OPERATIVE PROPOSALS FOR THE SOCIO-HEALTH INSTITUTIONS OF THE MEN AND WOMEN RELIGIOUS

In times of general crisis where unexpected and unpredictable elements come across and coalesce, the Orders and Congregations whose charisms and traditions are dedicated to the social and health needs are traversing the phase of uncertainty. The issue at stake here is neither the question of their institutional values, nor its charismatic potentials of healing and evangelization but mainly their **continuity in the actual context of precariousness** and the scarcity of its economic and material resources.

In such situation, for many Orders and Congregations, it is a high risk to seek new and more sustainable adjustments of their charism without adequate discernment, **to dispose, to transfer or to alienate** their facilities to private parties, who certainly resolve the problem at stake, but are often driven by speculative intentions.

The Commission of Health of the USG/UISG, after confronting the issue through a Study Committee, has issued a document entitled *"The Donkey of the Samaritan fell ill. Religious Healthcare Institutions as an instrument to exercise Charity in the 21st Century."* This document offers interesting topics for reflections as integral part of this present endeavor. After conducting ample consultations, this present reflection which is now to be submitted to the Assembly of the USG/UISG, and which acknowledges the analysis of the above-named Document, traces possible ways and offers operative proposals.

Possible paths of work

Providing sustainability to our Institutions by modifying in part their operation, without however denaturalizing or selling them, is possible and within our scope. Many of these represent the realities and models that give testimony throughout the world. The goal of this effort is not to illustrate specific cases, it is however by examining these that we believe we may identify some common work processes that can be applied in the short term.

The common denominator of these proposals is the search for coordination and reconstruction of the modern fragmentation.

3.1) Coordination

Based on an updated reading of our charisms and experiences of the founders, we could identify with greater clarity, specificity and precision the values, tensions, particularities and characteristics which distinguish our experience in the field of healthcare from the one of others. We could attempt to develop an actual **strategy for coordination** and **integration with the changing world of healthcare** based on these distinctive capabilities. None of our Orders and Congregations can face the complexity of the changes in progress alone. In order to operate together, we need to recognize in what name and toward which objectives we must focus our common energies. We are certainly called to share and create synergies among the significant parts of our **"logistics"**, from common supplies to the sharing of organization and administrative models, from external communication to the maximum use of technological and information technology equipment. We are however also called to increasingly share our gaze to **read the signs of the times** and the voice to deal with them. A mere institutional representation is not enough: we need

organizations which can jointly express a **unified voice** and make operational choices that can bring about real results. We must work for such a possibility to come true.

3.2) Hub & Spokes

A real experience in coordination and integration between Orders and Congregations may serve to situate our services within the social systems of public and private health services.

It is foreseeable that Healthcare Systems, especially in the Western world, will increasingly evolve over the coming years toward a so-called "hub & spokes" (radial) model, in which some major facilities will acquire a **central role in the integration** and general coverage of the more specialized needs and many other smaller facilities will become **articulations** or territorial facilities, to address the simpler or specialized health requirements to deal with specific needs and disorders in the most effective and efficient possible manner. In such a situation that presents a strong risk of further fragmentation of care processes, the role of those facilities able to offer people an integrated experience, by giving priority to quality and relationship and positioning or repositioning our institutions in a sensible and effective manner in the changing healthcare systems, may acquire a particular significance.

3.3) Community Hospitals

The perspective to invest in the creation of facilities such as the so-called "community hospitals", **small facilities focused on the individual** for **post-acute or chronic treatments** and to manage milder health emergencies ("white codes") which today public facilities struggle to address, represents an extremely interesting activity for our institutions which could allocate some room within their institutions for these interventions or convert their presently unsustainable facilities to that effect. These types of facilities represent, in fact, the future for a large part of contemporary healthcare systems available; by involving the community, the third sector and primary care physicians, they provide effective responses, at a cost up to two thirds less than conventional hospitals, to some needs affecting population sectors in continuous growth.

3.4) Folk and territorial medicine

Through a process of reinterpretation of their own missions and operations, the Institutions belonging to Orders and Congregations might focus their attention and resources on **folk and local area medicine** and on the organization of **inclusive services** with a particular attention to the health and well-being of the **most disadvantaged categories** such as dependent people, the poor and lonely elderly, the homeless, drug-addicts and psychiatric patients who are increasingly "forgotten" by public healthcare systems, particularly now, after the general decrease of the systems of public welfare.

Our facilities offer us the opportunity to manifest our **authentic and quality closeness** to them. If, in accordance with the principle of subsidiarity, it is right and proper for the responsibility toward the weakest individuals to be shared by all; however, in times of growing individualism and fragility in social ties, some have a **prophetic duty** in this area. We believe that our facilities should be among them.

3.5) Network and Collaboration

The connection between social and health spheres, the subsidiary and innovative reconstruction of economic and material resources of people, families and communities, the valuation of the social and cultural capital of the intermediate bodies in society, all represent sources of energy and resources which could effectively be put to good use and help in providing sustainability to our facilities, even from an economic standpoint. Many are working at identifying the most adequate forms and proposals to create these **collaborations with the crucial world** of associations, cooperation, social enterprise, social representation and the movement for civil and social rights; this is a **generative task**. We believe that our facilities must become involved in these processes in a unified and shared manner, to enrich them with our own history and skills and to be enriched through them by learning new and more sustainable manners of performing health services in communities and generating well-being for all. The network allows also to

rethink healthcare as an integrated system of services and activities that precede and follow the hospitalization phase, assuring continuity and variety (prevention – cure – rehabilitation)

3.6) The resource of laity

Our Orders and Congregations could be boosted in this direction by a greater internal **involvement and awareness** of **lay** collaborators. The lay personnel collaborating with us, volunteers, formal and informal associations which in time were created and developed alongside our activities and the faithful we encounter in our religious life, represent a source of energy, ideas and resources which we probably do not use sufficiently. We must have enough pastoral and organizational courage to offer them **more room** in our life and activities, to listen to them and involve them further, not fearing they will take over **responsibilities**, whether at the management or any other level. "Our" laity, especially if they are **young**, represent a **link** with the society which we should value more to promote our values and our mission and to acquire greater **freshness and innovation** in our organizational cultures. However, to make this possible, we must in turn learn to be sufficiently appealing to them by reviving both the demands of our charism and the possibility to carry out in our facilities experiences of **formation, development and research**, including technological, in tune with the times.

3.7) A new governance

One way to make all this possible in our Institutions could be through the consideration of new forms of *governance*, capable of connecting resources and charisms in a new and more effective manner. The forms of **joint *governance*** among several entities and congregations seem particularly promising and interesting; the management of activities is entrusted to **technical organizations**, inspired however specialized, which foster synergies and management enhancements, while the set-up, control and guidance of facilities remain with the single congregations. We can therefore maintain the identity, stories and charism without giving up effectiveness, thereby building realities capable of "rescuing" many facilities undergoing a crisis in our world. Best practices of this sort already exist and, especially, can be further developed. However, it takes determination and courage. Only a process of joint, serious and thorough work may reveal whether these circumstances exist and if such solutions can actually be implemented among us.

It is not just a technical issue or one involving legal and administrative solutions as we often tend to envision and represent. There are in fact innovative experiences in the world, with often a common cultural matrix, that are attempting to put together solutions of this kind, whether on a large scale or in smaller contexts. Let us think for instance about the *Fundación Summa Humanitate*, which is attempting in Spain and Italy to help very many religious Congregations to not disperse their own assets and charism by entering in a non-profit manner into the effective management of facilities otherwise destined to be shut down or sold. Let us also look at experiences such as the one of *Welfare Italia*, a network of subjects from civil society who, from the bottom up and with purposes and processes of mutuality and cooperation, are developing in Italy a number of private multi-specialty clinics at a low cost and with high standards of quality, called "places of care" where, without giving up small profit margins, they practice a concept of folk medicine that is accessible and holistic. Another model (sample) is the institution of the Foundation, civil and/or ecclesiastical, of which there is a model in the Lombardo-Venetian Province of the Camillians. There are indeed legal and technical solutions to bring these experiences to life; these can be identified and adjusted to nearly all forms of requirements, also given the high interest on the part of public authorities.

OPERATIVE PROPOSALS

I – First proposal

In order to realize the above-mentioned, we propose to the Major Superiors **to institute an inter-congregational working group** which acts as the voice of the Major Superiors in the field of health. This working group will be in charge of:

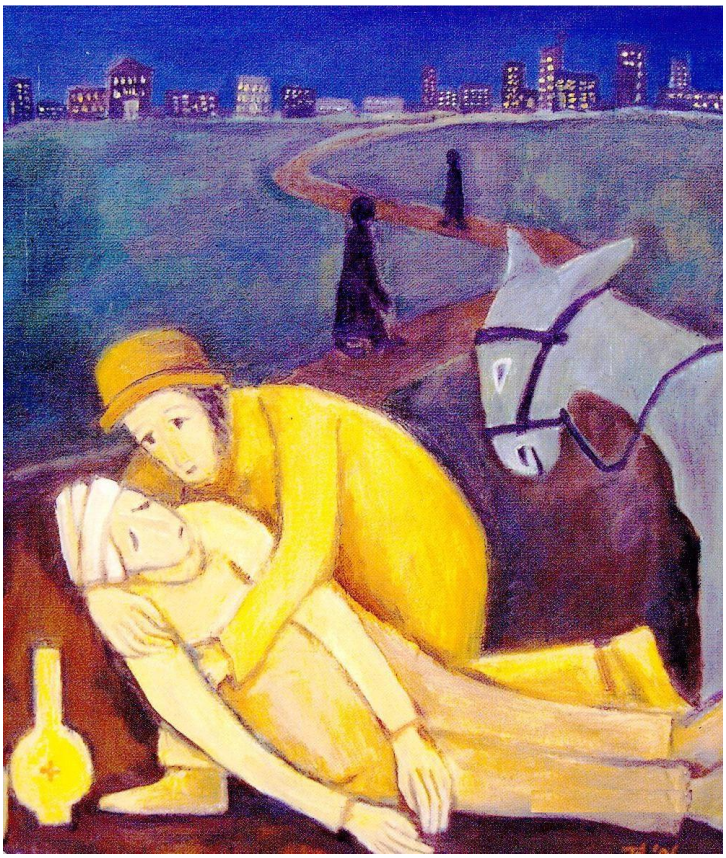
1. **Identifying operative proposals and best practices** that responds to the crisis of the health institutions;
2. **Monitoring the innovations applied**, evaluating its efficacy and ensuring a follow up;
3. **Studying juridical (legal) solutions** and supporting its actualization (realization) in collaboration with or with the advices of the other competent partners;
4. **Activating channels,** in the name of the two Unions**, with the ecclesial authorities and the like civil entities.**

This working group stabilizes an **operational budget** and standard operating procedures meant to submit **a regular and frequent report** to the USG/UISG (ex. quarterly progress report).
The working group must be characterized as
- **international** (confronts the issues of health in an international or global perspectives);
- **specific** (deals with the issues relative to the socio-health institutions as providers of health services characterized by multiple actors involved);
- **practical** (aims ad intra to create links among charisms, and animates ad extra the local churches);
    - eventually we suggest that the working group **include religious and lay persons,** thus overcoming possible incommunicability.

II – Second proposal

We suggest to the Major Superiors to call - within their proper institutional assemblies or at a scheduled meeting - a day of reflection relative to the crisis of the socio-health institutions and conduct studies to find the way out.

PS: Here below you can read the basic text from which the OPERATIVE PROPOSALS written above were taken.



And [he] cared for him
Lk 10,34

THE DONKEY OF THE SAMATIRAN FELL ILL
Religious Healthcare Institutions as an instrument to exercise Charity in the 21st Century

1) INTRODUCTION: THE CRISIS AND ITS WOUNDS

We are living in times of difficult contradictions. What we call crisis in fact appears as a radical malaise which denounces the exhaustion and illusion of an idea of man and a model of development.

The Church, as Teacher of Humanity, is more sensitive than others to this event and does not cease to exhort, through its own Magisterium, the women and men of our times to open up to the light of the Gospel which alone can reveal the truth about humanity and its future and properly direct human action toward real goals of sustainable well-being. This is a task for all Christians which especially involves consecrated life.

The religious Orders and Congregations engaged in the healthcare apostolate feel specifically concerned by this call that is perfectly in line with the **sense of charism** deployed over time through their own founders; even now, standing by the man struck and wounded by illness and malaise, sharing his suffering and the cross can lead to walking together along the path of Healing, which, through this closeness, can lead to the truth of the agape and to salvation.

The quantity and quality of socio-medical facilities that religious Orders and Congregations have established over time throughout the world constitute a specific vehicle of responsibility and opportunity in that respect.

Nevertheless, accepting this call means realizing with **bluntness and courage** that today, even our institutions are struck and wounded in their resources and specific possibilities to exercise their ministry in a manner that actually conforms to the real needs of our time. Our hospitals, clinics and socio-medical facilities in general (Institutions) are under the crossed impulse of many factors and increasingly struggle in their pursuit of a dutiful sustainability to have a specific and significant impact on the real health needs manifested by the people of our times, namely the most disadvantaged ones.

It is not the value of the Institutions that is being questioned, or their charismatic potential for care and evangelization, rather their **continuity in the present context of precariousness** and growing shortage of economic and material resources.
This situation causes many Orders and Congregations to run the risk of searching for new and more sustainable variations of their own charism, while proceeding with no adequate discernment to **dismissing**, **assigning or selling** their own institutions to private subjects, who are certainly solvent but often moved by speculative intentions.

We do not believe that this is the path to live and renew our charisms; rather, we do not think that this process, which could sometimes seem appropriate, should be considered and undertaken without an extensive discernment, adequate to the size of the challenge presented by the signs of the times and beyond the economic aspect.

The disposal of a medical facility by a religious Order does not only represent a cost reduction, but also a surrendering to others of a piece of its own history; the abandonment of a place of protection of physical and spiritual health in a territory; the interruption of a large number of relationships with employees, collaborators, patients, relatives and other stakeholders. In addition, we cannot help considering it as an instance of **global contraction in socio-medical public services;** the religious Orders' facilities which have always offered **popular access**, also represent a fundamental social protection for health and well-being. They therefore represent a sort of local common good, as is often clearly recognized by the population involved. Whenever said facilities are sold to private *for profit* subjects, who are necessarily and primarily interested in profits, this function can only be lost.

We must therefore face with courage and responsibility the different dimensions of the present crisis as an **opportunity** that is offered to us which we must use wisely and with no rush.

The search for solutions to the structural crisis of our institutions inspired by the **imagination of Charity** encompasses the material and technical aspects of the organization of work, the *governance*, to produce overall sustainability.

By way of this document which is the base for an **in-depth analysis table** and for the planning of new paths, the Orders and Congregations making up the Health Commission of USG-UISG intend to attempt to define some fundamental coordinates to develop the necessary discernment and seek to effectively face the crisis of meaning and resources affecting society and our institutions.

2) REFERENCE POINTS

2.1) Sustainability:

Sustainability is a key word in the contemporary discourse regarding the future of our social and economic systems and this term concerns us as well. **Providing sustainability to our Institutions** is our main concern; through them, we believe we can and must reach the ultimate goal of our apostolate: **to announce and provide a testimony** of the Gospel to all people and to lead all those entrusted to our care to Salvation and Eternal Health.

For us, sustainability cannot only mean a balanced budget at year end. In order for it to be a common reference point, sustainability must first and foremost be defined as the **maintenance and testimony of the charism**, as a **style** in our action and as a universal attention to the needs of all; budget balancing is fair and necessary, however it must be instrumental to these goals. In summary, we could state that we want to keep our "hospitals" alive while at the same time safeguarding the "**hospitability**" that is, the attention to the person and to the humanization of material and spiritual aspects which has characterized us throughout history and that some of us have been exercising in our facilities since the year 1200.

2.2) The charism of Care

At the core of it all there can only be the Charism. The charism of our founders is what should guide our work and our discernment. We cannot analyze a balance or make strategic or management choices unless we have firstly turned our look toward the charism that moves and inspires us. Although charisms are different and distributed as the Spirit desires, there is however, a sort of **unitary charism** which links Orders and Congregations engaged in the healthcare pastoral and their works: we call it "the **Charism of the Care**".

We call Care a *modus agendi* which was of Christ himself and of the Church as a whole; a style which, with the help of the Spirit and through the meeting with the other who is wounded and whose dignity is affected by illness, discomfort, poverty and suffering, necessarily becomes a mutual **taking charge** and a process of physical, psychological and social **liberation** from a malaise that constrains and restricts the freedom of the person to choose what is good. It includes the technical and scientific dimension of care but goes far beyond, aiming at the wellbeing and happiness as an overall state of the person and a condition to achieve in the *agape* of the Father revealed by Jesus Christ.

From the standpoint of care, **relationship is what is first and foremost therapeutic;** the care and socio-assistance relationship stems from the **connection**, the **interdependence** and the **reconstruction** of the human experience.

This perspective certainly characterizes our institutions as a whole.

We must however be brave and honest in recognizing a decrease in the charismatic tension over the last few decades. The growing complexity of needs, the secularization of society, demographic and social changes, the increasingly higher level of technology in medical activities along with their cost increase, the ever so complex and strict regulation in the industry, the crisis in public institutions and the drop in

religious vocations are all factors that certainly had an impact on this dynamic. The fact remains that such a **decline in "charismatic tension"** is in deep contrast with our most profound and authentic identity; it would be too simplistic and minimizing to think that we can deal with it by only disposing of hospitals and clinics and resolve it by delegating our responsibility to others.

Therefore, we must firstly purify our gaze and start to refer our choices and their organizational consequences to our original charisms in an increasingly direct and compelling manner, undertaking in a hopefully unified and shared fashion, some serious discernment processes and selecting appropriate indicators to evaluate the choices made. The Church social teaching certainly constitutes a primary and fundamental reference in this process. Even the history of our Orders and Congregations and the careful reading of our founders' testimonies, in the light of the Spirit, may constantly reveal new and current aspects we can learn from.

2.2.1) Places of Care

It is fundamental for Care to find a place where it can be exercised, or rather that "Places of Care" may continue to exist and to be recognized by all in our society, where we may experience the entire processes that Care entails.

In order for this to occur, our tangible places and often precious buildings are not sufficient. It is necessary for these to remain rooted in the territory and in relation with the same.

The **integration between facility and community** represents an essential point of reference for us. We must unfortunately notice that often times, at least in the Western developed world, said reference has grown weaker until it was almost lost. In the name of a dimensional growth and an excellent specialization, still useful for financial sustainability and reputation, many of our institutions have neglected that what actually Heals, as learned from the parable of the Samaritan: is not so much and only the doctor or nurse as much as the community where the healed person returns and to which the caregiver redelivers the individual.

The developing countries where our Orders and Congregations are active and often represent a large part of available health services are masters in this respect.

It is natural and essential for us to fully integrate hospital and healthcare facilities with local area communities. Without said integration and in the absence of a constant and daily osmosis among the healthcare capacities of these two realities, we will not succeed in achieving even a small part of the task we perform in those environments. Why, doesn't the same occur in developed countries? Why do we not manage to apply community healthcare formulas in these realities as well? These are fundamental questions which we may only answer by placing at the centre of our attention a **renewed interest for the territory** and for the role we may play in local communities through our facilities and our testimony. We cannot fear the change that such an outlook may require of our established organizational models. We were born in the territory, within specific communities; we developed there, our vocation resides there and that is where our real home is located. We must necessarily go back to the community and territory with our facilities if we discover to have moved away from them.

2.2.2) Appropriateness and humanization of Care

In these times dominated by technology and the illusion that it can resolve all of men's problems and malaise, the reference to the **appropriateness** and **humanization** of care is crucial to us in our activities in the healthcare field.

Appropriateness of care means we must firstly provide a care that is adequate to the situation of suffering we encounter, avoiding the administration of unnecessary although "convenient" care from a clinical standpoint, and apply therapeutic treatments whose usefulness is not scientifically certain. However, appropriateness also means giving a **more comprehensive significance**, along with the patient and his or her relatives, to the treatment course undertaken, while also supporting the relational, emotional and

spiritual dimensions and taking the opportunity of the suffering to help people open up to the wider dimension of the **value of suffering** and the search for **genuine well-being**. Modern society is undergoing demographic and cultural changes which move the axis of healthcare toward dimensions such as chronic states, alleviation, prevention, specialized care and technology applications. These tendencies are not always easily understood or correctly addressed. Nevertheless, these phenomena certainly call into question our capability **to read the changes** in the healthcare system, and to undertake **updates** and **repositioning** whenever necessary. The ample idea of appropriateness we wish to suggest may in this respect represent a fundamental criterion for orientation and discernment.

This manner of **treating with care** holds the key to the humanization of care processes that situate **the person at the centre**, with his or her interests, motivations, desire and thirst for life, and rearranges the entire manner in which care is provided according to his or her experience of suffering. This was and still is a constitutive and original task in most of our facilities; however, we must also note a decline of tension in this field over the last few decades. It has certainly not been an explicit choice, rather a conditioning which seems to have been surreptitiously induced by certain organizational and clinical health practices. We once again need discernment and courage to re-promote it in a dialogue with the progress of medical science and the organization of the healthcare systems in which we are engaged. In moral terms, we could say that between the appropriateness and humanization of the care intended in a merely technical sense and the way in which it must be practiced in our facilities, the same relationship stands between Justice and Charity, as we are reminded by the most recent Encyclical Letters by Pope Benedict XVI. The first one is unavoidable: dare not to offer as charity what is actually due by justice, states *Apostolicam Actuositatem*; but the second one can really provide an authentic boost toward humanization. It is something "extra" not just intangible that people perceive and often seek but not always succeed in finding.

2.2.3) <u>The directions of Care</u>

Prior to listing some possible directions that may be undertaken, we believe it is necessary to indicate a few more points of reference, which seem fundamental in our reflection to revive the action of our facilities while facing the problems before us without abandoning the healthcare field or disappearing into a liminal irrelevance.

2.2.3.1. Animation

We first of all wish to underline the topic of Animation, intended as an **action that is "dense" with meaning and accompaniment** on the paths people undertake when they come in contact with our institutions, whether directly or indirectly. It is an ample and ministerial action concerning patients and their relatives as well as their communities, which also equally extends to our personnel and collaborators and to the candidates for entry to our Orders and Congregations. As hard as the crisis in vocations is affecting us, it is not sufficient to justify a decline of attention in the pedagogical formation of religious figures called to operate in our facilities to clearly develop in them the necessary capabilities and skills for animation, including the necessary attention to prevention, to the ecological dimension of well-being and education for simple and correct lifestyles. The technical and leadership formation of candidates may acquire an appropriate meaning and dimension only if it is adequately inserted in such a formative plan that is perhaps not deemed very crucial today.

2.2.3.2 The popular dimension

Secondly, in accordance with the initial spirit of the founders, we believe that our Institutions should and can maintain a strictly popular dimension in their structure, understood **as a permanent attention to the accessibility to good quality care** for the largest possible number of people. Healthcare for the elite and only the wealthy is not part of our ministry and vocation since the preferential option for the little ones, the simple, the poor although with no pauperism and ideologies, remains a fundamental element of the same. We must note that, in addition to the public financing we receive in many cases thanks to the agreements we subscribe, many of our facilities relate their material survival to the possibility of demanding high charges from their users. If on the one hand that may be justified by the high level of technical and reception quality they offer, on the other hand it represents a significant risk of losing that **popular**

connection with the territory and its needs which we must in turn recuperate with strength, going back to searching for the last ones.

2.2.3.3 Unity versus self-reference
Last but not least, is the reference to the **unity among us**, Orders and Congregations, and with the Church; a unity which can not just be proclaimed through words, rather which must become a **daily practice** of management and **solidarity among facilities**. Said unity, a reflection of the Unity that in Christ binds us to the Father and the Spirit, is called to become a visible Communion and to have explicit and evident missionary reflections. It is unfortunately not a mystery that this is far from being a reality in our Institutions. Too often have we only half-heartedly tried to "do things together" and then preferred to remain locked up within our own fences, both at the pastoral and organizational level. Too many times have we placed our little daily interests before the need to be the visible face of the Church together in the field of healthcare. This **self-reference prevented us from building authentic and effective networks** among us and with others and is revealing all its short-sightedness through the crisis. We feel the urge to apologize for this to the Father, the brothers and sisters by taking on an attitude of conversion of the heart and of the gaze, a necessary and unavoidable pre-requisite to also favour an organizational change, a restructuring of our activities and greater collaboration among facilities and us.

3) POSSIBLE WORK PROCESSES

Providing sustainability to our Institutions by modifying in part their operation, without however denaturalizing or selling them, is possible and within our scope. Many of these represent the realities and models that give testimony throughout the world. The goal of this effort is not to illustrate specific cases, it is however by examining these that we believe we may identify some common work processes that can be applied in the short term by Orders and Congregations active in the healthcare field.

The pathways we imagine and that we wish to implement in a community and fraternal manner are headed to dimensions of coordination and reconstruction of the modern fragmentation.

3.1) Coordination
Based on an updated reading of our charisms and experiences of the founders, we could identify with greater clarity, specificity and precision the values, tensions, particularities and characteristics which distinguish our experience in the field of healthcare from the one of others. We could attempt to develop an actual **strategy for coordination** and **integration with the changing world of healthcare** based on these distinctive capabilities. None of our Orders and Congregations can face the complexity of the changes in progress alone. In order to operate together, we need to recognize in what name and toward which objectives we must focus our common energies. We are certainly called to share and create synergies among the significant parts of our **"logistics"**, from common supplies to the sharing of organization and administrative models, from external communication to the maximum use of technological and information technology equipment. We are however also called to increasingly share our gaze to **read the signs of the times** and the voice to deal with them. A mere institutional representation is not enough: we need organizations which can jointly express a **unified voice** and make operational choices that can bring about real results. We must work for such a possibility to come true.

3.2) Hub & Spokes
A real experience in coordination and integration between Orders and Congregations beyond the practical divisions that often led each of us on our own path over the last few years, may serve as a basis and a testimony to better achieve a coordination and reconstruction also within the social systems of public and private health services.

It is foreseeable that Healthcare Systems, especially in the Western world, will increasingly evolve over the coming years toward a so-called "hub & spokes" (radial) model, in which some major facilities will acquire a **central role in the integration** and general coverage of the more specialized needs and many other smaller facilities will become **articulations** or territorial facilities, to address the simpler or specialized health

requirements to deal with specific needs and disorders in the most effective and efficient possible manner. In such a situation that presents a strong risk of further fragmentation of care processes, the role of those facilities able to offer people an integrated experience and an effective and lasting relational accompaniment during treatments may acquire a particular significance. A role of this sort, along with a territorial vocation and a constant pressure for the inclusion of all in the system, may represent a way to exercise our specific charisms by positioning or repositioning our institutions in a sensible and effective manner in the changing healthcare systems.

3.3) Community Hospitals

The perspective to invest in the creation of facilities such as the so-called "community hospitals", **small facilities focused on the individual** for **post-acute or chronic treatments** and to manage milder health emergencies ("white codes") which today public facilities struggle to address, represents an extremely interesting activity for our institutions which could allocate some room within their institutions for these interventions or convert their presently unsustainable facilities to that effect. These types of facilities represent, in fact, the future for a large part of contemporary healthcare systems available; by involving the community, the third sector and primary care physicians, they provide effective responses, at a cost up to two thirds less than conventional hospitals, to some needs affecting population sectors in continuous growth. We believe that religious organizations may play a decisive part in the renewal of this supply system.

3.4) Folk and territorial medicine

For these purposes, it would be necessary to lead the Institutions belonging to Orders and Congregations through a process of reinterpretation of their own missions and operations to focus their attention and resources on **folk and local area medicine** and on the organization of **inclusive services** with a particular attention to the health and well-being of the **most disadvantaged categories** such as dependent people, the poor and lonely elderly, the homeless, drug-addicts and psychiatric patients who are increasingly "forgotten" by public healthcare systems.

In circumstances of general contraction of public welfare systems, all these categories of people with scarce or no abilities to pay for treatment on their own run the risk of finding themselves abandoned to a residual state as to their health in addition to their social situation. Our facilities offer us the opportunity to manifest our **authentic and quality closeness** to them. We must however reconsider many of our organizational and management models to make room for them in the ordinary operational patterns and to use the best resources to that effect. Orders and Congregations, as well as the Church as a whole, can only serve as a testimony of charity in this area. In accordance with the principle of subsidiarity, it is right and proper for the responsibility toward the weakest individuals to be shared by all; however, in times of growing individualism and fragility in social ties, some have a **prophetic duty** in this area. We believe that our facilities should be among them.

3.5) Network and Collaboration

A specific form of coordination and integration is necessary and must be applied among our facilities and the Third Sector, in the Civil Society we belong to. These years, there is much talk about "networks" and "collaboration"; however, words are followed by poor practices, at least in the health field. The connection between social and health spheres, the subsidiary and innovative reconstruction of economic and material resources of people, families and communities, the valuation of the social and cultural capital of the intermediate bodies in society, all represent sources of energy and resources which could effectively be put to good use and help in providing sustainability to our facilities, even from an economic standpoint. Many are working at identifying the most adequate forms and proposals to create these **collaborations with the crucial world** of associations, cooperation, social enterprise, social representation and the movement for civil and social rights; this is a **generative task**. We believe that our facilities must become involved in these processes in a unified and shared manner, to enrich them with our own history and skills and to be enriched through them by learning new and more sustainable manners of performing health services in communities and generating well-being for all.

3.6) The resource of laity

Our Orders and Congregations could be boosted in this direction by a greater internal **involvement and awareness** of **lay** collaborators, inside and outside of our Institutions. The lay personnel collaborating with us, volunteers, formal and informal associations which in time were created and developed alongside our activities and the faithful we encounter in our religious life, represent a source of energy, ideas and resources which we probably do not use sufficiently. We must have enough pastoral and organizational courage to offer them **more room** in our life and activities, to listen to them and involve them further, not fearing they will take over **responsibilities**, whether at the management or any other level. "Our" laity, especially if they are **young**, represent a **link** with the society which we should value more to promote our values and our mission and to acquire greater **freshness and innovation** in our organizational cultures. However, to make this possible, we must in turn learn to be sufficiently appealing to them by reviving both the demands of our charism and the possibility to carry out in our facilities experiences of **formation, development and research**, including technological, in tune with the times.

3.7) A new governance

One way to make all this possible in our Institutions could be through the consideration of new forms of *governance*, capable of connecting resources and charisms in a new and more effective manner. The forms of **joint *governance*** among several entities and congregations seem particularly promising and interesting; the management of activities is entrusted to **technical organizations**, inspired however specialized, which foster synergies and management enhancements, while the set-up, control and guidance of facilities remain with the single congregations. We can therefore maintain the identity, stories and charism without giving up effectiveness, thereby building realities capable of "rescuing" many facilities undergoing a crisis in our world. Best practices of this sort already exist and, especially, can be further developed. However, it takes determination and courage. Only a process of joint, serious and thorough work may reveal whether these circumstances exist and if such solutions can actually be implemented among us.

It is not just a technical issue or one involving legal and administrative solutions as we often tend to envision and represent. There are in fact innovative experiences in the world, with often a common cultural matrix, that are attempting to put together solutions of this kind, whether on a large scale or in smaller contexts. Let us think for instance about the *Fundación Summa Humanitate*, which is attempting in Spain and Italy to help very many religious Congregations to not disperse their own assets and charism by entering in a non-profit manner into the effective management of facilities otherwise destined to be shut down or sold. Let us also look at experiences such as the one of *Welfare Italia*, a network of subjects from civil society who, from the bottom up and with purposes and processes of mutuality and cooperation, are developing in Italy a number of private multi-specialty clinics at a low cost and with high standards of quality, called "places of care" where, without giving up small profit margins, they practice a concept of folk medicine that is accessible and holistic. We could list many more examples. We already mentioned the many virtuous experiences of integration between Institutions and booming local communities in the southern part of the world thanks to the efforts and persevering vision of many of our religious; they constitute real righteous models that could also be implemented in the Western world to not only improve the healthcare system, but also help a fragmented and disoriented society in rediscovering the meaning and power of the Care that exists in community life. There are indeed legal and technical solutions to bring these experiences to life; these can be identified and adjusted to nearly all forms of requirements, also given the high interest on the part of public authorities.

4) CONCLUSIONS

Our intention for this document was not to demand reasons or prescribe solutions. Faithful to the reflexive and animation inspiration that moved us, we intended to bring to our attention at first, and then to the one of the Superiors in our Orders and Congregations, some possible **directions for common work** suggested by the daily reading of the signs of the times in our facilities.

We humbly share them, along with the availability we offer to any interested brother or sister, to pursue, review, expand and specify this reflection in a common work table that may lead us to specific proposals and actual tests to provide sustainability to our activities and to heal the wounds that, we, as systems, bear today.

The patrimony entrusted to us by our Orders' traditions is far too rich to just sit still as we watch it crumble down.

Our charism is embodied and also lives in the walls and the stories told and represented by our facilities.

We cannot go any further.

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