions require for people and for the different religious confessions and cultures.

Called to be witnesses in different parts of the world

My experience of being universal centres around the prism of Europe. I was happy to share our group deliberations with people who in practice come from the five continents of the world.

This leads us, as we have done on many other occasions, to be a Church of principles that contemplates situations from close at hand. I believe that we are given great hope by the fact that we have openly shared our experiences, our difficulties, and the great satisfactions that we receive in the world of mission.

In the case of Europe, I believe that we are called to strengthen a kind of identity that knows how to be present evangelically in a secularised world, open to respect for others and the understanding of their realities in the vulnerability of illness, We must do this, however, beginning with our identity experienced like Jesus with very humanitarian approaches, trying to illuminate the lives of people on the basis of our experience of faith. Illness and death lead us normally to ask ourselves about the meaning of existence and we must know how to illuminate them with tenderness and ability.

Our experience of the living Christ, our training, our cocktail of spirituality and ethics, our acting with intelligence and the heart, allows us to be witnesses in this Europe that is positivistic and materialistic but which needs to give a meaning to its own existence.

Called to promote actions with great sensitivity for the poorest

The sick are poor because of the fact that they are sick, above all in cases where no cure exists. The mentally ill are poor because of their poverty of equilibrium, of wisdom, and of harmony in their personalities. The sick become even poorer when they live in a state of existential poverty that impedes them from gaining access to a possible recovery of health.

Our Europe is rich in resources but it has selfish approaches, it thinks only about itself, it also takes advantage of the poor, and it is not inspired by solidarity in some of its forms of behaviour.

This conference has reminded us once again that in order

to give health to everyone our health-care work must be motivated, that to the extent that this is possible we must create networks of health-care activity throughout the world, and promote actions that foster a change in the potentialities in this globalised world so that people can live everywhere with dignity.

I believe that we recommence from here with all of us being more aware of the prophetic dimension of our lives and of the need to be involved in advocacy on behalf of those who are most in need. We realise that within our institutions as well we must foster care for those who do not have resources and welfare coverage so that they can have access to those of our services that they need because of the particular conditions of life in which they find themselves – the unemployed, immigrants etc.

Called to grow as a group thanks to acting in associations

I can state as a result of my own small experience that the AISAC as an association is reaching its adulthood. The proceedings of these recent days have led our association to reflect on how it can be better organised and on the response that Catholic hospitals or health-care centres are called to give.

Only if our centres have the inner energy, a defined vision and mission, clarity in their expressions and in their way of acting, leaders trained for what we are called to be, a theology of health care based upon experience and a link between care, teaching and research, will they have the possibility of really associating together and creating a strong presence in the world as Catholic hospitals, a presence that brings together living cells that want to vivify and not dead realities that do not know how to resuscitate.

We are called to grow in vitality in our local realities and in our national and international realities.

It is in this way that our association will offer a sign of great vitality for health in the world and as a Church.

We have been called to create the future

In recent days we have analysed many elements beginning with illuminations that I see as opportune and positive and the exchange of the ideas that we have had.

We are present in the world with different situations, moved, however, by the wish to do good and to be witnesses to the merciful Christ through our lives, expressed in our health-care vocation.

We cannot improvise. In recent days we have spoken about the many things that we can and we must do, and amongst these is a good strategic plan.

As an association, I hope that both those who are most directly its protagonists and each one of us wherever we are commit ourselves to creating a future for the health care of the Church, which is of our world, with greater knowledge and involvement.

The future is always an opportunity, it is a reality that is before us every day and in relation to which we must be committed in a living and dynamic way.

I very much like a phrase of John Paul II from 'The Consecrated Life': 'You do not only have a glorious history to remember and to narrate, *but a great history to build*'.

Let us commit ourselves to living our future with great hope, to creating it despite the difficulties that we may encounter which we know about and have commented on in recent days.

Conclusion

Allow me to bring to your minds again the image with which His Eminence Cardinal Lozano Barragán ended his paper, that is to say Christ who knocks at our door.

Christ is now knocking at the door of our being, the being of each one of us, at the door of the AISAC, and at the door of our conference, now.

Let us listen to his voice. He is our great hope.

Thank you.

Bro. PASCUAL PILES FERRANDO OH,
Former General Prior of the Hospital Order of St. John of God, Member of the Pontifical Council for Health Care Workers. the Holy See

III. Reflections on the Congress Through One North American's Eyes

1. The First Sign of Hope I Identify is the Gathering Itself

– 100 men and women-lay, religious and ordained, committed in a variety of roles to the ministry of Catholic healthcare, gathered to reflect together on the heart of the ministry and its future.

– This gathering is an expression of the universality and beautiful diversity of the Church.

– This gathering is a sign of the whole Church embracing and expressing the healing mission of Jesus.

– Implicitly we are a sign of continuity with all those who have done this ministry ahead of us and a sign of hope that there will be others to continue the ministry after us.

– The design and objectives of the gathering clearly point to the inherent value of meeting and being with one another.

2. Another Sign of Hope is the Methodology of the Gathering – the Dynamic of Theological Reflection

– We have articulated the realities and experiences of those providing Catholic healthcare throughout the world – expressed as both challenges and creative responses to these challenges.

– We placed that experience in dialogue with the Gospel, the good news of Christ who came to bring healing and wholeness for every person.

– We spoke of Jesus the healer, the doctor.

– We referred to the paradigmatic story of the Good Samaritan.

– We remembered Peter giving the gift he had received – healing a man by saying, "stand up and walk".

– As the result of this dialogue between the tradition and our experience,

– We have explicitly asked ourselves: Where is God in this? What are we being called to do?

– We have articulated some possible actions.

– And the reflection continues – the meeting itself is now the object of our thoughtful and prayerful reflection.

3. It is a Sign of Hope that we See the Challenges Outlined by Various Representatives of the Continents as Calls to Greater Fidelity to the Mission of Catholic Healthcare

– The presence and action of the Holy Spirit can be seen, I think, in the convergence of challenges, issues and possible actions around:

- Catholic identity.
- Formation.
- Collaboration.
- Solidarity with those who are poor, and
- Advocacy.

– Although these realities may be experienced differently in the various cultural and social settings we are part of, naming them in similar ways is a source of unity among us.

4. There is also a Sense that we Have All that we Need to Face the Challenge

– This is our faith in God who is with us.

– But it is also based on the recognition that we have many resources that can be shared with one another.

– I have heard explicit commitments to share these resources, and

– Several of our proposed action steps are about finding mechanisms to share more effectively.

5. By Explicitly Focusing on Solidarity with those who are Poor, Collaboration and Advocacy, we Demonstrate that we are Indeed the Followers of Christ in the Spirit of Gaudium et Spes

– The joys and the hopes, the griefs and the anxieties of the people of this age, especially those who are poor or any way afflicted, these too are the joys and hopes, the griefs and anxieties of the followers of Christ.

6. I am Particularly Energized and Hopeful Because of Our Emphasis on the FORMATION of all those Responsible for Catholic Healthcare

This gives dramatic and concrete expression:

– to Vatican II's emphasis on our common baptismal call to holiness and service

– and to a sense that we are all responsible for the mission of being Christ in the world.

I am hopeful because I know the efforts that have already been made in this area and because this was discussed among us with such passion and commitment.

I am hopeful because a focus on formation opens up

many opportunities for collaboration and the sharing of resources.

I am hopeful because these formation programs are already building up the Church in wonderful ways.

7. Finally , Our Grappling with the Issue of Catholic Identity Energizes me – it is an Ongoing Theological Reflection

By reflecting on Catholic identity and struggling to give it verbal and practical expression,

– We have shared our deepest convictions and beliefs.

– We have respected our diversity and recognized that we approach this and so many other things very differently.

– We have struggled to have the largest world view; in fact, the mind and the heart of Christ.

This reflection has put us squarely in the continuity of history where every generation has been called upon to apply the Gospel in the context of its social, political, economic and cultural milieu.

In this Easter season, it may be appropriate to express the meaning of this gathering in terms of the Pentecost event.

– We have been in a kind of upper room, filled with some fear and more anticipation.

– We have had a sense of the Holy Spirit among us – the energy and power of God; and

– We leave this place with renewed commitment to the mission of Catholic healthcare and a renewed sense of its evangelizing and sacramental power for a world in need of healing and compassion.

KATHERINE GRAY, CSJ,
Directive Member CHAI, USA

IV. Reflection on the Congress Themes from the African Delegates

1. The Identity of the Catholic Healthcare Ministry:

We have realized that though we instructively know 'the identity' it is critical that we explicitly define it in order to provide guidance and direction to ourselves, understanding those we serve and a foundation for continuity for those who will follow us.

2. The Challenges confronting the Ministry:

The challenges are the same in all five continents albeit in different stages pf evolution/development. The strategies for solving/addressing are the same in principle but necessarily can be resolved or applied in the context in which they exist.

3. The Responses of the Ministry:

Again the responses are similar and possibly the same in principle. Responses reflect different stages of socio-cultural and economic developments in respective nations but all are fundamentally geared towards sustaining the health ministry of the church.

4. Proposals for advancing the Ministry:

a. The proposals are reflective of the challenges and issues raised.

b. The proposals are generic in that sense I mean they address the fundamental/core issues and challenges

c. At least Africa can identify with the proposals and can see a way forward in how it can prepare and position itself to continue and sustain the ministry.

d. This meeting has brought about an increased awareness and appreciation of how "the same we are".

e. The meeting has set the framework/conceptual basis that encourages us to take the responsibility and exercise the mandates we all have by virtue of our faith and evident strong conviction to continue the ministry.

f. Collaboration in all its forms is being acknowledged as mutually beneficial and satisfying as both parities are givers and receivers at the same time in any collaborative relationship

In short:

We are encouraged that our efforts, activities, achievements and failures have not been in vain. We appreciate that we are in evolution and follow the cycle of life where man is born, starts to crawl, stands, walks with support, then walks steadily on his own, and then requires support again.

– So we are now walking with support and will continue making mistakes and falling but we are encouraged that we are on the right track to addressing the challenges in our context.

– And we are happy to know that in solidarity our older brothers and sisters are there to help us as we will be there to help then when they are old and will we will provide support for our younger brothers and sisters when they come along.

Dr GILBERT BUCKLE,
Executive Secretary
Department of Health National
Catholic Secretariat,
Accra, Ghana

V. We Too Can Meet Jesus

We too can meet Jesus as we journey throughout the Oceania Catholic health world today. I acknowledge there are as great or greater needs in other parts of the world but I am just concentrating on this part of the universe as we know it.

I will refer the following countries only as Oceania is too large to cover in total – Australia, New Zealand, Papua New Guinea, Indonesia, Samoa, Solomon Islands and Tonga. Likewise, I will concentrate on mental health and what leads up to this very neglected and debilitating condition and not try to cover the whole gamut of health care.

Australia is no doubt the leader in Catholic health care and is currently expanding its mental health care with the foresight and work of the Sisters of Charity and the proposed joint efforts of the Sisters of St John of God and the Brothers of St John of God. I have always advocated Catholic Health Care providers working together and not in competition, so hopefully this will mark the Catholic sector's current expansion of its mental health services. After all, providing healing in the name of Jesus is the goal, not personal or organizational aggrandisement.

There is no argument that the larger Catholic hospitals in Australia cater largely for the people who can afford health care insurance and sadly this includes mental health patients.

In New Zealand there a few, very small, Catholic hospitals, none of which provide for people with mental health problems. In the public area we have some psychiatric hospitals and because of various government policies over the years such as deinstitutionalization this is a mess.

Papua New Guinea has one small psychiatric hospital which houses patients who are of significant danger to themselves and others. No psychiatrist is present at this institution. Other primary health needs take priority. All are substandard even when compared with other third world countries. The only Catholic health care is that provided by religious congregations or orders whose members have minimum, but sufficient qualifications to meet that countries health care standards..

Indonesia can boast of somewhat better health-care resources, but in Samoa, the Solomon Islands and Tonga, conditions are much the same as in Papua New Guinea.

In all of the countries I have mentioned visiting medical practitioners and surgeons cater for most medical conditions. However such services are not available for a person who is suffering from a psychiatric illness.

From studies that have been done through various universities not only in Australia and New Zealand but also some in the USA the percentage of people suffering from mental illness is between 12% and 37% of any given population. "Suicide rates continue to escalate in all age groups and cultures.

One of the tragedies associated with depression is the fact that a person is 33 times more likely to complete suicide as someone who doesn't have depression" (SVDP, *A Long Road to Recovery*)

For example in Australia since the 1970s youth suicide has tripled and is now one of the highest in the world. Just over five young Australians take their lives every week. It is the leading cause of death in the 15-24 year age group.

I wish to point out here that having visited Papua New Guinea on many occasions over the last nine years the suicide rate among similar age groups is very much the same.

So what causes this great problem? Simply it is caused when people are not able to cope when faced with one or more of life's difficult situations, e.g. natural disasters, putting oneself under stress with unrealistic study or career goals, death of a loved one, homelessness, drug and alcohol abuse, having been sexually abused as a child and any number of other situations.

Let me just relay this true story to you: In 1998 John, at 26years of age committed suicide. John was a young man with a bright future. He had completed a university degree in his home city and went to work away from home. John had a great relationship with his family and was in a steady relationship with a young lady. He was very much loved and loved in return.

John was also a tough footballer and played first grade for a local team. At the time of his death he had completed 10 out of 12 units in a masters degree in business administration at university and achieved excellent results. The university presented him with his degree posthumously. This background information may help you understand the disbelief and nightmare that his suicide caused to all who loved him.

What went wrong? I believe part of the problem was the stress that John was under both at work and at university with his studies. His employer was funding his studies and this placed extra stress on him as if he failed a subject he would have to repay his employee and pay for the next semester's units as well.

Furthermore, John's company was restructuring and as he worked in the human resource area he was directly involved with a lot of the redundancies and faced some rather difficult decisions regarding the future of many employees. John became very stressed and took two weeks' leave, just when the restructure was to take place.

Ten days prior to John's death he returned to work in a

distressed state. It was suggested to him that he see a doctor or a counselor. He made the appointment with the counselor but never got to keep it.

Now this happened in Australia where health care is relatively well resourced, what about our neighbours in Oceania who do not have the resources to address a rising rate of suicide or indeed to research the probable causes?

What can be done?

There has been an international debate for years about the twelve step program and its level of success. Can over one million alcoholics be wrong? I don't think so.

Therefore I believe those responsible for Catholic health care in Oceania can do something to help with mental illness on a temporary basis by introducing them to the twelve step program and adapting it to their particular problem. This has been very successful in many other areas.

The other issue to be addressed is fear. In many cultures people are scared to talk about their mental illness for fear of what may happen to them.

Most people in third world countries are not well informed about mental illness so they take sufferers to inappropriate medical practitioners. As a result the clinical outcomes are poor or non existent.

Conclusion

Irrespective of whether we are in Australia, New Zealand, Papua New Guinea, Indonesia, Samoa, Solomon Islands or Tonga the treatment and care of homeless, anxious, depressed and mentally ill people presents the Catholic community at large with a tremendous challenge. These people are here among us. We cannot ignore them, or the plight of those trying to care for them from many parts of the world. There needs to be a greater awakening to the extent of the problem and a significant injection of resources both human and financial, properly administered, to bring about change.

A greater proportion of health and social service budgets should be devoted to mental health by all governments.

Brother PETER BURKE OH,
Brothers of St John of God, Australasian Province.

Conclusions of the Third International Congress of the International Federation of Catholic Health Care Institutions

VATICAN CITY, 3-5 MAY 2007

In response to the recommendation of the interim board of the International Federation of Catholic Health Care Institutions the Pontifical Council for Health Care Workers invited us to constitute the Third International Congress of Catholic Health Care. We are over one hundred in number and come from over forty countries and all the continents of the earth. We serve in diverse dimensions of the ministry of Catholic health care and in a variety of settings. Like the Servant of God John Paul II we recognize that Catholic health care is an essential ministry of the Church. A ministry that has been called by His Holiness Pope Benedict XVI to an *aggiornamento,* that is, to a new impetus that "implies renewal and deepening of the pastoral proposal itself."

After two days of input and discussion in which we affirmed that the foundation of all that we are about is in our identity as witnesses to the spirit of hope that is grounded in the mystery of the Resurrection, we have developed the following recommendations to ourselves and to our colleagues in the ministry about how we can promote this *aggiornamento* of the ministry under the title of *advancing our stewardship of the ministry*.

Catholic health care entities should articulate the essential characteristics of the ministry and measurable outcomes for the same in a manner that they can be actualised in the organization's strategic planning process.

In order that all who serve in Catholic health care can be nourished and guided by a fulsome understanding of the ministry, an integrated approach to the professional and ministerial development of all those who serve in the ministry should be developed in a manner appropriate to their mode of service. This should be reinforced by on-going formation and continuous evaluation.

The ministry should deepen its understanding of, and commitment to, collaboration within the ministry and with other ecclesial ministries. There also should be collaboration, as appropriate, with secular entities in a manner that does not compromise Catholic identity. To advance this collaboration there should be dissemination of effective models of collaboration.

The ministry should be known for its special commitment to providing health care to the poor, marginalized and vulnerable in a manner that truly advances their human dignity and does not encourage dependency. This commitment should be expressed in a strategic and transparent manner that is facilitated by efficient and effective models of care and that encourages cross-country sharing.

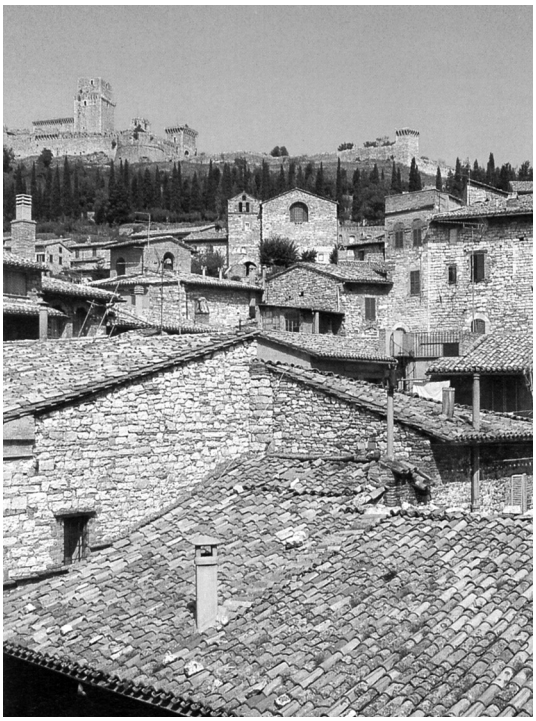
Catholic health care should be known for its advocacy for access to health care being a fundamental human right. This advocacy should begin with the manner in which at the local level the ministry provides for the health care needs of the community it serves and by the vision of person and society that animates this service. Such advocacy should be based on accurate social analysis and be made effective by the appropriate training and education of those who would carry it forward.

As we have engaged in conversation and reflection about these imperatives we have considered how to advance collaboration with diocesan bishops and Episcopal Conferences as well as appropriate national and international collaboration. As regards our collaboration as a ministry of the universal Church, we recognize the important contribution AISAC can make to encouraging, facilitating and empowering such collaboration and sharing. Consequently, we actively support the animation of AISAC as an international federation, with ecclesial and civil status appropriate to its role. This renewed reality should be constituted after appropriate consultation with the ministry, with the Pontifical Council for Health Care Workers and other appropriate dicasteries.

As we conclude our time together we express our gratitude to the Pontifical Council for Health Care Workers and in special way to its President, His Eminence, Cardinal Lozano Barragán. We also extend our prayerful best wishes to His Holiness, Pope Benedict XVI, and ask for his blessing of our dedication to carrying forward the healing mission of Jesus "the divine doctor."

Rev. MICHAEL PLACE
Chairman AISAC

Topics



A Gospel Rethinking of Life:
a Gift of God and
the Consequences for Man

Ethics and Law

The Health of the Elderly

A Gospel Rethinking of Life: a Gift of God and the Consequences for Man

Ten years ago John Paul II published his encyclical letter *Evangelium Vitae.* The occasion of its anniversary is more than opportune for rethinking about the specificity of the Christian message about life, at least for two reasons. The first lies in the fact that the culture of death is increasingly advancing and the claim of a personal right to a child is growing, even on the part of homosexual individuals. The second reason lies in the wish to offer some principles to guide legislative initiatives. For both these reasons, both for the negative one as for the positive, I would like to make immediately clear, with the Holy Father, that: 'Every individual, precisely by reason of the mystery of the Word of God who was made flesh (cf. Jn 1:14), is entrusted to the maternal care of the Church. Therefore every threat to human dignity and life must necessarily be felt in the Church's very heart; it cannot but affect her at the core of her faith in the Redemptive Incarnation of the Son of God, and engage her in her mission of proclaiming the Gospel of life in all the world and to every creature (cf. Mk 16:15)'.[1] This clarification by the Holy Father commits the Church in a completely special way because we are witnessing a striking multiplication and intensifications of threats to the lives of people and peoples, above all when those lives are weak and undefended. Indeed, 'In addition to the ancient scourges of poverty, hunger, endemic diseases, violence and war, new threats are emerging on an alarmingly vast scale'.[2] Pope Wojtyla refers here to the cultural situation of new forms of attacks on the dignity of the human being 'which gives crimes against life a new and-if possible-even more sinister character, giving rise to further grave concern: broad sectors of public opinion justify certain crimes against life in the name of the rights of individual freedom, and on this basis they claim not only exemption from punishment but even authorization by the State, so that these things can be done with total freedom and indeed with the free assistance of health-care systems'[3] Addressing these moral and legal examples of libertinage, it is my intention to perceive the liberating and elevating meaning of the preaching of the Gospel of life proclaimed by this papal document.

The Gospel of Life: a Gift of God

It is striking how the Pope with his preaching of a rethinking of the Gospel of life wishes first and foremost to enter into profound communion with every brother and sister in faith; but at the same time he feels animated by sincere friendship for everyone. I would like to immediately indicate the basic reason that forms the basis for his confessional wish and this general feeling of his. John Paul II is led to a rethinking and preaching of the Christian message of life by its splendour of truth that illuminates consciences, the limpid light that heals the darkened gaze, the inexhaustible source of constancy and courage to always address the ever new challenges that we encounter on our pathway.[4] However the Pope addresses himself first and foremost to all the members of the Church because they are the people of life and for life. At the same time, the Pope makes clear once again, 'To all the members of the Church, the people of life and for life, I make this most urgent appeal, that together 'we may offer this world of ours new signs of hope, and work to ensure that justice and solidarity will increase and that a new culture of human life will be affirmed, for the building of an authentic civilization of truth and love'.[5]

This hope and wish of ten years ago finds specifically in these days of *seaquake* a major confirmation at a truly world level. Never as much as now does mankind welcome the cry of solidarity without 'ifs' and 'buts'. It does not matter that one is dealing here more with emotional philanthropy than with Gospel-based charity. For that matter, grace employs nature, and thus this rethinking of the Christian message on life finds today specifically its own positive response, without precedents, when faced with a natural catastrophe. However, what follows below transcends a purely humanitarian analysis. 'The *Gospel of life* is not simply a reflection, however new and profound, on human life. Nor is it merely a commandment aimed at raising awareness and bringing about significant changes in society. Still less is it an illusory promise of a better future. *The Gospel of life* is something concrete and personal, for it consists in the proclamation of the *very person of Jesus*'.[6]

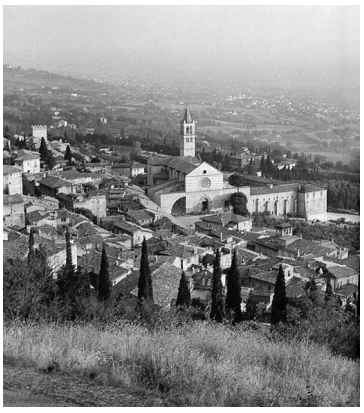
In this definition of the description of the Gospel-based value of life we must pay attention at the outset to a rather negative clarification, that is to say to a reflection that does not accept the Christian message on life. Certainly, and I say this to remove every misunderstanding, the Gospel of life does not deny the originality and the profundity of human life and is not opposed to the consequential commandment which means both the sensitisation of the moral conscience towards it by individuals and the provocation of significant changes by society as a whole – on the contrary. However, the Gospel of life aims at a meditated reflection on life in that this is a historical reality that is completely personal precisely because it refers to the preaching of the divine Person himself of Jesus of Nazareth. 'Je-

sus made himself known to the Apostle Thomas, and in him to every person, with the words: "I am the way, and the truth, and the life" (Jn 14:6). This is also how he spoke of himself to Martha, the sister of Lazarus: "I am the resurrection and the life; he who believes in me, though he die, yet shall he live, and whoever lives and believes in me shall never die" (Jn 11:25-26). Jesus is the Son who from all eternity receives life from the Father (cf. Jn 5:26), and who has come among men to make them sharers in this gift: "I came that they may have life, and have it abundantly" (Jn 10:10).[7] Here we are at the heart of the Christian message on life or the message that Christ himself revealed.

I will allow the Pope to explain this: 'Jesus is the Son who from all eternity receives life from the Father (cf. Jn 5:26), and who has come among men to make them sharers in his gift: "I came that they might have life, and have it in abundance" (Jn 10:10)… In Christ, the *Gospel of life* is definitively proclaimed and freely given…As the Second Vatican Council teaches, Christ "Jesus perfected revelation by fulfilling it through his whole work of making himself present and manifesting himself: through his words and deeds, his signs and wonders, but especially through his death and glorious resurrection from the dead and final sending of the Spirit of truth. Moreover he confirmed with divine testimony what revelation proclaimed, that God is with us to free us from the darkness of sin and death, and to raise us up to life eternal"'[8] Jesus, therefore, is not only the fullness of Life, because he is Life, but he is also the Giver of life because he is its Source. Here we encounter the idea of life as a fundamental and primary good.

Life is Always a Good

In Jesus, the "Word of Life", God's divine and eternal life is thus proclaimed and given and thus in its earthly phase as well human life acquires fullness of value and meaning. Indeed, divine and eternal life is the end towards which the man who lives in this world is directed and called.[9] The most obvious and reasonable consequence of this 'celestial' direction of every 'earthly' human life lies in the certainty that life is always a good! 'The fullness of the Gospel message about life was prepared for in the Old Testament. Especially in the events of the Exodus, the centre of the Old Testament faith experience, Israel discovered the preciousness of its life in the eyes of God. When it seemed doomed to extermination because of the threat of death hanging over all its newborn males (cf. Ex 1:15-22), the Lord revealed himself to Israel as its Saviour, with the power to ensure a future to those without hope. Israel thus comes to know clearly that its existence is not at the mercy of a Pharaoh who can exploit it at his despotic whim. On the contrary, Israel's life is *the object of God's gentle and intense love*. [10] 'Through it, Israel comes to learn that whenever its existence is threatened it need only turn to God with renewed trust in order to find in him effective help: "I formed you, you are my servant; O Israel, you will not be forgotten by me" (Is 44:21)'. [11]



Illuminated by the faith of these words of God and assured by trust in the faithfulness of God, the sapiential books move from the daily experience of the *precariousness* of life and awareness of the threats that imperil it to trusting recognition of participation in the eternal life of God. Revelation progressively enables us to understand with ever greater clarity the seed of immortal life placed by the Creator on the hearts of men. *Kohelet*, the son of David, the King of Jerusalem, reveals this to us with every emphasis: 'He (the Creator made everything beautiful in its time but he has placed the notion of eternity in their hearts' (Ec 3:11). However, 'In Jesus' own life, from beginning to end, we find a singular "dialectic" between the experience of the uncertainty of human life and the affirmation of its value. Jesus life is marked by uncertainty from the very moment of his birth. He is certainly accepted by the righteous, who echo Mary's immediate and joyful "yes" (cf. Lk 1:38). But there is also, from the start, rejection on the part of a world which grows hostile and looks for the child in order "to destroy him" (Mt 2:13); a world which remains indifferent and unconcerned about the fulfilment of the mystery of this life entering the world: "there was no place for them in the inn" (Lk 2:7)'.[12] At this point we are led to share with great conviction what Pope Wojtyla asserts about life as a perpetual good: 'In this contrast between threats and insecurity on the one hand and the power of God's gift on the other, there shines forth all the more clearly the glory which radiates from the house at Nazareth and from the manger at Bethlehem: this life which is born is salvation for all humanity (cf. Lk 2:11)'.[13] This statement on the liberation and elevation of every phase of human life on the new earth, in its contradictions and its risks, finds incontestable confirmation in St. Paul: we are taken on to the full by Jesus of Nazareth. Indeed, 'though he was rich, yet for your sake he became poor' (2 Cor 8:9). In the view of the Pope we find an even more substantial confirmation of this in John: 'It is precisely by his death that Jesus reveals all the splendour and value of life, inasmuch as his self-oblation on the Cross becomes the source of new life for all people (cf. Jn 12:32). In his journeying amid contradic-

tions and in the very loss of his life, Jesus is guided by the certainty that his life is in the hands of the Father. Consequently, on the Cross, he can say to him: "Father, into your hands I commend my spirit!" (Lk 23:46), that is, my life. Truly great must be the value of human life if the Son of God has taken it up and made it the instrument of the salvation of all humanity!' [14]

However, and this is an important point, human life is also a good because in the world it is an expression of God, a sign of His presence, a trace of his glory (cf. Gen 1: 26-27; Ps 8:6). Only man, of all the visible creatures, is 'able to know his own Creator'.[15] Life, as a gift of God, is a tension towards fullness that consists in participation in the eternal life of God Himself. The existence of every man goes beyond the very limits of time and space. 'For God created man for incorruption , and made him in the image of his own eternity' (Wis 2:23). This is why man is perennially dissatisfied. Made by God, bearing within himself an indelible trace of God, man naturally tends to Him. This is what is taught by the *Catechism of the Catholic Church*: 'The desire for God is written in the human heart, because man is created by God and for God; and God never ceases to draw man to himself. Only in God will he find the truth and happiness he never stops searching for'.[16]

To understand even further the free giving of the divine gift of human life, I will refer to original sin. The wonderful project of God with man was obscured by the irruption of sin into history. With sin, man rebelled against his Creator, ending up by *idolatrising creatures*. When *God is not recognised as God*, the profound meaning of man is betrayed and communion between men is prejudiced. But thanks to the mercy of God the project of life consigned to the first Adam, a ruin and disruption of the design of God for the life of man because man introduced death into the world, found in the redemptive obedience of Christ, the second Adam, the source of grace that is poured on man, thereby opening the doors of the kingdom of life (cf. Rom 5:12-21). The Apostle of the Gentiles further makes clear: 'The first man Adam became a living being; the last Adam became a life-giving spirit' (1Cor 15:45).[17]

The Commitment of Every Man: to Love the Human and Divine Dimension of Life

The Christian message on the ontological value of human life obviously involves deontological existential consequences, that is to say consequences of a moral order. First of all and above all towards Christ, then towards personal life and last but not least towards the life of every brother and sister.

In relation to Christ, the restorative design of God has a primary and radical consequence: the following of Christ. The author of *Evangelium vitae* writes here: 'All who commit themselves to following Christ are given the fullness of life: the divine image is restored, renewed and brought to perfection in them. God's plan for human beings is this, that they should "be conformed to the image of his Son" (Rom 8:29). Only thus, in the splendour of this image, can man be freed from the slavery of idolatry, rebuild lost fellowship and rediscover his true identity'.[18]

The first consequence of being regenerated by God and taking part in the fullness of His love lies in the non-reduction of life to mere existence in time and space. The life that Jesus came to give is 'the life' because it constitutes the specific object of the mission of Jesus, he who 'comes down from heaven and gives life to the world' (Jn 6:33). Thus Jesus can state with full truth 'whoever follows me…will have the light of life (Jn 8:12). Whoever believes in Jesus and enters into communion with him has eternal life (cf. Jn 3:15; 6:40). The adjective does not only refer to a supra-temporal perspective. 'Eternal' is the life that Jesus promises and gives because it is fullness of participation in the life of the 'Eternal'.[19]

Now we can understand better what 'knowing God and His Son' means. It 'is to accept the mystery of the loving communion of the Father, the Son and the Holy Spirit into one's own life, which even now is open to eternal life because it shares in the life of God'.[20] The Christian message on life thus reaches its peak. The very life of God is at the same time the life of the children of God. It should be, noted, however, that this dignity 'is linked not only to its beginning, to the fact that it comes from God, but also to its final end, to its destiny of fellowship with God in knowledge and love of him. In the light of this truth Saint Irenaeus qualifies and completes his praise of man: "the glory of God" is indeed, "man, living man", but "the life of man consists in the vision of God"'.[21]

Thus the reasons why man can, indeed, must, love his life in the earthly condition are twofold: one is natural, the other is supernatural. Indeed, from a natural point of view man loves his life, in an instinctive way, because of the fact that it is a primary and fundamental good. From a supernatural point of view he loves it because in it is already sprouted and in growth eternal life. 'Similarly', concludes the Pope, 'the love which every human being has for life cannot be reduced simply to a desire to have sufficient space for self-expression and for entering into relationships with others; rather, it develops in a joyous awareness that life can become the "place" where God manifests himself, where we meet him and enter into communion with him. The life which Jesus gives in no way lessens the value of our existence in time; it takes it and directs it to its final destiny: "I am the resurrection and the life...whoever lives and believes in me shall never die" (Jn 11:25-26).[22] 'Through the words, the actions and the very person of Jesus, man is given the possibility of "knowing" the complete truth concerning

the value of human life. From this "source" he receives, in particular, the capacity to "accomplish" this truth perfectly (cf. Jn 3:21), that is, to accept and fulfil completely the responsibility of loving and serving, of defending and promoting human life'.[23]

It is true that this demanding conclusion concerns first of all and above all else the members of the Church, the mystic Body of Christ. However, and I would like to stress this point, this commitment concerns every man and woman and thus has echoed in every conscience 'from the beginning', that is to say from the time of the creation itself, in such a way that despite the negative consequences of sin, *it can also be known in its essential traits by human reason*.

Lastly, the Pope draws attention to the responsibility of every man before God as regards veneration and love for the lives of everyone. If the life of man is a gift of God, His Image and imprint, because a sharing in His vital breath, it is evident that He is the only Lord of life and that no one can dispose of life. God himself emphasises this to Noah after the flood: 'For your own lifeblood, too, I will demand an accounting… and from man in regard to his fellow man I will demand an accounting for human life' (Gen 9:5). The life and the death of man, therefore, are in the hands of God, in His power. This is what Job exclaims: 'In his hand is the life of every living thing and the breath of all mankind' (Job 12:10). He alone can say 'It is I who bring both death and life' (*Dt* 32:39). However this is not a threat but of a statement of care and loving concern towards his image-creatures! 'God did not make death, and he does not delight in the death of the living. For he created all things that they might exist' (*Wis* 1:13-14). Thus human life is inviolable because it has its foundation in God and His creative action. The commandment of God to safeguard the life of man thus has a more profound aspect in the *requirement to venerate and love* every person and his life.

Conclusion

The Christian message on human life, brings, to conclude, our gaze to the 'Child born for us' (cf. Is 9:5) and to the Lamb who was sacrificed for us. It is in him that we contemplate 'the life' that 'is manifested' (1 Jn 1:2); it was in him that was fulfilled the encounter of God with man and the pathway of the Son of God on the earth begins, which culminated in the giving of his life on the Cross. It is indeed by his death that he defeated death and became for the whole of humanity the beginning of a new life. As the sacrificed Lamb he lives with the signs of his passion in the splendour of his resurrection. For this reason, he alone is master of all the events of history: he opens its "seals" (cf. Rev 5:1-10) and proclaims, in time and beyond, *the power of life over death*. In the 'new Jerusalem', that new world towards which human history is travelling, '*death shall be no more*, neither shall there be mourning nor crying nor pain any more, for the former things have passed away' (Rev 21:4). And as we, the pilgrim people, the people of life and for life, make our way in confidence towards "a new heaven and a new earth" (Rev 21:1), we look to her who is for us "a sign of sure hope and solace".[24]

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Note

[1] *Evangelium Vitae,* encyclical letter of John Paul II on the worth and inviolability of human life, Rome, 25 March 1995, Libreria Editrice Vaticana, 1995, n. 3. Hereafter *EV*.
[2] *EV*, n. 3.
[3] *EV*, n. 4.
[4] Cf. *EV*, n. 6.
[5] *EV*, n. 6.
[6] *EV*, n. 29.
[7] *Ibidem*.
[8] Dogmatic Constitution on Divine Revelation *Dei Verbum,* n. 4.
[9] Cf. *EV*, 30.
[10] Cf. *EV*, 31.
[11] Cf. *Ibidem*.
[12] *EV*, n. 33.
[13] *Ibidem*.
[14] *EV*, n. 33 at the end.
[15] Second Vatican Council, Pastoral Constitution on the Church in the Contemporary World *Gaudium et spes*, n. 12.
[16] *CCC*, n.27.
[17] Cf. *EV*, n. 36.
[18] *Ibidem*.
[19] *EV*, n. 37.
[20] *EV*, n. 37 at the end.
[21] St, Irenaeus, *Against Heresies,* IV, nn. 20, 7: quoted in *EV*, n. 38.
[22] *EV*, n. 38.
[23] *EV*, n. 29.
[24] *EV*, n. 105.

Ethics and Law[1]

The subject on which I am about to offer only certain points for reflection does not concern specifically my sector and my specialisation: the terms 'ethics' and 'law', which are examined here in tandem, constitute in definitive terms two essential aspects of a single reality that have been thought for far too long over these last two centuries as being opposed or indifferent or irrelevant to each other. Indeed, the opposition between law and morality, and from certain points of view the primacy of law over morality, have led to a severing of these essential ties between man and his nature, which every everyone in the individual and the social world, in the private sphere as in the public sphere, feels they lack The disassociation that is evident in daily life between values and laws, and between actual and normative aspirations and behaviour is so strident, that one lives either in a constant tension that finds no outlet, or in a mortifying indifference, or in a lacerating rebellion.

From the same situation and the same matrix spring other concerns that fill the souls of everyone: the disappearance of sacredness and the sacred, which also involves the mystery of life, and from which comes genetic engineering; intolerance and contempt towards others that is also expressed within natural societies such as the family; the inability to govern nature, which is almost rebelling against the deterioration caused by a foolish mankind.

Today as yesterday we are on the threshold of a new millennium and today as yesterday the individual, not as a never to be repeated entity or a number that is indistinguishable from many others, but simply as a man beyond an unrewarding optimism or a radiant pessimism, has to confront himself with himself and with others and thus climb step by step the steep mountain, learning from the pathway that has been followed and the perils that have been overcome, but without stopping, continuing on his journey but without impossible flights ahead.

Aware of his finitude and his limits, he has to make himself one with others in order to live and to express his dignity to the full, which is neither self-assertion (the exercise of rights) nor renunciation (subjection to duties), but rather aware and correct relationships and communications with other people, with things, and with the absolute.

This uncomfortable millennium, which is already showing in relief the signs of the third, has been characterised down the whole of its pathway by individuality, and as an individual, man woke up after a thousand years to discover himself and mature as an individual (the feudal lord, the merchant, the *clericus),* then as a thinking entity endowed with rationality *(homo rationalis)*, and lastly as a producer *(homo oeconomicus).* Each of these characteristics has given him a way of acquiring an increasing awareness of his being made in the image of God, the heir of His kingdom, already redeemed of his fragility.

However, the moment has come for a further advance in awareness so that one does not succumb to selfishness, intolerance and hatred. This is offered by the juridical, understood as a practice that operates at all levels and in all sectors, as a set of 'rules' that are observed not because they are imposed but because they resolve conflict and eliminate contrast; which are lived because they concretise values and do not constitute privileges or monopolies; and which are required to improve quality of life to the benefit of everyman and not the few.

That this further advance in awareness is not a utopia derives from contemporary history itself and from the history of the first millennium, whose pre-eminent characteristic, which in fact has fostered subsequent histories, is represented by *christianitas,* the only hope for today and tomorrow.

It is observed, therefore, that I, like everyone else, am a man apart, aware of being so, with all the limitations that this involves, but also with all the riches that spring from a daily commitment to living in a certain way, to addressing problems in a certain way. Obviously with more doubts than certainties. These are certainties that are very often fallacious, such as those of Don Ferrante, or those that Descartes ironically pointed out as being specifically of the '*loicus*'.

In this way, to move out of the use of metaphor, I should immediately identify the subject of my analysis: the individual in himself considered both in relation to others and to things and as a generator of mechanisms of coexistence and the user of these mechanisms, and as an essential component of structures that at the same time give him a voice, guarantee him, and defend him.

To our great good fortune, the contemporary world tends to uphold and defend man in his integrity and wholeness (at least at the level of statements of principle), no longer, however, in relation to himself but rather and above all in relation to others and on a par with others. Even though, today more than yesterday, individualism and above all particular forms of selfishness, or group forms of selfishness, are still winners, even though the long pathway has begun towards a greater and better social awareness, with the consequent reaffirmation of the criterion of justice as a basis and foundation for law.

This means that this defence does not relate exclusively to the values of positive law, that is to say those principles that are expressed in rights that are explicitly recognised, but in-

volves the fact that it is indispensable that the law pursues and actuates meta-positive values.

As everyone will remember, there was a season not so very long ago when the mere appeal to universal principles, which I refer to above as meta-positive and which are to a certain extent to be referred or connected to religious realities, were rejected in the name of the secularity of the 'state' or juridical positivism.

With the unity of the medieval system disrupted following the revolution of 1789, a frequently misunderstood natural law approach, above all on the secular front, which was nevertheless in its own fashion effective and proved to be essential, produced, anyway, the first declarations of essential rights and constitutional charters. Above all with the revolution of 1789, secular society took on in the first person the recognition and the consequent safeguarding of absolute rights.

This took place above all on the basis of a choice in favour of the defence of the individual considered in himself, whom the state, the expression of an indistinct and indifferent general will, and for that reason the sole generator of reality, watched over in an autonomous and above all inevitable way. The necessary consequence of this was the embodiment of rights in statutes through codification and the pre-eminence of the aspect of a validity of a norm over the search for truth in order to actuate justice.

With law entrusted exclusively to the legislative power, there became established, as a result, that providentialism of law itself which is still current and widespread in almost all systems of a political and ideological matrix.

But the law in itself, as everyone can see with their own eyes, has shown that it is not suitable and that it is inadequate. And above all where it is given concrete expression, albeit in terms of absolute law, in the regulation of the opposing interests of individuals or groups, in order to resolve conflicts, without referring to fundamental values, to achieve their concrete defence.

The same solemn declarations of rights have not impeded, as is well known, the dramatically grand events which have taken place since the Second World War onwards. Who can fail to remember the extermination of millions of people which is still today of contemporary relevance, indeed, which still takes place today. Of such a level as to lead to the postulating against crimes against humanity (if you recall not only as an individual but also and above all else as *civis,* because of the impulse that comes from society itself and from public opinion. In this way these societies assign to their state institutions a task involving aggregation, the meeting of needs and the safeguarding of values, and of a meta-positive nature as well. And the first evident result is represented by the fact that the national sets of law, which tend, and often are by definition constitutional, and which appear as closed normative

this phrase was enunciated for the first time at the Nuremberg trials) of a law of humanity that was higher than the law of states, which no longer referred to legislation, and which no longer referred to positive law. But without going too far we have before us nowadays the epoch-making change of the regimes in Eastern Europe.

What is happening to these regimes? What seems to be happening above all from the point of view of the historian and the jurist? In these regimes the social body no longer wants a judgement as to whether the behaviour of men in government was in conformity with the law, the law that was then in force, but a judgement as to whether they acted in conformity with rights that were not yet written into that legislation: the rights of freedom, social rights, and political rights.

These societies, but we could also add our own society, are attempting today to retrieve man in his wholeness systems (so-termed rigid Constitutions), are required to transform themselves into systems of material justice by accepting the subordination of the contents of their own laws to the control of values outside systems. Here one needs only to look through the decisions of the Constitutional Court to see that in the Italian system as well there is this widening, this recognition of values. And to such an extent that reference is made to secular morality when in essential terms the same rights of freedom are nothing else but a recognition of innate rights which constitute the foundation of the human person and make up and defend his wholeness. Such a defence cannot remain a mere enunciation but must operate within reality, being translated into effective normative safeguards and combating every form of shameless abuse, arbitrariness and injustice. Their actuation, therefore, cannot be a matter for the category of justice but rather of effective incidence

and the immediate verifiability of injustice.

I do not believe that one has to go very far, not even to a conceptual level, to adopt as a point of reference not positive value but its opposite, which is achieved specifically at the level of experience. This obviously implies a hermeneutic approach.In this sense one may call to mind different philosophers, but above all two, whose thought is emblematic: Luigi Pareyson and Hans Gadamer.

The first, in opposition to the determinists and to all those who champion relativism, even though in part he embraces their theses, begins with the anxiety that lies in every man and which is opposed to happiness. He begins with sadness and not with joy and thus deals with concepts of a negative character such as radical evil, the ambiguity of reality and man himself, non-freedom, life as a risk and as an absolute wager. The sated man of the capitalist West does not want to hear about these things: he is aware of his condition of inertia and fear, he well knows that he has put into other people's hands his own life – he strives to crush his inadequacy with individual or group therapies or with psycho-pharmacies, if not, indeed, with drugs, but at the most he manages to achieve out of selfishness his own artificial paradise in which to exorcise self-generated loneliness and boredom, in which he is called upon and favoured by mechanisms that produce ephemeral happiness, so as to exercise more freedom, indeed with arbitrariness and power, to obtain profits and selfishness, elevated into a system.

It is certainly true that it is very difficult to give a meaning to pain, to accept the unfathomable, for that matter, as a justified destiny of atonement; marked in each of its limits and apparent caducity. Christian culture has tried this for centuries but it cannot offer paradise on earth; instead it offers self-renunciation to man and to his selfishness, to become a man like the other and for the other. Beyond the Gospel message which reveals a mystery that is no longer given to the intelligence of the few but shared in freely because as John says, the Word was made flesh and came to live amongst men, man observes that evil is not specific to his original nature and thus it is possible to remove it, to be redeemed in relation to it, and thus to expiate it.

And the meaning of suffering lies in this expiation which is promoted with positive action that is performed at both an individual level and also (necessarily) at a social level. Once this approach has been understood and implemented, pain is removed with it and one reaches joy, because as Pareyson says and concludes, it would not be real joy if it did not know about suffering. And unfortunately the current modern epoch fears suffering more than it fears injustice, whereas in the classical-medieval perspective injustice was much more feared than suffering. But the approach of this philosopher is not sufficient if one does not consider the other as a fellow; if, that is to say, as Gadamer says, one does not keep one's own claims under control, one's own desires, impulses, hopes and interests, so that the other does not become invisible and does not remain invisible. This philosopher introduces another category which is also, at an apparent level, negative: the category of wrong, but in a totally special way. That one should say that another is right, that one should be wrong in relation to oneself and one's interests, is not something that is easy to understand or accept. We must learn to respect the other and pay attention to him. This implies that we must learn to be wrong. We must learn to lose in the game, something that happens very early on, as is well known, indeed, during the first years of life. Those who do not learn this, above all so early on, will not manage to deal with their tasks in their future lives.

To live with the other, to live as the other of the other, is a fundamental task that is valuable on both the small and the large canvasses. The way in which we learn to live as individuals in relation to another individual also applies, evidently enough, to the other great human complexes: peoples and States

Obviously, law does not deal with evil in all the multiplicity of its dimensions: it deals with it under a nonetheless essential profile, that of the unjust alteration of relational inter-subjectivity.

Thus it does not seem too audacious to state that we, mankind, will perhaps survive if we manage to learn that we must simply exploit our means of power or the ability to act. Yet we should learn to halt before the other as the other – before nature as before the cultures of peoples and States that

have by now grown up. It is for this reason that we must discover the other and others as others in relation to ourselves, so as to be able to acquire a reciprocal participation

This approach, obviously enough, does not reveal and does not explain everything to the full, above all it does not explain its consequence in the physical world, which makes of the corporeal not a point of attrition but rather a factor that expresses in itself a value, the corporeal that does not limit the spirit but which becomes a means and a vehicle of the experience of each person, and thus of history.

But here one can employ another module, already followed for centuries as a value which is also apparently negative, that of tolerance, which in order to be effective must be located within experience and practice and should constitute the limit that cannot be crossed of a norm. Learning, exercising, exercising oneself in being wrong does not mean anything else but respecting the other and having tolerance towards him, towards the other in his diversity. Today's homogenised society no longer knows how to do this, it not longer has a sensitivity towards motives, to which reference has already been made, and towards that justice that St. Thomas Aquinas saw as made up of the very truth of things and the right order of being.

Public opinion is a sounding box of criticism for its own sake, of condemnation of malaises which are at times certainly real, yet a condemnation that generalises, of accusations of disorganisation, with generalisation here as well, seeing above all in authorities, in bureaucratic apparatuses and in state institutions that do not function the real culprit. We are not the culprit, indeed today more than yesterday the culture of protest, carefree imprudent condemnation and the lacerating attribution of blame of anyone who has any power or authority, have grown in importance. On the other hand, emphasis is placed on success, on personal advance, on easy profits, on being smarter than others, on enjoying privileges and monopolies, and on the carefree use of public matters.

And the real scandal is not that of speaking badly of others; the right endeavour becomes that of giving and not taking from the other: of constructing and not breaking down what the other has built – at times specifically our of contempt or indifference.

However, an approach can come to our help that is, so to speak, serene, to any question or issue, above all if it involves the individual and society. One is dealing here with a way of feeling that is not very practicable today but which is anyway at the basis of that silent revolution, so much condemned by humanism and so much despised by the thinkers of the Enlightenment, which took place during the medieval period. This is the category of intentionality, the medieval virtue of the conscience.

This category, if employed as took place in practical terms during the Christian medieval period, should be taken on by everybody, should be acquired above all else in relation to other people, not only to defend positions that have been already won or to defend privileges that have already been obtained, but in order to be or become protagonists of life and of society.

It is then necessary not to forget that with the lack of such an approach society, and above all else capitalist society, remains the prisoner of those two fundamental aspects which almost portray its image: the first of these characteristics is what economists call the objective coldness of capitalist industrial society because it is directed towards the economy, towards the gathering and storing of information, and because it is bound up with mechanisms of self-regulation.

This involves on the sociological front at least a relative satisfaction of society which enjoys a functioning of structures that is not optimal, because this never takes place, but which is at least satisfying. The consequence of this is that society feels extraneous to this system, develops anxiety, and a contemporaneous need for relationships that are less cold, so that, on the one hand, an indifference of a social character, as well, is established, and a fracture with the institutions of the state, and, on the other hand, intentionality takes concrete form in the private sphere and in narrow spheres that have little influence on social factors and on the mechanisms of living together in society, and thus on the front of the regulation of interests, which is what law is.

The second characteristic, which, however, only indirectly produces a request for intentionality, is constituted by a trend, which at first sight cannot be stopped by society, towards reproducing oneself, one's behaviour and one cultural codes. One need only think here of the homogenised and homogenising behaviour of youth fashion, of machines, and of everything that tends in some way to make uniform. Thus there are some positive effects – the poor man is no longer distinguished from the rich man or the industrialist from the intellectual. But there are also aspects which are negative in this homogenisation because there is no longer a direct and original approach of people to reality, a desire to stand out from others, and above all the power of imagination, which is the principal engine in the creation of new spaces and the opening up of new horizons. Imagination is, for that matter, another category; it seems very far from juridical concerns and analyses, but, in contrary fashion, it is not.

Obviously enough, such approaches are not negative in themselves; indeed, they can also constitute and lead to self-sufficiency and to the self-reproduction of society such as to constitute its force. But before everyone's eyes there is the tiredness, the indifference, the lack of interest, of curiosity, and the sadness that makes everyone have a grey life, a life that is melancholic, because that life is in part a matter of habit, and to such an ex-

tent as to seem not authentic because it is so distant from the models and the stereotypes imposed by the mass media.

In industrialised and technically advanced societies, after a certain fashion the battles for free time have come to an end, and so many times today, although perhaps not so much in Italian society but certainly in American society and Japanese society, in order to escape the repetitive and the void of free time people prefer to remain at their workplaces, to lengthen the time needed to return home, or fall sad in front of audiovisual machines or places of entertainment. These are audiovisual machines that also reproduce, however, stereotypes, that take the place of the imagination by killing it, and this in the best of cases. Obviously, those aspects that we have indicated as being positive aspects, that is to say the raising of society, the abundance of the superfluous to satisfy voluptuary needs, and greater wealth, are taken for granted.

These observations of mine are notes delivered in a shower and are not completely homogenous in relation to a subject which because of its complexity and its influence, in the practical aspects of things and the life of every society, would require systematic in-depth analysis and a more coherent approach.

I would like, however, to emphasise that the division that is usually engaged in of two sectors, in which the relationship and the mutual penetration of ethics and law are seen as fundamental – that external sector relating to the agreement between two normative systems and the internal sector concerned with personal and social responsibility in the exercise of any activity and connected with the formation of the conscience of each individual – does not appear to me to be suitable, not even at a theoretical level. I believe, on the contrary, that it is not useful to distinguish between two normative systems – that based upon the juridical as an internal dimension of the logic of politics and that connected with morality as an internal dimension of the logic of conscience. If ethics and law exclusively represent two autonomous normative systems, it is obvious that in the first system, the juridical one, there must necessarily be reference to juridical positivism and formalism of law should become necessary, and that the second should interact with the first solely for that space that the system of positive law offers to fundamental rights of the person, recognised, for that matter, and accepted in an original way such as to become positive rights as well, within the sphere of the first system. In contrary fashion, just as it is necessary to retrieve man in his wholeness, so one should reassess the social dimension of existence and thereby achieve a dialectical re-affirmation of the dignity of man. On the other hand the law should, as pure affirmation of authority, as a simple regulator of opposed interests, and as an instrument of external and formal defence of rights, retrieve its strictly juridical nature, that nature, that is to say, of reasonableness and the affirmation of the criterion of justice.

Western culture, during its centuries-old effort to investigate instruments to achieve an increasingly rich social life and one that meets the aspirations of man, has always learnt from certain '*praecepta*', which were so effectively summarised by Roman culture and traditionally attributed to Ulpian , those of '*honeste vivere*, '*alterum non laedere* and '*suum cuique tribuere*. Such an ethical characterisation of law is evident and is within the phenomenon of the juridical, from which it cannot be separated: it is the real answer to the coldness and distance of the law, because, as St. Augustine stated, '*Non est lex quae iusta non fuerit*, for, as Thomas Aquinas taught, '*ius est obiectum iustitiae*'.

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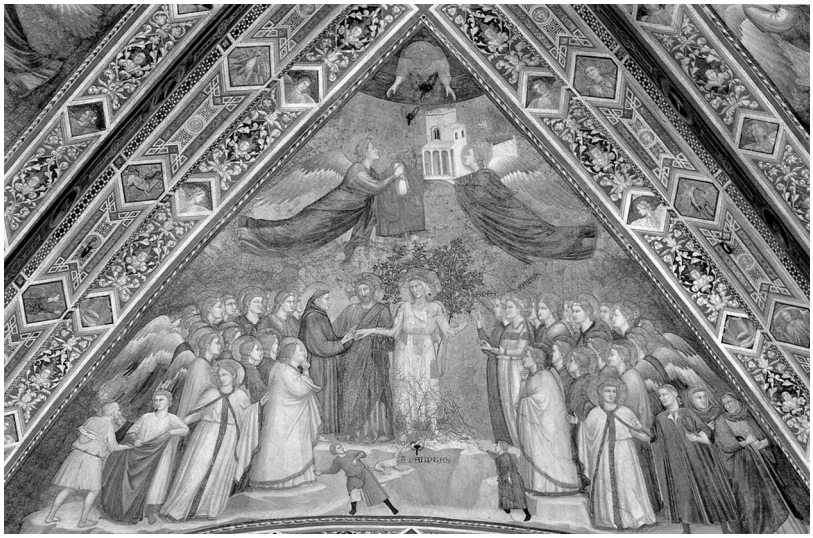
[1] Paper at the study day on 'Ethics and Religiosity in the Professions' organised by the *International Religious Foundation.*



The Health of the Elderly

The World Health Organisation, which in 1995 revised its programme for the health of the elderly, *Health and Aging*, believes that aging must be seen, from a health-care point of view as well, as an integral part of the life cycle and that the elderly should not be seen as a component that is outside the other age bands of the population.[1]

It is for this reason, then, that it is necessary to clarify the concept of ageing and the perspectives in which ageing is generally placed, that is to say the perspectives of an overall strategy.

With respect to ageing one can state that to age does not mean to avoid the problems, the changes or the losses that arrive with the growing older but that it means, rather, a constant commitment, notwithstanding the obstacles, to strengthen gains and minimise losses.

At the present time there is a vast complex of knowledge about ageing, the strategies and the mechanisms that can help us to face up to these losses – knowledge that is by now shared by gerontologists throughout the world. On the basis of such knowledge it has been understood that there exists an enormous variability in nature and time as regards the events of ageing, that elderly people possess hidden energies on which they can draw as they grow old, and that they are required to have a constant readiness to adapt and fit in.

This heterogeneity increases with age because environmental factors accumulate that accentuate individual differences. Illness as well increases this heterogeneity given that it can influence the process of ageing, differentiating it in various ways.

With respect to the concept of adaptability or 'plasticity', elderly people have many latent or sleeping reserves that are not used because they are activated by the requests of the environment.

The accumulation of these reserves begins from birth and continues throughout life. Elderly people tend to live in an environment that is not demanding, because it has few stimuli, whereas mental, social, psychological or economic requests could have the effect of activating these latent reserves.

It follows from this that the perspectives of an overall strategy to address the problems and issues of ageing should be based on certain specific premises:

– The addressing of ageing as a part of the life cycle rather than seeing health care for elderly people as a separate category.

– The promotion of health over the long term: there is growing awareness of the need to focus attention on the process of ageing in health given that both in the early stages and in the advanced stages of life people have a large number of opportunities to improve their own health as they grow old.

– The consideration of cultural influences: the environment in which one grows old plays a determining role in health and wellbeing.

– The adoption of strategies directed towards the community: in the world, in the richest nations as well, the great majority of elderly people live in a community and it is at this community level that many problems should be addressed – problems that often are not strictly health-care in nature but which usually have implications for health.

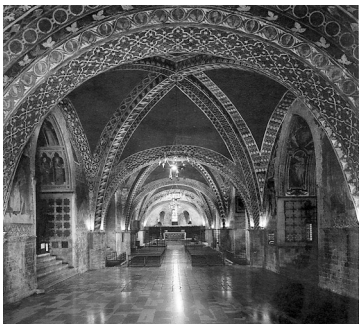
– The recognition of differences between the sexes: there are important differences between the health of men and the health of women and in the life expectancy of the two sexes, and this becomes more pronounced when people are elderly. Women have a greater life expectancy and this phenomenon, which has been defined as the 'feminisation of ageing', constitutes the current experience of many developed countries. In developing countries, where the life expectancy of women of sixty-five years of age is already greater than that of men, the increase in the percentage of women who reach this age and survive longer means that ageing is feminised, at least as, if not more than, in developing countries. The principal social significance of this increase in the advanced age of women lies in a prolonged period of widowhood. Widowhood takes place at a more advanced age in developed countries (roundabout the age of seventy) but the greater life expectancy of women, compared to that of men of sixty-five, in these countries, means that it is prolonged for a longer period.

Strengthening Inter-generational Ties: it is Necessary to Promote Strategies that Foster Cohesion between the Generations[2]

Naturally this prospect is not worldwide: in many countries the very dignity of the human person is at risk, in others ageing does not have the same meaning for men as for women – as a result, as well, of sexual discrimination – as for that matter the WHO had already reported in its previous documents.[3] What has been said hitherto in this paper, albeit in an extremely summarising form, confirms that the phenomenon of ageing does not require answers that belong solely to the health-care sphere. Indeed, at a general level as well, one can observe that the great epidemiological changes of this century – first of all AIDS and the recrudescence of tuberculosis, with an increasing resistance to antibiotics by microbacteria in areas of especial social malaise – demonstrate that the state of health of a popula-

tion is not only related to the technological advances of advanced medicine but also seems to depend to an even greater extent on the level of social fairness, on the organisation of the social sector and the health-care sector, and on the capacity of all these services to provide timely and efficient responses. This was emphasised again, as regards ageing, by the recent declaration of the International Conference held in Brasilia in July 1996, which stated that ageing is a normal dynamic process and not an illness.[4] Whereas ageing is an inevitable and irreversible process, the chronic conditions of disability that often accompany ageing can be prevented or delayed, not only by medical measures but also by economic, social, environmental ones as well. The basic requirements of quality of life – let us remember that this is the objective of the WHO for the next century – are adequate food, drinking water, housing, safety, sufficient economic resources and the possibility of access to primary care. It follows that in order to take into consideration correctly the needs of the elderly it is necessary to see them within the wider context of a social policy whose inter-sectorial measures should take into consideration the determinants of bio-physical, social, psychological, economic and environmental needs.

These problems and issues should naturally take into account ethical factors such as equal access to care and services and a fair allocation of resources.[5] The questions and issues connected with distributive fairness will in fact, according to the prospects before us, take on increasing importance. On the basis of an authoritative demographic prediction, a further notable lengthening of life expectancy does not yet seem to constitute the primary objective of health-care programmes in developed countries. Only futuristic discoveries in the sector of molecular biology will make realistic the hypothesis of a slowing down in the processes of senescence and will thus be able to produce a decisive further increase in the average life span: even eliminating all the principal causes of death (cardiovascular disease and cancer) – a goal that appears to be far from being achieved – life expectancy could have for both sexes an increase greater than 10-15 years. One would thus remain far from the difficult objective of 120 years, that is to say the greatest age that has certainly been demonstrated in man, As a consequence, quality of life is gradually replacing the lengthening of life expectancy as a primary and realistic objective. When reference is made to quality of life it is clear that one must refer above all else to the most advanced age groups, where not only are associated illnesses and dependency concentrated but where social inequalities also become accentuated.



At the level of facts, it is undoubted that where obligatory systems of social insurance have been adopted (as in France or Germany) or national health services (as in Great Britain, Spain or Italy) have been installed, a level of health better than in the United States of America, where the challenge has prevailed of private insurance which are at times more efficient but which are always more expensive and less effective in collective terms, has been achieved, with the allocation of less expenditure (in absolute and relative terms) to the health-care services. All the principal health indicators, from infant mortality to average life expectancy at birth, confirm this difference that is due, beyond and more than the specific action of public services, to the culture of the Welfare State, an approach that has been established in Europe through solidarity and struggle, statism and participation, and the search for wellbeing understood in its specific sense as being well personally and a commitment to collective health.[6]

Indeed, amongst the numerous challenges posed by the ageing of the population, reference is also made to an increase in health-care expenditure such that people talk about an unsustainable burden in the future, almost a fiscal 'black hole' that will absorb an unlimited part of national resources.[7]

At the same time, however, there is an absence of in-depth studies on this subject. The few studies that have focused on ageing as a factor in the increase in health-care expenditure have demonstrated that the impact of ageing and other demographic changes has been superseded by the combined effects of factors such the increase in the intensity and use of health-care services, the increase in costs of specific health-care sectors, and increases in general. [8] A recent study indicates that whereas the ageing of a population was responsible for about one fifth of the annual increase in health-care expenditure for constant care in the period 1987-1990, it was an irrelevant factor in the increase on expenditure for care provided by hospitals, expenditure on medical doctors and other forms of health care.[9]

This way of thinking comes from a precise wish to ignore the real terms of the question: the real factor that is able to modify health-care expenditure is not discrimination on the basis of age but the political will and capacity to rationalise services – first of all that of prevention – on the basis of the epidemiological realities and the results of controlled clinical studies.

Even if research in the field of health-care policy continues to emphasise a presumed economising derived from denying care to the elderly, it is important to consider the moral and social costs of rationing health care on the basis of chronological age.

A first important potential cost lies in the lowering of the

moral barriers to the ghettoisation of a group of human beings within a category that is marginalised from the rest of humanity. If the elderly are categorically denied access to health care, to what other group in the future could this also be denied? The suggestion that the elderly are not worthy of life-supporting care could be the beginning of a slippery slope.

Many elderly people who draw advantages from health-care provisions will still live for a further decade or more, still making a great contribution – to society, to the community in which they live, to their families, to their friends – during this 'extra' time. The principal cultures of the world have seen the elderly as a source of wisdom, of discernment, of productivity – as if in the process of physical decline further qualities of wisdom could emerge. Productivity is not correlated with youth: some forms of productivity can be greater when a person has met most of the challenges to development that life presents. The problem of elderly people, therefore, cannot be limited to an analysis based on care but rather the following points should be considered from a wider perspective:[10]

– The most important objective of medicine towards elderly will have to be a reduction of morbidity and disability and not only the reduction of mortality or an increase in life expectancy.

– The need to maintain and strengthen a strong sense of moral solidarity between the generations.

– The need for an integrated set of priorities for young people and elderly people as a part of the efforts to achieve a fair allocation of resources between the generations and within the generations.

– The need to draw up a new strategy in the division of responsibilities in informal care, reducing the present burden that falls on women and developing new forms of state programmes.

– The need to help elderly people to organise themselves politically and collectively so as to define and express their chief needs.

– The promotion of a public debate on the meaning of old age and the drawing up of ways by which to increase the possibility of work and the filling in of free time for the elderly.

A rationalisation of expenditure is only possible if the following three conditions are respected:

– The use of resources must be decided upon on the basis of real needs and this cannot be calculated without having epistemological data available.

– The assessment of the cost/efficacy ratio of measures must be measured with precision.

– It is necessary to consider the 'factory' of health for what it really is, that is to say a very complex system where sectorial measures always create more disadvantages than advantages.

A very significant example here is the negative effects produced on the whole of a health-care system by the lack of rationalisation of geriatric services.

The role of the medical doctor is unique within the productive system of health care. A medical doctor, in fact, determines expenditure without ever being able to be effectively controlled. It is thus indispensable that his training is based on the principle enunciated by one of the founding fathers of modern medicine, Virchow, who believed that 'medicine is a social science and politics is nothing more than medicine on a larger scale'. But as was said at the beginning of this paper, a concrete analysis of health cannot be confined to criteria for the allocation of public expenditure, that is to say to the ethics of resources, but, rather, must address the subject of prevention. This includes both specific measures (for example vaccinations) directed to combat factors for illness and the preventive possibilities that come from choices taken in other spheres (for example the diffusion of education, the humanisation of work, and improvement in nutrition and housing). These measures contribute in a decisive fashion to the promotion and the defence of health both because they manage to change the objective conditions of existence and because they introduce knowledge and stimuli into the personal sphere that work for the fostering and not the compelling of more health-inducing forms of behaviour.

It has thus been established that the only way of simultaneously addressing the level of expenditure and inequality in the protection of health is prevention. The whole of medicine certainly has health as its task but only prevention has as an intrinsic characteristic and has as its specific task the equality of every citizen in the field of health care.[11]

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Note

[1] 1. BONITA R. (ed.), *Women, Aging and Health. Achieving Health Across the Life Span*, World Health Organization, Geneva, 1996. Italian translation published in *Anziani Oggi* 1996;3:71-130.

[2] Cf. KALACHE A. and KICKBUSCH I., 'A Global Strategy for Healthy Ageing', *World Health*, Magazine of the World Health Organization, 1997;4: 40.

[3] BONITA R. (ed.), *Women, Aging and Health. Achieving Health Across the Life Span*, World Health Organization, Geneva, 1996. Italian translation published in *Anziani Oggi* 1996;3:71-130.

[4] Brasilia Declaration on Ageing, 1-3 July 1996 in *World Health*, Magazine of the World Health Organization, 1997;4: 21

[5] CARBONIN P.U., 'Gli insuccessi delle politiche sanitarie per l'anziano e la crisi della sanità nei paesi sviluppati', *Anziani Oggi*, 1994 ;1:5

[6] BERLINGUER G., 'Welfare state e riforme sanitarie', in *Storia e politica della salute* (Franco Angeli, Milan, 1991), pp. 221-242

[7] CALLAHAN D., *Setting Limits: Medical Goals in an Aging Society* (Simon & Schuster, New York ,1987).

[8] BINSTOCK R.H., 'Healthcare Costs Around the World: is Aging a Fiscal "Black Hole"', *Generations*, 1993; Winter:37-42.

[9] MENDELSON D.N and SCHWARTZ W.B., 'The Effects of Aging and Population Growth on Health Care Costs', *Health Affairs*, 1995;12(1):119-25.

[10] Declaration of Principles of the Hasting Report quoted in Callahan D., Ter Meulen R., and Topinkova E., 'Special Issue on Resource Allocation and Societal Responses to Old Age', *Ageing Society* 1995;15:157-161.

[11] SARACCI R., 'Pour en finir avec l'inégalité face à la santé', *Le Monde*, 10 October 1990:19.

Pontifical Council for Health Pastoral Care

Pontificio Consiglio per la Pastorale della Salute

February 5, 2008

HEADLINES

La salute

Cosa è la salute? Tutti sperimentiamo la salute quando l'abbiamo e la malattia quando arriva. Però dall'esperimento al concetto le cose cambiano, perché non è tanto facile descrivere la salute. Infatti, la salute è qualcosa che preserva la vita, ed entrare nel mistero della vita non è cosa facile. [View more]

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