

THE “GOOD COMPANY” IN THE HEALTHCARE FIELD

Adelaide Madera
University of Messina
ad_madera@tin.it

Abstract

The aim of this essay is to address the problems concerning the maintenance of a religious identity or inspiration by religiously affiliated entities which operate in the field of healthcare both in Italy and in the U.S.A., and to propose a comparison between the two juridical systems.

In both juridical systems the healthcare world has greatly changed, because of increasing state intervention, that implies both new and a greater form of forms of state control and a decrease of the economic resources available.

Religiously affiliated hospitals are currently being transformed into firms which have to coordinate their traditional role of assistance apostolates with the needs of efficiency and effectiveness in order not to be excluded from the healthcare market.

Besides, some religiously affiliated hospitals could provide operations that are in conflict with religious, moral and ethical values, in order to guarantee the most comprehensive healthcare offer.

An analysis of the pastorate/management difficult combination is appropriate, and an exam of new forms of equilibrium between the values of human dignity, solidarity, subsidiarity, preferential option for the poor and the needs of a productive firm, and to competitiveness on the market, balancing accounts, “objective profit”.

1. Preliminary remarks

The Church has to face a number of challenges, in a deeply secularized context, in order to continue to operate the service of apostolate, that is an important part of its mission.

Catholic institutions that began to operate as the most authentic and genuine expression of evangelical commandments are now part of highly structured systems, largely dependent on State interventions of healthcare policy, and they are bound to conform to the arrival of new technologies and marketing strategies.

The aim of this essay is to address the problems regarding the maintenance of a religious identity or inspiration by religiously affiliated entities which operate in the field of healthcare both in Italy and in the U.S.A., and to propose a comparison between the two juridical systems.

Healthcare is one of those sectors where interconnections mostly happen between civil law and the needs of religiously affiliated entities to maintain an area of speciality or to ensure that some identity aspects, which are connected with the specific religious affiliation of the entity, receive protection, even though having access to the (legal, fiscal and economic) benefits offered by the State.

Healthcare activity is particular for higher costs of management of its structures and high level of competitiveness in comparison with other entities that offer similar services. In a

comparative study of the two systems a common trend appears: in the last years an increase of healthcare expenses, the inadequacy of a public budget to cover it, and the consequent need of a more rational offer, that should be modelled on patterns of managerial organization, have been recorded.

The emergence of these pressing needs caused gradual transformations of the different healthcare systems. For these reasons the singling out of fixed models is becoming less distinct, while the trend towards “phenomena of convergence at a world-wide level” is accentuated¹.

2. The various models of healthcare offer in Italy and in the U.S.A.

In the U.S.A. the healthcare system is basically founded on private insurance (Consumer Sovereignty Model or Modified Market Model), whereas State interventions have an integrative character, and they just cover costs for certain classes of people by specific programs (Medicaid, Medicare), even though nowadays public interventions have been increasingly included in this model, in order to develop the social and solidarity aspects of the system.

In its turn, Italian law is inclined to abandon the Welfare State model, striving to put into effect a system based on an effective competitiveness between private (that include also private-religiously affiliated) and public entities; on one hand, this should guarantee a better allocation and quality of services, but on the other hand this imprudently and without careful meditation brings our system closer to the American model, risking to put into effect an enterprise model of healthcare that penalizes lower classes.

The Church, anyway, does not single out one ideal healthcare model, as this definition would imply evaluations of a political-social-economic character, but it operates in the various contexts in the light of the values of charity and subsidiarity, carrying on its mission of evangelization.

According to the words of John Paul II in fact : “it is not a Church duty to define which economic models and which healthcare systems can best solve the economics-health relationship; but its mission is to endeavour in order to provide and solve it, in the context of the so-called globalization, in the light of those ethical values that favour the respect and the protection of the dignity of every human being, starting from the weakest and poorest ones”².

3. The public character of the Italian healthcare system

In both juridical systems, till recent times, some too restrictive forms of the public-private and religious-secular relationships were serious obstacles for religiously affiliated hospitals, even if they did not succeed in preventing their increase. We are referring to both those interventions of “nationalization” of healthcare (in Italy), that is the State taking upon itself all assistance functions, that has had the negative consequence of creating a “breaking off between the State and the civil society”³, and the introduction (in the U.S.A.) of forms of

¹ See L. BRUSATI, *Le dinamiche evolutive dei processi di riforma sanitaria: problemi e soluzioni in prospettiva comparata*, in *Ragiusan*, 2000, n. 195-196, p. 10.

² See JOHN PAUL II, *Speech of the Holy Father to the participants of the Fourteenth International Conference promoted by the Pontifical Council for the Pastoral of the Health*, from the website www.healthpastoral.org

³ See G. DALLA TORRE, *Una definizione canonica di volontariato?*, in J. MIÑAMBRES (edited by), *Volontariato sociale e missione della Chiesa*, Roma, 2002, p. 70.

(fiscal, legal) discriminatory treatment of religiously founded non-profit organizations, that were branded as “sectarian”.

With particular regard to the Italian juridical system, the public character of the healthcare system was a factor that discouraged the numerical increase of religiously affiliated hospitals. First of all, the laws at the end of the nineteenth century, whose aim was the eversion of ecclesiastical property, caused a process of transferring of religiously founded or inspired institutions that carried out secular activities under public management. This situation has been defined as an anomalous expropriation (e.g. we can think of confraternities) that was surely detrimental for the connection of those entities with the ecclesiastical hierarchy⁴. Afterwards, even if the context of Church-State relationship was deeply changed, the laws about healthcare were not authentically entrusted with the financial and management difficulties of religiously affiliated hospitals. For these reasons, some religiously sponsored hospitals were converted into public hospitals.

In fact, even if the juridical-administrative autonomy of religiously affiliated hospitals was assured, they were put on the fringes of the organization of the healthcare system; only after the healthcare reforms in the Nineties and the achievement of the principle of subsidiarity at a constitutional level, an authentically integrated system between public and private institutions seems to materialize, and the contribution of non-profit (also religiously affiliated) structures has been fully emphasized.

Not only Catholic hospitals encountered those difficulties mentioned above; we can think of the Agreement between the State and the Union of Israelit Communities (that came into force through law n. 101 dated March 8 1989) which provides for the maintenance of the legal status only of some hospitals, recognizing their religious aim, even if connected with the development of secular activities; on the contrary a large number of religiously affiliated hospitals have been suppressed.

4. The problems connected to the access to public funding for the Catholic healthcare institutions in the U.S.A.

In the U.S.A. for a long time the State laws based on separatism principles (e.g. the Hill-Burton Act) caused a marginalization of the religious character of private religiously affiliated hospitals, even if they undertook the role of social buffering, in the absence of a national healthcare system. The anxiety to give a non-sectarian image of themselves caused a process of secularization of the institutions that developed “other than religious” activities, and the incorporation of apostolates civilly separated from the founding religious entities, without effectively considering the opportunity to maintain forms of control in civil law on the activities and the assets.

They operated in this way in order both to obtain access to the various forms of public funding and to avoid the ascending of economic and juridical liability for their secular apostolates on the religious communities.

Nowadays Authors are critically re-examining this historical phase, and they make a comparison between the secularization of religiously affiliated institutions in the U.S.A. and in Europe: in Europe the eversion of ecclesiastical property is due to Government policies

⁴ Nowadays this trend has been inverted; both the most recent laws, and some interventions of the constitutional jurisprudence, led those institutions again to privatization.

against the established Church; while in the U.S.A. the trustees of ecclesiastical property themselves put to risk and sometimes caused the loss of ecclesiastical assets, and they tried to carry out “an accommodation for public funding and protection from civil liability”⁵. Even if this process of secularization seems to begin inside the ecclesiastical world, we have to remember that it was caused by the need to ensure the survival of the apostolates and to protect them from adverse government policies.

In recent times this situation has been developing in a positive way, even if it has not been solved: on one hand religious entities elaborate increasingly sophisticated systems of civil control over the internal organization and the assets of the apostolates; on the other hand the State is beginning (as we will see more deeply in the following paragraphs) to introduce means of protection of the enterprises of a social character, without mortifying their identity inspirations.

5. The Catholic healthcare institutions in Italy and in the U.S.A.: common trends and new challenges

Even though they operate in different legislative systems, religiously affiliated hospitals are organizations where for profit-making purposes have not (or should not have) a prevalent role and neither do they accept only adherents to a specific creed, nor are they an environment devoted to proselytism.

Besides, the possibility for Churches to have direct access, or not, to forms of public funding undoubtedly affects the explicitation of the religious affiliation of their apostolates. Religiously affiliated hospitals operate in different healthcare models, where there are different levels of State involvement in the programming of their healthcare offer. The adjustment in a pluralistic healthcare system, that integrates public and private, for profit and non-profit, religious and secular entities, and the possibility to have access to forms of public funding, imply public and private forms of control on the activity and with respect to technical – qualitative standards.

Religiously affiliated hospitals are currently being transformed into businesses which have to coordinate their traditional role of assistance apostolates with the needs of efficiency and effectiveness in order not to be excluded from the healthcare market, to have access to public funding, to be included in healthcare programming; as all these factors decide the survival of an institution. However, this situation has caused the closing, restructuring or sale of some religiously affiliated hospitals to the State⁶ or to private owners for profit-making institutions⁷.

⁵ See J. T. BURTCHAEEL, *Out of the heartburn of the Church*, in *Journal of College and University Law*, Symposium on Ex Corde Ecclesiae, Spring 1999, vol. 25, p. 680 ff.

⁶ In Italy we have to remember the recent experience of the Tavola Valdese and of the Mauritian Order, that gave up their healthcare structures to the Region Piemonte. The religious institutions lost both the property and the control on the administration and organization of the hospitals and they maintained only a moral influence. The Region did not buy these structures in order to take upon itself the development of healthcare, excluding private/religious affiliated providers from this activity, but in order to resolve situations of heavy economic-financial difficulty of these structures, which could not be solved in a different way. A sort of partnership between religious and civil authorities has been created. This spirit of cooperation is proved by the norms that provide for the recognition of the specificity of the hospitals and for the protection of their religious identity.

⁷ In the U.S.A. an exemplary case of the economic-management difficulties undergone by the Catholic institutions was the alienation of the St. Louis University Hospital to a noncatholic network. The contract of alienation of the hospital signed by the board of trustees of the University, that was almost completely formed by

Besides, some religiously affiliated hospitals could provide operations that are in conflict with religious, moral and ethical values, in order to guarantee the most comprehensive healthcare offer. The ratio of efficient management introduced by the D.R.G. (diagnostic related groups) system could imply the risk that hospitals might operate a “selection of pathologies”, in order to secure the most remunerative cases, putting aside the less fortunate ones, or those that can cause excessive expenditures: e.g. long term or terminal diseases⁸. The strictness of the d.r.g reimbursement system and the consequent trend to shorten the periods of stay in hospital can cause sending home diseased people prematurely, without taking into account circumstances and conditions that can vary from person to person.

In the end, a healthcare system where healthcare operators have to be “productive” can make the doctor-patient relationship and the trust on which it has to be founded deteriorate.

6. The protection of ethical principles

The Catholic Church refuses a perspective where health is a “commodity to be produced on a pluralistic market”⁹, and understands the risks of healthcare models where economic results potentially incline to be preferred to the care of the person.

The Church underlines the central role of the person, in all its aspects and in every decision process, and the recovery of an idea of the healthcare world as “cross-roads of mankind”, where the Church has to offer the light and the guidance of the Gospel, and to recover the value of hospitality, that is to say listening, reception, and humanization of healthcare in all its periods (prevention, care, rehabilitation). This appears of particular relevance in an age distinguished by the “weakening of ethical consciences” and by the “subjectivism of consciences”, that renders more difficult the singling out of a “shared ethos”, most of all in connection with the great existential and eschatological questions¹⁰.

Even though the Church appreciates the scientific-technological improvement in the medical field, it refuses that “sort of prometheic attitude of man” that induces people to regard themselves increasingly as arbiters of the beginning and the end of life, being unacquainted with the limits of the human condition; at the same time the Church rejects the self-asserting “medicine of wishes”, which causes a trend to remove mentally the conditions of pain, disease, and disability¹¹.

Catholic healthcare institutions have to be a “gift of God”¹², in a pastoral perspective where health is the “penultimate good” in a hierarchy of values at the top of which is the “total well-being of a person”¹³.

lay people, was strongly contested by the community of the Jesuits which had not, in any case, any civil powers of control on the University to prevent it from signing the contract. The Congregation of the Institutes of Consacred Life passed the act of alienation on the condition that the Society of Jesus would put in act mechanisms in order to continue to exercise some form of control. The purchaser in fact engaged itself to respect the Catholic ethical-moral principles in the development of the healthcare activity.

⁸ See NATIONAL BUREAU OF THE ITALIAN EPISCOPAL CONFERENCE FOR THE PASTORAL OF HEALTHCARE, *The Catholic healthcare institutions in Italy. Identity and role*, § 35.

⁹ *Ibid.*, Introduction.

¹⁰ See EPISCOPAL COMMITTEE FOR THE CHARITY AND HEALTHCARE SERVICE, *Proclaim the Gospel and take care of the sick. The Christian community and the pastoral of healthcare*, §§ 16-23.

¹¹ *Ibid.*, §§ 9-10.

¹² See *The Catholic healthcare institutions in Italy*, § 15.

¹³ See JOHN PAUL II, *Address of the Holy Father for the world-wide day of the sick, February 11 2000*, in *Dolentium hominum*, 1999/3, n. 42, p. 6.

These institutions coherently reject both an excessively managerial healthcare model (the “no margin no mission” model), and those dangerous “too homologating (or, in another way, equalizing) fluxes of the general (even if divided and/or localized) teachings”¹⁴. The integration of all the entities in unitary categories (for example “*non-profit*”, “*integrated delivery systems*” “classified hospitals”, “business” “institutes of scientific nature for the hospitalization and care”, and so on), causes in fact the risk of the loss of some aspects of the “specificity” and of the original charism of religious entities.

An analysis of the pastorate/management difficult combination is appropriate¹⁵, and an exam of new forms of equilibrium between the values of human dignity, solidarity, subsidiarity, preferential option for the poor¹⁶ and the needs of a productive business, competitiveness on the market, balancing accounts, “objective profit”. The aim to pursue is a healthcare of excellence, that nevertheless maintains and promotes its humanitarian richness.

7. The maintenance of religious identity

In this perspective, a core of non negotiable values that should inspire the organization, the management, the activities and the relationships, not only with the staff and sick people, but also with other institutions, both public and private, that operate in the healthcare field, is gradually being defined in the Catholic context.

For this purpose, some aspects will be verified, as they are suitable for the maintenance of the religious identity of hospitals. Awareness has to be developed that religious identity is not a permanently fixed qualification, but it has to be responsive to the changes of the context where religiously affiliated institutions operate¹⁷.

First of all, we will examine the preparation of the mission statement, where the values to which activities and decisional policies of the hospitals should be inspired are defined. This is the most efficacious means to maintain the identity, as in the mission statement the purpose to conform the healthcare business to the mission and teaching of the Church becomes explicit. The religious hospital, when it operates, has to be consistent with ethical-religious values that should permeate every authentically defined Catholic institution; it should not be exclusively conditioned by the dynamics of profit, but it should be guided by the logic of solidarity and charity. Besides, the Catholic institutions are not only hospitals that have an assistential role in a substitutive or subsidiary way to State institutions; but also they are apostolates peculiar to their religious inspiration and to their communion with the Church; for these reasons they have to “see, judge and do everything in the light of faith”¹⁸.

Secondly, the education and the selection of the medical, administrative and managerial staff takes on great importance. Within the ecclesial community, the Church urges lay people to “overcome the barriers formed by a long tradition of passivity, and assume the role that

¹⁴ See S. BERLINGÒ *Enti ecclesiastici: costituzione e riconoscimento*, paper at the meeting *Vent'anni di applicazione e di esperienza della Legge 20 maggio 1985, n. 222*, Rome, November 25-26 2005, *pro manuscripto*.

¹⁵ See *The Catholic healthcare institutions in Italy*, § 34.

¹⁶ See *Christifideles laici*, § 41, where it is stated that charity apostolates are claimed by the Church as its own “inalienable duty and right”.

¹⁷ See M. DI PIETRO, *The interfacing of canonical principles and American law in the negotiation of joint-ventures between Church-related and non-Church-related corporations*, in *Acts of the Colloquium - Public ecclesiastical juridic persons and their civilly incorporated apostolates*, Rome, 1998, p. 193. The Author speaks about the “fluidity” of the Catholic identity.

¹⁸ See *Apostolicam actuositatem*, § 29.

belongs to them”¹⁹. Active participation of lay people is encouraged, in the light of the Church’s teaching²⁰, especially in those apostolates where the secular disposition of lay people can be better expressed²¹. This participation “is absolutely necessary for the Church in order to maintain its function of recovery and mercy” also using those new forms of administration that often involve “other than Catholic collaboration”²².

Lay people have to be more involved in Catholic healthcare institutions and their not only professional but also human training and education have to be emphasized. The knowledge and competence in the field of ethics and Catholic doctrine will therefore be of essential importance in order to define the policies and strategies of a business.

Nowadays it’s increasingly important to extend cooperation of lay people also at an executive level, and to educate new Catholic managers, trained to cooperate with religious people and also to replace them, and to work out new creative forms of administration and control of ecclesiastical assets.

The need to develop the training process of this “new generation” of lay Catholic managers has become increasingly urgent as it is logical to foresee that in the near future, lay people will mostly keep on and detain absolute control on apostolates²³.

8. Comparative aspects of civil laws about religious organizations developing secular activities

Specific relevance will be given to a comparison between the juridical instruments that are available for the Catholic hierarchy in both American and Italian juridical systems, concerning the ways of control of activities and property, as a means to influence the most important decisional choices of the hospital.

In both systems, in the framework of different Church-State relationship models, the Churches can use different forms of civil organization and civil means of checking so as to maintain control over their own apostolates. Regarding this, we cannot neglect the different assumptions on which the two juridical systems are based. In the U.S.A. the use of civil structures to protect Church interests is absolutely necessary as canon law entities do not receive recognition in State law; in Italy the use of forms of civil organization has importance only as an integration of the agreement instruments, in order to emphasize all the possibilities offered by the juridical system to the maximum level. Every real situation involves a different configuration of “duties, rights and responsibilities both inside the healthcare institution and in the relationship with the universal Church, the local Churches and the Major Superiors of the religious institutes in the relevant situations”²⁴.

¹⁹ See *Proclaim the Gospel and take care of the sick*, § 45.

²⁰ See *Apostolicam actuositatem*, § 1; *Christifideles laici*, § 29.

²¹ See *Christifideles laici*, § 15.

²² See THE CATHOLIC HEALTH ASSOCIATION, *Catholic and other than Catholic collaboration. Lessons from the field*, St Louis (Mo.), 2000.

²³ See M. C. GRANT – P. VANDENBERG, *After we’re gone: creating sustainable sponsorship*, Ashland (Oh.), 1998, p. 119.

²⁴ See NEVES DE ALMEIDA, *Il punto di vista del diritto canonico*, paper presented at the A.I.S.A.C. worldwide meeting “Catholic healthcare institutions as witness of the Church” July 1-3 1999, in *Dolentium hominum*, 1999/3, n. 42, p. 17.

Nevertheless, in both systems the Catholic Church is investigating new forms of organization in order to develop secular apostolates. These organizations should both satisfy the need of a more flexible administration, and follow the Vatican directive to develop a “new fantasy in charity”²⁵, even though they should not lose those particular identity aspects that distinguish a religiously affiliated institution. Pointing out forms and ways for the operation of apostolates is in fact one of the pastoral duties of these institutions, taking into account different places and times where these institutions are founded and developing proper means for their introduction into the civil law systems.

Besides, the U.S.A. case largely shows us that the concept of religious identity is often consequent to the emerging risk of the partial or total loss of property. Notwithstanding this, the experience of American religious institutions teaches us to encourage the endeavours to verify the possibility to emphasize Catholic identity through a plurality of organizational forms, investigating new links with ecclesiastical authorities. On this subject, recent Vatican documents emphasize the “variety of vocations” and they include a commitment to promote “the various aggregative realities both in the traditional forms and in the new ones”²⁶.

9. New forms of cooperation

We should also analyze the forms of cooperation between religious hospitals and secular (also for profit) hospitals whose purpose is to continue to operate some apostolates. The hospital as an independent economic actor, is increasingly going to be substituted by complex structures, whose aim is to put in act a continuum between healthcare services, professional performances and sometimes social services.

In the U.S.A., the evolution of the “payor contracting”, that is to say those economic agreements between all the subjects that pay the costs of healthcare, the transition from the prospective payment system to the one founded on the D.R.G., the cut of public funding and, especially, the introduction of the managed care, the formation of healthcare networks or integrated delivery systems, and the important role that health maintenance organizations (H.M.O.) have assumed, as a trait d’union between providers and beneficiaries of healthcare, have caused very high levels of competitiveness on the market and they press (also religious) hospitals to investigate new forms of cooperation or real structural, functional or sometimes also legal integration (both at a horizontal and vertical level)²⁷; in order to carry out a co-ordination of activities, assets and structures so as to reach a common goal.

On the contrary, examining the Italian healthcare “market”, the presence of both public and private providers mainly emerges. The duty to guarantee co-ordination of activities is entrusted to public healthcare enterprises, in order to assure a proper fulfillment of the healthcare needs in a specific geographical area. A new model of delivery of tasks is developing: the Local Healthcare Enterprises are going to maintain only the financial burden of healthcare; the role of providing healthcare services is going to be assigned to different (both public and private) subjects²⁸.

The trend is to set up a clear-cut division between providers and purchasers of healthcare services, between funding responsibility and management powers; mechanisms of de-

²⁵ See *Novo millennio ineunte*, § 50.

²⁶ *Ibid.*, § 46.

²⁷ See B. SHIH, *Healthcare transactions: a guide to mergers, acquisitions & integration*, Washington, 1998, p. 453 ff.

²⁸ See P. BOZZAO, *Tutela della salute e ruolo delle organizzazioni non-profit*, in *Ragiusan*, 1999, n. 176, p. 6.

integration of the public system are developing, fostering increasingly sophisticated forms of contracting out. Every single Region seems, in a logic of cooperation, to go towards the achievement of a network of healthcare structures, in order to share human and structural resources, to harmonize the programming and administration of services, and to pursue synergic aims²⁹.

A move in the direction of the American system can be found, where the hospitals standing alone have been substituted by networks, even though the different Italian context has to be taken into account, as the public agencies in Italy maintain powers of co-ordination and supervision over the system.

The Church gives a positive appraisal to the sharing of experiences, resources and projects³⁰, but partnerships can sometimes give rise to the risk of openings to morally illicit operations. For these reasons, the effect of partnership on an institution and on the development of the healthcare market in that specific geographical area where the original institution operates during the long period has to be carefully considered.

10. “Internal” and “external” aspects of religious identity

The Church is aware that its institutions cannot come to be a “party-spirit healthcare” and cannot follow a policy of isolation, but they have to integrate into the complex context of the healthcare offer³¹. The aspect of ecclesiastical property is nowadays only one element (and not the most important) of religious identity. This factor has to be considered in a secularized context of activity, taking into account both internal aspects (organization, administration, adherence of the staff to ethical-moral principles, Catholic doctrine regarding healthcare) and external ones (State laws, forms of State control, market pressure)³².

Whether a hospital has its own autonomous juridical status or not, the Church is developing the awareness of the need to share the power of decisions. The religious entity (even if it is the owner, the founder or the administrator) will inevitably not be able to have exclusive control over the hospital, but it will have to accept cohabitation with internal influences (the staff, the chief executive, patients) and external ones (public and private agencies that supply forms of funding, other - religious or not - hospitals, that put themselves on a competitive level) even if all this happens respecting the purposes of the institution.

A strict prospective focused on a narrow “ownership approach” can lead to neglect that intrinsic identity part that should, on the contrary, measure the catholicity of a hospital³³: the quality of medical assistance, the healthcare offer being in agreement with the needs of the

²⁹ See S. LAZZINI, *Principi di accountability nei sistemi sanitari italiano e statunitense*, Milano, 2005, p. 108 ff., gives the example of the Union of Large Area in Tuscany, the Macro-areas in Emilia Romagna, the Quadrants in Piedmont.

³⁰ See NATIONAL CONFERENCE OF CATHOLIC BISHOPS, *Ethical and Religious Directives for Catholic Health Care Services*, in *Origins*, December 15 1994, vol 24, p. 452. The American Ethical-Religious Directives were partially elaborated again and the new version was approved by the American Bishops on June 15 2001. See U.S. BISHOP MEETING, *Ethical and Religious Directives for Catholic Health Care Services*, in *Origins*, July 19 2001, vol. 31, p. 153 ff.

³¹ See *Catholic healthcare institutions in Italy*, Introduction.

³² See E. WIDMER, *Azioni pratiche da promuovere per gli ospedali e gli altri centri sanitari*, Acts of the Sixteenth International Meeting promoted by the Pontifical Council for the Pastoral of Health on “Health and power”, November 15-16-17 2001, in *Dolentium Hominum*, 2002/1, n. 49, p. 116.

³³ In this sense, see M. DI PIETRO, *An examination of the universitas rerum and the universitas personarum of new public juridic persons succeeding to the healthcare apostolates of religious institutes in the United States*, Rome, 2004.

community, the effect that management choices (allocation of resources, services, structures, closing or transformation of activities, achievement of new forms of cooperation) can have on access to healthcare for the poorer classes³⁴.

Church apostolate in the healthcare field is therefore being increasingly outlined not as a form of exercise of a (social, economic, politic) power, but essentially as a witness of charity and service.

11. The development of the ethical dimension of the business

Efforts directed to humanize healthcare, to conceive hospitals not only as businesses but also as systems of relationships and means of the promotion and development of personality, and to give back to the patients the role of protagonists in healthcare activity, do not come exclusively from religiously affiliated organizations.

For these reasons it is appropriate to find a connection between Church and the political community (not only in its institutional aspects, but also in its community ones), in order to pursue the aim of the “common good”.

In both juridical systems, at a social-juridical-economic level, consciousness has been developing (or returning) that the product offered by healthcare providers is a particular one; the health good cannot be totally linked to the logics of the market. Requests (both public-institutional and social-community) to estimate (public or private) businesses on the grounds of their ability to generate a value for the community where they operate are increasing, that is to say not only value as the profit, but also as the ability to give social answers.

Healthcare businesses can be qualified as systems where there is a plurality of individuals, that generate and have interests, and that at the same time are actors in order to reach these aims. They are defined as stakeholders, and their needs and expectations have to be satisfied, in the framework of a process of the balancing of interests and values³⁵.

Even though the operative contexts are different, demands of both internal and external (institutional, social, managerial, professional, personal, and nowadays also inter-institutional) accountability have been developing. Demands identifiable in the ethic dimension of the operative processes of the business and in the principles of social responsibility are growing, and they involve evaluations on the correctness and transparency of business action and operative processes, monitoring of the quality, control over administration, on the effective achievement of the programmed aims, on the social impact in the long run. In the end, these demands urge businesses to a progressive responsiveness (that is something different and more than responsibility) concerning their policy, their relationships, forms and results of their actions and the social-solidarity effects of all these, also regarding ethical aspects³⁶. With regard to this, in both systems legislative initiatives have been developing; proper tools and (internal and external, public or private) bodies of control and supervision are being established; forms of incentive coming from both public-institutional agencies and the market are also evolving, in order to reward the ethic policy of a business and to promote a more equitable and democratic healthcare system.

³⁴ See J. BEAL, *Ospedali cattolici: in che misura saranno cattolici?*, in *Concilium*, 1994, 5, p. 115 ff.

³⁵ See S. LAZZINI, p. 9.

³⁶ See S. LAZZINI, p. 107 ff.

12. The healthcare reform in Italy

With specific regard to the Italian system, it is overtaking the public and centralized lines and assuming private characters as a consequence of the process of transformation into hospital undertakings. The organization of the healthcare system has been completely altered by the general processes of administrative simplification, privatization, and by the arrival of federalism. There is a transition from forms of bureaucratic – book-keeping accountability, to a managerial accountability, as far as an accountability of expectations.³⁷

Regional authorization is necessary for both the building of new structures and the modifications, restructuration, transformation of existing ones. This authorization is required to verify that a structure has those minimal structural, technological and organizational qualifications defined by the Region. The accreditation mechanism of hospitals is aimed to guarantee the efficiency and effectiveness of services, a more equitable allocation of resources, the functional character regarding the directives given by Regional programming, the audit of the achieved outcomes, and also to prevent a duplication of services in the same geographical area. The loss of accreditation, when a structure is no more consistent with the required qualifications, causes the exit of the hospitals, both public and private, from the healthcare market. Finally, contractual agreements bring about a choice between private and public structures, in order to provide healthcare, operating a comparative evaluation of costs and quality, defining the maximum level of service, in typology and form, that a hospital will provide, receiving a reward from the Region.

In this process of renovation of healthcare, the mechanisms of informed consent become also specifically relevant, as they make the individual no longer a passive subject, but a participant in choices and medical therapies.

13. The federalistic model

It is astonishing that Italy is increasingly going towards a federalistic model, while the American “cooperative federalism” model is moving towards a reinforcement of the Federal power, that is gradually occupying spaces previously reserved to the single States. Decentralization causes risks of fragmentation of the healthcare offer and the outcome of more inequalities in the various geographical areas, even though it achieves a system closer to the needs of the single communities.

A further risk which religious organizations should take into account is the fragmentation of the choices that involve ethical-moral aspects. These aspects should receive both a more general and at the same time integrated attention.

It is desirable both that in Italy some subjects will continue to receive attention also at a national level, developing bureaus of co-ordination between State and Regional policies and that new synergies with religious authorities, that are aimed at protecting religious freedom in a large sense, will develop³⁸.

14. Managed care in the U.S.A. and corrective mechanisms.

In the U.S.A. the system remains still regulated by the rules of the market, and the managed care system has increased the unfairness of the system.

³⁷ See S. LAZZINI, p. 310.

³⁸ See S. BERLINGÒ, *Fonti del diritto ecclesiastico*, in S. BERLINGÒ – G. CASUSCELLI– S. DOMIANELLO, *Le fonti e i principi del diritto ecclesiastico*, Torino, 2000, p. 20 ff.

The allocation of resources assigned to healthcare remains committed to market mechanisms, instead of to government decisions and to public funding programs. The freedom of choice of the health operators and of the structure does not pertain to single individuals, but it is entrusted to third parties. For these reasons, moral responsibilities to take decisions that influence the wellness of the community are entrusted to private entities³⁹.

However, an awareness is developing that it is difficult to put in action mechanisms that sufficiently guarantee the social justice, the democracy of the system and a basic level of assistance to everybody in the ambit of the market.

Mechanisms not only of market accountability (that are aimed at developing the awareness of the purchasers of healthcare services about the options offered by health plans, their quality standards, their limits of insurance cover, the names and credentials of their medical staff, the possibilities offered to receive emergency assistance or in structures external to the network) but also of accountability of reasonableness (that are aimed at guaranteeing greater clearness in the choices of the H.M.O., and at assuring that their policies are based in a more coherent way on standards that impartially balance a high level healthcare offer and the limitation of the resources available) are developing, in order to avoid the negative effects of managed care⁴⁰.

Besides, there is an increase in the forms of “social reporting”, entrusted to both public agencies and private organizations⁴¹.

A large number of organizations (also representing specific groups of interests) have been developed, side by side with the Joint Commission on Accreditation of Healthcare Organizations, which is a non-profit corporation that grants the accreditation (a qualification absolutely necessary to have access to public funding and to contract with the H.M.O.) to the hospitals. The activity of these organizations is aimed at monitoring, collecting information, compiling reports about the structures, the services, in order to evaluate the costs and quality of the services and to try to influence healthcare policy decisions.

Instead of sanctions (as exclusion from public funding programs) forms of additional rewards are stated, in order to incentivate hospitals to produce the required information; they obtain these rewards when they reach high quality levels. Standards of management of human resources, attention and sensitivity towards the beneficiaries of the services emerge among the evaluated standards.

15. Interventions of healthcare programming

In the U.S.A., legislative initiatives have been developing, whose aim is to subtract from the market the exclusive power to give legitimacy to decisional processes regarding the delivery and the limits of healthcare offer, and the hospitals are increasingly subject to forms of public and private audit about the effective adequacy of healthcare services for specific social

³⁹ Cfr. N. DANIELS – J. SABIN, *The ethics of accountability in managed care reform*, in *Health Affairs*, 1998, vol. 17, n. 5, p. 63. The Authors note that in the single payer systems, that is in the models where there is a national healthcare system, on one hand it is easier to focus a single responsible for the legitimacy of the system; on the other hand the cause of the shortage of the public budget is largely used to justify healthcare policy choices that would otherwise be disliked by the community.

⁴⁰ See N. DANIELS – J. SABIN, p. 52.

⁴¹ See S. LAZZINI, p. 284 ff.

classes⁴². Forms of healthcare programming have been put in action, that is, not the institution of a system where all its parts are coordinated between them, as happens in Italy, but, instead, a set of interventions whose aim is a fairer equal delivery of healthcare.

These social goals of the U.S.A. legislation are witnessed by the fact that hospitals, in order to have access to public funding, should open their services to all the community and a certain volume of services has to be guaranteed to poorer people⁴³. The single communities are the main point of reference in order to address the political-decisional choices, which should have a positive effect on the communities.

Besides, the hospitals which have access to public funding should accept patients whose services are paid for by Medicare and Medicaid.

These duties have become heavier and more effective following the coming into force of the National Health Planning and Resources Development Act, which introduced more restrictive forms of control on the use of public funding⁴⁴.

With the same law these controls, which were previously entrusted to State agencies, have been centralized, entrusting them to a Federal bureau (Department of Health and Human Services). Non-profit hospitals are not exempt from these forms of control: the burden of the Government of less fiscal entries, due to fiscal exemptions that these institutions enjoy, has to be balanced against the benefit received, that is a proper volume of non-profit healthcare for poor people in a specific geographical area provided by non-profit hospitals⁴⁵.

In both systems mechanisms of accountability of expectations are developing, that is the emphasis of the community expectations, whose aim is more clearness and external appraisal of hospital operations; the right to be informed both about the use of resources devoted to healthcare, and the validity of the aims pursued, is given to citizens⁴⁶.

16. New juridical instruments: the social enterprise in Italy

Both juridical systems seem directed to promote new forms of social action, understanding expectations that non-profit/religious organizations have had for a long time. The trend is to overcome the traditional lines of distinction (for profit/non-profit; public/private; religious/secular), which are no longer considered in antithesis; on the contrary, they pursue new synergies, in order to put in act the integration, cooperation or foundation of networks or partnerships between entities different by their nature and regulations.

⁴² We can remember the Consumer Bill of Rights and Responsibilities, approved under Clinton's government, a large number bills at both federal and state level, the quality standards defined by the National Committee for Quality Assurance. We can also remember the recent institution of the CSM (Center for Medicare & Medicaid Services) whose purpose is a service to citizens, in order to let them reach a more aware use of programs of public assistance.

Besides, the P.R.O. (professional review organizations) check the quality of services and the percentage of use by beneficiaries of public programs.

⁴³ See 42 U.S.C. 291(c)(e).

⁴⁴ Hospitals should have a licence in order to exercise healthcare activities and the National Health Planning and Resources Development Act, passed in 1974, stated that all the hospitals should have a certificate of need; so a public agency has to authorize the expenses, the purchase of new equipment, the opening of new structures whose costs exceed a specific amount.

⁴⁵ Fiscal and antitrust controls have to be added, and they are specifically relevant for non-profit hospitals.

⁴⁶ See S. LAZZINI, p. 38 ff.

A careful law-maker grasps the importance of the support that religiously affiliated organizations can give, and emphasizes religiously founded non-profit organizations, giving them the chance to operate on an equal level with secular ones and requiring them less and less frequently to renounce their inspirations and ideals. This is happening recently, as a strong input has been given to laws about social cooperation (in Italy) or about charitable choice (in the U.S.A.).

In the Italian system, new perspectives are offered by the new juridical person of the “non-profit” entrepreneur and by its extension also to the secular activities of religious entities. The recent law about “social enterprise” makes it possible, in fact, to exercise business enterprises with non-profit goals, for a large number of subjects that operate in the social field, including also ecclesiastical entities. This new law also offers an input to overcome the dichotomy between companies and other types of juridical persons, privileging not the juridical nature of the entity, but the nature of the activity (social enterprise) in order to make coherent the “pursuing of altruistic goals with the maintenance of the qualification of entrepreneur”⁴⁷.

Besides, this law is a sign of overcoming the traditional disapproving attitude of the Italian juridical system (also verifiable in the American system) towards forms of blending between for profit and non-profit activities⁴⁸.

Even though the main Church commitment is towards the poor, it does not refuse the development of for profit activities, when they have an instrumental and secondary character in comparison with the principal activity.

17. The charitable choice programs in the U.S.A.

In the U.S.A., the directive towards new forms of pluralism are pointed out by the charitable choice programs⁴⁹. These are programs which provide for public funding to private institutions, in connection with the development of specific services of a social character. The faith-based providers are involved in these programs on an equal level with respect to secular institutions, without imposing restrictions on their religious character, negotiations about identity⁵⁰, additional forms of civil control by public agencies, the renouncing to specific exemptions which religious corporations have been provided with in the employment field.

These programs are not in conflict with State neutrality, if the State commits itself to supply also a secular equally accessible choice, which has the same quality standards. In this way the freedom of choice and therefore of conscience of every individual at the highest level is protected.

18. The propulsive role of Catholic hospitals

⁴⁷ See S. BERLINGÒ, *Enti ecclesiastici: costituzione e riconoscimento*.

⁴⁸ In the U.S.A. the non-profit organizations qualified as 501(c)(3) can also operate a for profit activity, as a collateral one, and whose gains will be fiscally considered as Unrelated Business Tax Income; however this for profit activity should have a secondary character and it should not be connected with the principal activity, otherwise the organization risks to lose its tax exempt status.

⁴⁹ At the moment these programs concern only social assistance entities, but in the future it is desirable that these programs will be opened to organizations that operate in other fields of social activity. The connection between the healthcare field and the social assistance one is witnessed by the various forms of operative cooperation which are developing nowadays.

⁵⁰ For this expression, see A. GALLIN, *Negotiating identity*, Notre Dame (Indiana), 2000.

It is important that the enterprises of religious inspiration develop more awareness that ethical and responsive action, when it is the leading guideline of enterprise policies, will cause positive effects, in the long run, on the profits curve, and will contribute to putting in act a new equilibrium on the market, as well as being favoured by recent laws⁵¹.

The realization of this model founded on the ethics of behaviour needs the participation and collaboration of all the parts of the system. Otherwise, the enterprises which accept it isolatedly could be put on the fringes of the market and in the end they might abandon their service commitment or conform to the most common market models (that would be equivalent in any case to a loss of the apostolate regarding its identity aspects, and it would be not less serious than the simple closing of the hospital or the alienation of the assets).

In the healthcare ambit, Catholic institutions have to develop a propulsive role of promotion of an alternative model, which would succeed in balancing the new needs of efficiency and effectiveness against the respect of ethical-moral values and principles.

In the course of time, the Church did not limit itself to adapting to history, conforming its doctrine and its praxis to the evolution of times or to the emergence of new circumstances; on the contrary “the ecclesial community succeeded in preceding the times, not only becoming a protagonist, but also circumscribing their coordinates”, and “generating history”⁵². Even though the Church persists in its tradition of charity that has always characterized ecclesial action, at the beginning of the new millennium the needs of “even more inventiveness emerge in guiding the activity of the apostolates”⁵³, provided that, in any case, “the charitable activity of the Church will maintain all its brightness and will not vanish in the common assistential organization, becoming a simple variant”⁵⁴.

There are different forms of inclusion in the various healthcare systems: Catholic institutions can operate at an integrative, complementary or subsidiary level as regards the public system and the civil society; it is important they do not abandon their identity and their role of anticipating the needs which the public system or the private for profit institutions tend to leave unsatisfied.

They should also keep open a dialogue both with the other (public, private) healthcare providers which operate in the same area and the public agencies, setting up a network of connections whose aim is to increase forms of interaction between all the parts involved, focusing on a basis of common principles and operative goals: the promotion of the common good, human dignity, the protection of the person in all its aspects, enough healthcare for the poor.

The guideline in order to let Catholic institutions not only survive on the market, but also point out the directives for the development of those parts of ethics and equity of the system, and influence the choices of decisional processes concerning healthcare policy, is that of a joyful and continuous search for renewal: a search for “new operative lines, new forms of

⁵¹ See S. ZAMAGNI, *The ethical anchoring of corporate social responsibility and the critique of CSR*, on the website www.stthomas.edu/thegoodcompany

⁵² See *Le istituzioni sanitarie cattoliche in Italia*, §§ 4-5.

⁵³ See *Novo millennio ineunte*, § 50.

⁵⁴ See *Deus caritas est*, § 30.

organization, new vocational identities, new perspectives of collaboration, new openings to dialogue, new apostolates”⁵⁵.

⁵⁵ See *Le istituzioni sanitarie cattoliche in Italia*, § 33.