shining a light on those who give

- what the 2011 federal budget means for health & aged care
- celebrating refugee week
Sr Maria Cunningham rsc OAM is known to many within the Catholic Health Australia (CHA) community.

Sr Maria, who commenced as a nurse at St Vincent’s Darlinghurst in 1966 and went on to Chair the Sisters of Charity Health Services, was instrumental in establishing CHA. She was a promoter of “Integration 2000” and served on the Board of the National Health Insurance Commission, among many other achievements throughout her long working life before retirement just a few years ago.

Sr Maria was in April awarded CHA’s inaugural Lifetime Contribution Award. In fact, the CHA Stewardship Board has named this new award the “Sr Maria Cunningham Lifetime Contribution Award”. This new award has been created by CHA to recognise those who over the course of their life have given extraordinary service to the Church’s health and aged care ministry. Sr Maria was an instant and unanimous choice for this award when the Board started considering contenders.

Handing out awards is fraught with difficulty. In naming one person, by inference you risk overlooking the merits of another person. This level of difficulty is escalated within Catholic circles—there appears sometimes to be something in the DNA of many Catholics that holds them back from having a moment in the spotlight.

Yet the contribution of Sr Maria, and thousands of others like her, needs to be acknowledged, cherished, and carried forward. Understanding and building on our origins and heritage is important as the Church’s ministries in health and aged care continue to expand and grow.

For each of us working in our different areas of health and aged care ministries, we will all have different perspectives as to who has made significant contributions. Some contributors have high profiles, others through their work are lesser known.

Sr Anne Moylan rsm is one of the lesser known. She worked at the Mater Newcastle in maternal care for over 50 years. She delivered thousands of babies from across the Hunter region, many of whom came back to have their babies delivered by Sr Anne. Like so many of her generation, she worked long and hard for little recognition, but nor did she seek it. She was happy in her service.
A few weeks back I delivered the eulogy for my great-aunt Sr Anne, who had lived a long and mostly healthy life well into her nineties. The funeral was one of celebration of a life well lived, and a life dedicated to service. She has a special place in my family, and those of the lives she touched. Hers was the hand of Jesus at work on earth.

For those lucky to have a Sr Anne or Sr Maria within their lives, we should give thanks. We should also seek to let them know their contributions are valued.

Valuing the contribution people like Sr Anne or Sr Maria have made to the health of the nation is a harder task. Government’s today are less interested in the common good benefits of non-government human services, and are moving to treat non-government bodies on a level playing field to government or for-profit enterprises.

Yet the special contribution of Catholic care is both valuable and worth preserving. That will require us to engage afresh with consumers and funders on the special community benefit derived by having vibrant Catholic services within the broader community.

We’re going to need to have that discussion with government sooner rather than later. This edition of Health Matters looks at proposed reforms for not-for-profit bodies, and will have arrived in your mail box at a time when government is setting up quality performance and cost efficiency bodies to oversee hospitals and aged care. Catholic hospitals and aged care services have terrific evidence to share of high quality and efficient services.

But we’ve also got terrific people, who in the past have helped build our organisations and who today are helping carry Jesus’ work into the future.

This edition of Health Matters seeks to shine a light on just some of those people who are doing the work of the Church and deserve recognition for their contribution—big or small. It also invites you to give them that recognition, in whatever way you can.
A four hundred year old law governs the way in which not-for-profits operate in Australia. The Charitable Uses Act 1601, or the Statute of Elizabeth, was enacted by the British House of Commons to protect trusts established for charitable purposes in the mid-Renaissance.

In contemporary Australia, we shouldn’t feel bound to this antiquated law of another country. In contemporary Australia, surely we can craft our own definition and legal meaning of charities?

That appears to be the view the federal government has taken, having announced in the May Budget plans for a new definition of charity.

The government proposes the creation of a one-stop-shop for charitable reporting, coupled with a review of income tax, fringe benefits tax, and goods and services tax arrangements for not-for-profit bodies, with a principal focus on Churches.

This has been greeted by some as a long overdue reform agenda. After all, there have been countless reviews, inquiries, and reports proposing changes to not-for-profit law over the last two decades. Other not-for-profit bodies, Catholic Health Australia (CHA) included, have viewed the reforms as a solution in search of a problem. The reforms propose changes to an area of law long settled—400 years in fact. We’re scratching our heads as to why any change is actually needed, and if the reforms take a sledge hammer to something needing just a little spruce up.

The minister with carriage for the reforms, the Assistant Treasurer Bill Shorten, says the government supports the provision of welfare, education, sports, arts, worship, culture and community services provided by not-for-profits through access to significant tax concessions.

“But”, Mr Shorten said, “the government believes it is important that charities use their tax concessions only to assist disadvantaged people and not for unrelated commercial activities. The government’s reforms will encourage charities to direct profits generated by unrelated commercial activities back to their charity’s altruistic purposes.”

This is fine, and Catholic health and aged care services, together with most services of the Church, are likely therefore not to be impacted. All Church purposes fall within the current legal understanding of altruistic through one avenue or another.

“CHA has already identified several possibly unintended consequences of these proposals on Catholic hospitals and aged care services.”
What if the definitions we’ve relied on for over four hundred years change? What if an entity of the Church that acts in a commercial manner retains earnings for a purpose that doesn’t neatly fit within the new tax definition?

The “what ifs” are likely to pose some challenges for the government, and possibly for different parts of the Catholic Church and the broader not-for-profit community.

CHA has already identified several possibly unintended consequences of these proposals on Catholic hospitals and aged care services. We’re pleased with the constructive discussions we’ve had with the government, who appeared keen to settle our problems before they start to cause headaches.

But the biggest challenge of all will be trying to create a new not-for-profit definition and reporting system capable of dealing with the vastly different not-for-profit bodies across Australia. Just as a hospital structure differs from a community aged care provider, so too does a local tennis club differ from a national welfare charity. One size to fit all may require some to be ill fitted, and attempting to sort this out over the next twelve months sets a very ambitious timeline.

For Catholic hospitals and aged care services, and all other arms of the Catholic Church, the reform consultation that commenced in late May will require each of us to assess the different and varying ways in which these new arrangements will impact. For some, the only change they might notice may be an eventual need to lodge an annual return to the new one-stop-shop, if the states and territories agree to give up their role in not-for-profit regulation to allow a new federal body to be created. States and territories ceding their powers to Canberra is fraught with difficulty, and a fair amount of work will be needed if this is to be achieved.

For others Church bodies, legal or accounting changes may be needed. For some, a material impact may be felt giving rise to changes to tax status. In the mean time, all not-for-profits are being asked by the government to endure a period of regulatory uncertainty as the consultation and new definitions are designed.

“We’re scratching our heads as to why any change is actually needed …”

At least, unlike in some other areas of national reform, the minister in charge appears to be listening and willing to act on the needs put to him on behalf of Catholic hospitals and aged care. Let’s hope the government keeps listening, as there is little doubt some other challenges will pop up as more start to come to terms with the enormity of what these reforms actually mean.

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THE FACTS

- Government will set up an Implementation Taskforce from 1 July 2011.
- Government to establish new statutory agency—the Australian Charities and Not-for-profits Commission (ACNC)—by 1 July 2012.
- Government will introduce a statutory definition of “charity” from 1 July 2013.
- Not-for-profit entities will pay income tax on profits from their unrelated commercial activities that are not directed back to their altruistic purpose, that is, the earnings they retain in their commercial undertaking.
- Not-for-profit entities will not be able to use input tax concessions, such as FBT and GST concessions, for their unrelated commercial activities.
Apart from the much heralded and welcomed additional funding for mental health services, this year’s health budget was relatively uneventful—particularly in the context of recent years where health initiatives received significant increases as part of the national health reform process.

Given the tight overall funding environment and foreshadowed deep cuts across all areas of expenditure, there were many sighs of relief heard on budget night. None more so than in the many labs involved in health research, where, if it had been introduced, the widely leaked figure of $400 million to be saved over the next four years would have had a significant detrimental impact in one of the few fields of endeavour where Australia genuinely sits in the top international league.

For those of us whose job it is to understand the entrails of policy and budget formulation, we look forward to one day gaining an insight as to whether there was actually a serious intention to introduce cuts of the scale leaked or whether this was part of what has become known as “pre-budget theatre”. Whatever the reality, there is no denying the compelling case mounted by the medical research community.

Following is an outline of some of the initiatives that actually did make it to the budget.

Mental health

The government’s $2.2 billion ($1.5 billion is new money) mental health package was undoubtedly the centrepiece of the health budget and has been welcomed by the mental health community as at least a good start.

The package comprises:

- $419.7 million over five years to establish up to 12 new Early Psychosis Prevention and Intervention Centres (EPICC), and 30 new headspace sites to help young people with or at risk of mental illness.
- $343.8 million over five years to provide more coordinated care services to people with severe mental illnesses.
- $269.3 million over five years for community mental health services, in particular to expand family mental health support services and increase the number of personal helpers, mentors, and respite care services.
- $201.3 million over five years for a National Partnership Agreement on Mental Health. Funds from this agreement would be made available to state and territory governments on a competitive basis for projects designed to address major gaps in mental health services.
- $205.9 million over five years to expand access to allied psychological services programs in hard to reach and low socioeconomic areas.

Other important initiatives include the establishment of a Mental Health Commission and an online portal to make it easier for people to find and access mental health services.

Pathology funding

After several years of uncertain funding, including a price cut of 5% in the 2009–10 budget, the government has negotiated a five year funding agreement with the pathology industry to start on 1 July 2011. The agreement will save the government around $500 million over five years by slowing the growth in outlays for pathology from
the long-term average of 7% per annum to around 5%. The agreement has been welcomed by CHA as it provides a degree of certainty of future funding. It also brings the key stakeholders to the table ensuring that future funding decisions affecting this area of rapidly changing medical science are better informed.

Means testing of the private health insurance rebate

Whilst not included as a discrete budget announcement, this year’s budget also includes savings from the introduction of a means test for the private health insurance rebate, which will mean that those on higher incomes will either receive a reduced or no rebate at all. The government will also correspondingly increase the Medicare Levy Surcharge for those on higher incomes who choose not to hold private health insurance.

The introduction of a means test will need to be included in legislation separate to the budget bills. This legislation has been rejected by the parliament in the past and at the time of writing, it is not clear that it will be able to pass the House Representatives. If it does successfully pass the House of Representatives, it is highly likely that this time round it will be supported by the Senate following the change in Senate representation after 1 July 2011.

CHA opposes the introduction of a means test particularly out of concern that any diminution in private health insurance membership will add to further pressure on public hospitals.

Departmental strategic review

One part of the budget that has and will receive little attention outside of Canberra relates to changes to the Department of Health and Ageing itself. Following a strategic review undertaken over last two years, the department will stream-line its program management.

The department currently runs 350 separate programs; 159 of these are to be rolled into 18 new “flexible” programs from 1 July 2011. CHA members that interact with the department will hopefully experience a streamlining in the way the department administers programs—with less red tape. There will also be an $82 million saving in the departmental budget resulting from cuts in departmental staffing.

The budget also includes $1.6 billion for national Partnership Agreements on Closing the Gap in Indigenous Health Outcomes (with $39 million for Link Up Services and $35 million for quality care accreditation). Funding has also been provided to continue the national bowel screening program and $52 million to fund 150 dental internships in public hospitals.

In summary, some welcome funding for mental health in an otherwise steady as she goes budget.
If one were to trawl through the Commonwealth’s budgets over recent decades, one would be hard pressed to find one that contained fewer new aged care measures than the 2011–12 budget.

The new spending for aged care in this year’s budget is limited to three very modest measures:

1. Continuation of the Ambassador for Ageing program ($4.4 million over four years).
2. Continuation for another year of the 40% increase in the viability supplement announced in the 2009 budget for eligible rural and remote services, and extending the supplement for the first time to “around 67 providers delivering specialized services to residents who are homeless, Indigenous Australians or receiving low care”, at a total cost of $16 million in 2011–12.
3. A contribution of $4.4 million towards the construction of an “aged care facility” in Hughenden, North Queensland, (approved outside the normal capital allocation process linked to the Aged Care Approvals Round).

The budget papers also include a saving of $209 million in aged care over the next four years. The saving stems from the release of more community care packages than planned following the low take up of new high care residential places in recent Aged Care Approval Rounds due to viability concerns. The savings reflect the lower cost to the budget of delivering care in the home, mainly because the average care subsidy in residential high care is higher than an EACH package, and fewer people would receive an accommodation supplement. The level of savings also increase each year over the forward estimates because residential places require longer lead times before services can commence and attract a subsidy.

Nevertheless, total Commonwealth expenditure on aged care in 2011–12 is estimated to increase by 6.6% to $10.9 billion.1 The increase is mainly due to more people being cared for, rising average resident acuity and the indexation of aged care subsidies. The lack of new measures in this year’s budget can be viewed against the backdrop of the government’s election commitment to make aged care “a second term priority”, and the fact that the final report of the Productivity Commission’s inquiry into aged care was not scheduled to be provided to the government until after the 2011–12 budget. On this basis, one could surmise that aged care has been put into a “holding pattern” until the government has a chance to consider the Productivity Commission’s final report, which is due by the end of June 2011. There is other evidence to support this view. Minister Butler’s budget media release indicates that “reform will continue as the Productivity Commission continues to develop detailed options for redesigning Australia’s aged care system”. A budget-related media release issued by the Treasurer Wayne Swan states that “the government has commissioned the Productivity Commission to undertake an inquiry into

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Minister Butler’s comment that reform “will continue” in the meantime refers to the commitment to implement aged care reforms under the Council of Australian Governments’ Heads of Agreement on National Health Reform. These reforms include:

• the Commonwealth assuming full policy, funding and administrative responsibility for the Home and Community Care program as a first step to creating a nationally integrated aged care system (including further negotiations with Victoria and Western Australia on this matter)
• the phased implementation of the 2010 budget “one stop shop” information and access measure and steps to improve aged care assessment
• the implementation of enhanced prudential regulations to better protect bonds paid in residential aged care.

All of these reforms are essential building blocks for any further reform that may arise from the government’s consideration of the Productivity Commission’s final report.

Being placed in a “holding pattern”, however, comes with risks. In the lead up to the budget, and before, the sector was warning the government that capital funding for residential care had to be addressed in the 2011–12 budget if the under subscription for places in recent Aged Care Approvals Rounds is not to be repeated. Given the weight of evidence of under-funding, CHA argued strongly that a phased increase in accommodation payments should commence in the 2011–12 budget. Without a change in policy, the sector is looking at a repeat of the under allocation of residential aged care places in the 2011 Aged Care Approvals Round, which will have longer term implications for the supply of residential care given the long lead times required to establish new services.

The viability in the short term of many in the aged care sector will be impacted upon by the level of indexation to be applied to basic care subsidies in 2011–12. At the time of writing this article, the level of indexation had not been announced by the minister. Under current policy, indexation will be linked to movements in minimum wages as determined by Fair Work Australia. These movements have not kept pace with wage pressures in the aged care sector, so current pressures on the viability of services can be expected to continue. For the longer term, there is little doubt that, on its performance to date, the Productivity Commission will deliver a blue print for the reform of the aged care sector which would provide the basis for a sustainable aged care system which provides greater choice of, and better access to, aged care services which are more responsive to individual needs, and are affordable to the individual and the community. There is also a growing consensus in support of the Commission’s reform directions. It now remains for all elements of the aged care sector, service providers, consumer organisations, unions and professional bodies, to get behind Minister Butler so that he can achieve for the aged care sector in the 2012–13 budget what he achieved for mental health in the recent budget.

CHA will continue to work closely with the National Aged Care Alliance and parliament to ensure this happens, and to ensure that the sector is closely consulted on the details of the reform and the transition arrangements for implementation. Front and centre of CHA’s advocacy will be ensuring that the marginalized in our community in need of aged care services can have easy access to quality services.

Another matter announced in the budget context which warrants a mention concerns the administration of funding programs by the Department of Health and Ageing. Following a review of administrative arrangements in the department, the government has decided to consolidate funding programs in order to reduce administrative overheads. For aged care, this will mean the consolidation of 16 existing programs into two new funds—the Aged care Workforce Fund and the Aged Care Service Improvement and Healthy Ageing Grants Fund.

As well as reducing costs by, for example, reducing the number of separate contracts to be administered, the consolidated funds would increase the flexibility to respond to emerging priorities as a result of reduced program boundaries. By the same token, however, consolidation would make it administratively easier for programs established to target specific purposes, such as the dementia programs, to be eroded or lost, or to lead to a reduction in the level of transparency and accountability. The budget papers also refer to the creation of a $558 million National Workforce Development Fund to be administered by a new $25 million Workforce and Productivity Agency to be established within the Education, Employment and Workplace Relations portfolio.

The purpose of the fund is to respond to the most critical emerging skills needs by co-funding with industry up to 130,000 training places over four years. Employers will be required to contribute an average of 50% of training costs, depending on the size of the enterprise. The budget documentation suggests that aged care may be one of the skills needs areas to be targeted. CHA will be liaising with the new agency concerning the potential for the new fund to support community and residential aged care.

1. Including aged care funding appropriated to the Department of Veterans’ Affairs
2. The Budget papers show a reduction of 67 staff for the Department’s aged care functions in 2011-12.
In an effort to respond to the economic and fiscal pressures of an ageing population the government has looked towards creating an environment for strong economic growth. This growth is affected by the nation’s productivity. “Productivity is the key to higher economic growth in the face of an ageing population” [2010 Intergenerational Report (IGR)].

The budget’s 2011–12 Building Australia’s Future Workforce: trained up and ready for work is an initiative that supports higher productivity growth. According to the IGR, Australia’s recent productivity performance has slowed, averaging only 1.4% over the past decade, compared with 2.1% in the 1990s, pulling down the 30-year average productivity performance from the previous IGR.

The 2010 IGR suggested that if Australia’s productivity growth could be increased above the long-run average, the economy would be bigger, living standards would be higher and fiscal pressure from the ageing of the population would be reduced. If, for example, annual productivity growth was to average 2% over the next 40 years, then:

- annual real GDP growth would average over 3% over the next 40 years and the economy would be $570 billion bigger in 2049–50, and
- real GDP per capita in 2049–50 would be 15% (or around $16,000) higher.

The Building Australia’s Future Workforce: trained up and ready for work budget initiative aims to build an educated and skilled workforce and ensure there are opportunities for all Australians to experience the benefits of work.

The Skilling Australia’s Future Workforce initiative will spend $3 billion over six years, and includes reforming the training system. Initiatives include:

- $558 million in a new National Workforce Development Fund—partnering with industry to deliver more training outcomes designed to meet the needs of a growing economy.
- An estimated 130,000 industry-focused training places.
- $100 million to support new approaches to training to ensure skilled apprentices can gain their qualifications sooner.
- $101 million for mentoring to support apprentices and trainees through to completion of their training, including funding to provide advice to prospective apprentices on the right trade for them.
- Review the Commonwealth’s $1.4 billion per annum investment in the National Agreement on Skills and Workforce Development to secure reform outcomes and develop a whole-of-government commitment to training.
- Additional investment of $1.75 billion over five years from 2012–13 under a new National Partnership with the states and territories, conditional on more ambitious reforms to make the VET system more transparent and productive.
- $143 million to provide 30,000 additional commencements for job seekers in the Language, Literacy and Numeracy Program.
- $80 million for additional training places for single and teenage parents.
- $20 million to expand the Workplace English Language and Literacy program to support businesses who want to boost the basic employment skills of their workers.
- $20 million to ensure disadvantaged job seekers can access the Australian Apprenticeships Access Program.

The National Workforce Development Fund will provide $558 million over four years to support training and workforce development in areas of current and future skills need. The key features of the fund build on successful programs such as the Enterprise Based Productivity Places Program and the Critical Skills Investment Fund. Under the fund, enterprises will identify their current and future business and workforce development needs. The enterprise would then apply for funding to support the training of existing workers and new workers in the area of need. Large enterprises will contribute 66% of the cost of training, medium enterprises 50% and small enterprises 33%. Industry Skills Councils will play a key role in assisting enterprises to identify their training needs, facilitate the selection of a training provider to meet these needs and in monitoring the implementation of successful proposals.

What will the impact be on health and aged care? In trying to read the tea leaves it seems that within the establishment of the National Workforce Development Fund, $359.3 million, over the next four years, will be directed to support enterprise based training in critical occupations in identified high need sectors in the economy. This assistance will be focused on economically significant sectors with projected strong employment demand and occupations in key demand across the economy.

The priority sectors to be targeted in 2011–12 will be
construction and aged care in addition to the sectors currently targeted under the Critical Skills Investment Fund. The Department of Education, Employment and Workforce Relations budget papers say that these sectors are either most at risk of experiencing skills shortages in the near future, or, critical for our future sustainable economy. “Strong growth in demand for aged care services is occurring, driven by demographic change. This funding for the aged care sector will complement other workforce development initiatives in this sector.”

**Are we aiming for full employment?**
The budget package also improves incentives to work, including: rewarding work through better income tests and employer incentives; providing new opportunities to get more people into work through training, education, childcare and employment services; new requirements for teenage parents, the long-term unemployed and Disability Support Pension recipients; and new approaches to address entrenched disadvantage in targeted locations.

What is the government trying to achieve with these improved incentives? It is estimated at any one time there are 250,000 job vacancies with approximately 1.5 million people looking for work. To simply suggest that providing greater incentives will equate with more people working is not true. Even if you add in the “up to 500,000 jobs” that will be created over the next four years, there is still a mismatch in the sums. Australia’s unemployment rate is currently 4.9%, which Treasury has in the past defined as “full employment”, beneath which inflation and interest rates start to increase. The improved employment incentives in the budget fail to recognise the structural and social barriers that many jobseekers face, particularly in the form of the social determinants of health. Unemployment issues require whole of government responses that address education and training, social isolation and access issues.

At the same time health promotion, illness prevention and community capacity building activities should be funded to actively engage unemployed people in order to build confidence, knowledge and skills and to strengthen social networks. This is an approach that CHA has been advocating to government in relation to health outcomes, and is equally applied across both health and welfare.

There is a need for more structured political consideration of the social determinants of health. One way to commence this consideration would be to establish a far reaching Senate Inquiry into the social determinants of health. Terms of reference could include an examination of the:

b. extent, adequacy and funding for programs, services, that address the social determinants of health
c. capability of existing health and community services to meet the needs of populations who are adversely affected by the social determinants of health
d. extent to which health and community services need to be educated about the social determinants of health
e. extent to which the broader community require education about the social determinants of health.

Lifting social equity needn’t be difficult or costly, in fact to do so will support higher productivity growth, thereby achieving the aspirations detailed in the 2010 Intergenerational Report.
Catholic governance is an expression of our fidelity to Christ.

The Church is... the living presence of the love of God leaning down to every human weakness in order to gather it into the embrace of his mercy.

Creativity and vision is required to recognise what may no longer need to be done or may need to be done differently.

You can never communicate too much.

Over two glorious autumn days in April, approximately 150 delegates from around the country assembled at the Crowne Plaza, Coogee Beach. The motivation was to explore the evolving governance structures of health and human service organisations within the Catholic Church in Australia.

A particularly welcome feature of this Catholic Health Australia (CHA) gathering was the participation of representatives from education and social services.

The conference was enriched through the sharing of a wealth of wisdom from a wide range of presenters. The generosity of each presenter in giving of their time to reflect on and share their experience was a gift to all gathered.

We heard from those involved across decades in discerning and planning for the devolution of responsibility from religious institutes to new structures. We were challenged by academics as well as experienced practitioners to an appreciation of the disposition and practical skills necessary for effective governance.

We were inspired by our colleagues from the Catholic Health Association of the United States to recognise that our journey is shared internationally and others are successfully negotiating the challenges we face. There was a wealth of “take home” wisdom. The gems reflected in the thought bubbles that accompany this article are just some of the inspiration shared.

Formation needs to enable relational as well as cognitive outcomes.

When considering partnerships and alliances, alignment of culture trumps strategy every time.

You can never communicate too much.
It’s not enough to have a critical mass of Catholics on the leadership team—we need to invest financially for formation.

The faith which underpins our mission can’t be reduced to a common set of values in the corporate sense.

We must to resist the temptation to measure our resources too narrowly ie in monetary terms only.

It is hardly surprising that the conversation about "reconfiguring Catholic governance" is expected to continue. Indeed participants provided valuable feedback and insight into areas that will require deeper exploration on other occasions. CHA is committed to contributing to the facilitation of these conversations so we warmly encourage you to “watch this space”!

We have chosen to share in full just two of the many conference papers. During their assigned session Archbishop Wilson and Sr Anne Derwin participated in a warm and informal exchange about their perceptions of this landmark moment in the history of the Australian Church.

Their more detailed thoughts are contained in the papers they have provided to CHA for this edition of Health Matters (please refer to pp 12-19).

For those who were unable to attend and anyone wishing to refresh their memory, many of the papers are now available on the CHA website at www.cha.org.au.

We are not just service providers – we are doing the work of the Kingdom.

Boards need to create opportunities to develop as a genuine community.

There is a danger that the role of the Canonical Leaders becomes simply that of second guessing the Board.
Allow me to first acknowledge my colleague and friend Sr Anne Derwin who, having borne the heavy responsibility of leading her congregation through the wonderful canonisation ceremonies for Saint Mary of the Cross, has generously taken up the role of leader of Catholic Religious Australia. To the CHA Chairman Tony Wheeler, I thank you for this opportunity to speak. And to the many other friends and companions at this gathering I say thank you for being here.

I am pleased to have this opportunity as Bishops Conference President to share my thoughts on the dynamics of the partnership of bishops and religious institutes, and of the interaction between bishops and the many ministries founded by religious that are today increasingly managed by the many capable lay leaders of our Church, who in doing so are responding to the call of the Gospel.

We are all working together for the welfare of the Church and society. A unity of vision and purpose made faithful by a wide variety of gifts and charisms of religious orders and diocesan traditions give us the possibility of fulfilling Christ’s invitation to compassion and service in the best possible ways.

“The Catholic health care ministry stands at a critical moment in its history. But this is not only a time of challenge, but also a moment of opportunity for Catholic health care,” said the National Conference of Catholic Bishops in the United States in 1997.

“I would add the contribution of the religious has not just made it easier for the Church to do good works; indeed, the religious have very often been the drivers of good works, especially in health care across Australia.

Reflecting on the history of the contribution of the religious in Australia, there is much to be proud of. Religious institutes in our nation’s early days enabled many Church ministries to be developed. These Church ministries have become the public face of the Church and a powerful...
witness to the presence of Jesus throughout Australia. We can credit the number of children educated in Catholic schools, the number of disadvantaged people cared for in Church welfare agencies, and the great number of patients treated in Catholic hospitals or cared for as residents in Catholic aged care homes to the pioneering spirit of the religious of today and times past.

It is precisely because of unity of purpose with Christ and the Church that religious have been successful in these endeavours. In the past, some have seen the religious as the workers of the Church. They ran the institutions and ministries. Yes, the religious have done much work to benefit the Church, but in the past the error has been made to discuss their contribution as being somewhat separate rather than integrated into the overall life of the Church. Today, we know better. We are all—clergy, religious, and lay—part of one Church, all equal to each other. The work of the religious is part of the work of the Church, and in a spirit of collaboration, part of our shared commitment to sharing God’s love.

Pope John Paul II said in a pastoral letter to US bishops and religious in 1983, “So often, the many wonderful men and women religious, who are faithful and constant, and who are always present and available to do any good work, are taken for granted. We must thank them in the name of Jesus Christ and his Church. We must continue to recognise them, acknowledge them, and support them.”

“In recent decades … there has been an … increase in the genuine concern of some bishops on the question of the maintenance of Catholic identity.”

John Paul was right. I too seek to honour and give thanks for the contribution of the religious to our community and the work of the Lord.

The massive scale of current Church ministries in Australia is in part a result of the good partnership that bishops and religious have historically enjoyed. Many of you will be quick to say, and some of you in years past have said it directly to me, that certain moments of challenge in relationships between some bishops and some religious has not always contributed to a warm inner glow about our history of Church partnership.

I suspect I don’t need to offer illustrations of where this has been the case, but the history of St Mary of the Cross and her interaction with Church hierarchy immediately comes to mind, particularly in the context of today where the Australian Bishops Conference President is speaking along side a successor of St Mary’s ministry.

Folklore stories of where bishops and religious sisters and brothers have achieved good works without controversy are not as well remembered in our oral histories. They are not as well remembered because they are indeed the norm. The norm is that in most cases in Australia and abroad, the Church does indeed work as one Church in the name of the Lord. This is the bulk of my experience, and I am proud to cherish the many friendships I’ve formed since my ordination as priest with the many sisters and brothers with whom I’m pleased to have worked alongside in praise of Jesus.

Bishops and religious sisters and brothers do however occupy different yet complementary roles in the life of the Church. Understanding these differences, embracing the creative tensions the differences generate, contributes to vibrancy and relevance of the mission Jesus calls us to serve. As successors of the apostles, bishops are also successors of the model of service to which Jesus called the apostles. The image of shepherd features significantly here. In the Gospel of John, Jesus portrays himself as the Good Shepherd bringing fullness of life. Later he encourages Peter three times to “feed my lambs, and feed my sheep”. Jesus was inviting Peter to the role of spiritual shepherd, to nourish and nurture the flock of humanity.

A shepherd guides, protects, stays vigilant against attacks from predators and other threats. A good shepherd devotes his life to feeding, protecting, and caring for
his flock. Traditionally shepherds lived with their flock, meaning they knew them intimately. The protection of the flock requires the bishop to promote the Gospel and to maintain the tradition of the Church, ever more so in times of secular challenge, and relaxing community norms about moral standards and ethical practices.

In contrast, the religious sisters and brothers and the ministries they have established are called to take the love of the Lord into new frontiers. Of course, missionary priests and other members of the clergy work expanding God’s word into new environments, but Pope Paul VI noted the special role of religious sisters and brothers saying:

“Thanks to their religious consecration, the religious are above all free and can spontaneously leave everything and go to announce the Gospel to the ends of the earth. They are prompt in acting: and their apostolate frequently excels because of the ingenuity of their projects and undertakings, which evoke admiration in all who observe.”

Pope John Paul II put this another way in his 1983 letter to US bishops and saying “Religious are called to radical discipleship.” Without intending to impose a rigid dichotomy between these roles, this perspective nevertheless serves to illuminate the necessary dialogue that we are called to. In this spirit I return to the three priorities I introduced at the outset. The first was a need to ensure the fulfillment of pastoral responsibilities in all the works of our Church.

pastoral practice. Can this be done by the bishop alone, in isolation? Again, John Paul II in a letter to US bishops in 1983 on relationships with religious institutes said: “While a bishop has ultimate responsibility, one way of helping to promote a clear understanding of this would be to meet on a regular basis with the religious who serve in a dioceses so that there might be more effective coordination of mission. The religious, who are your collaborators in the apostolate, can assist you in formulating and carrying out your pastoral plan.”

This 1983 letter, that reminds us religious and bishops are “collaborators in the apostolate”, was the conclusion of a three part process the Holy See had established to review the pastoral interactions of the bishops and religious in the United States. The first part of the process was a listening, the second part a dialogue, and the third a Pontifical Commission that outlined some options for renewal of the pastoral partnership. The process, undertaken some twenty eight years ago, might guide us in Australia, in that listening and dialogue were seen as central to an effective partnership.

If you listen to what occupies the minds of some bishops, it is a need for reassurance that today and into the future the people and structures that deliver the mission of the Church will be faithful stewards of the vision and model of Christ. My reference to both people and structures points to two different needs. The first is that bishops seek assurance that the formation of Catholics and non-Catholics in relevant positions of authority is comprehensive and ongoing and results in a lifestyle and example which attracts people to Christ and to his vision of compassion. The second is that the bishops also seek assurance that emerging structures, be they public juridical persons or otherwise, are set up in a way that alongside corporate effectiveness enables governance that provides authentic stewardship of the ministry, with a commitment to the unique vision and demands of Catholic services.

I raise these concerns of bishops with the formation of personnel, and the Catholic identity within governance structures, not to suggest formation is not being attended to. For indeed it is. The commitment I have seen to fulfilling the vision of Christ is apparent in our schools, our hospitals and aged care services, and our social service agencies around Australia. This commitment needs however to be supported by constant care, vigilance and induction of new
staff into a truly Catholic way of thinking and acting. As lay leadership of Church works has grown, what has not grown perhaps sufficiently is the listening and dialogue processes whereby all bishops can appreciate with confidence that the particular needs of Catholic formation, the structures and resources to support it, are being attended to.

Here lies our opportunity. Our opportunity, for we bishops, for those of you who are religious, and for those of you lay people who share the work of our Church with great competence and commitment, is to contemplate a new listening and dialogue about what is required in this new time. What is dialogue, and what is listening? Dialogue is embracing the reality of the other. Listening requires self-awareness of not having the full picture, and a willingness to welcome the opinions and experience of others.

We need to find new ways to listen and dialogue about the good work you are doing, not just in formation but also in the expression of your commitment to Christ’s vision. This Church is our Church, in which we equally share the task of discerning God’s call, and seeking a contemporary response to this call.

The complexities of administering Church ministries in the current age also demand new dialogue. I have nothing but respect for the doctors and nurses who work in our hospitals, for the care givers who tend the aged in my own diocesan aged care services. In years past, the religious mostly managed the complexity of planning and managing these ministries, for which I am personally very grateful. Few bishops relish the call to become involved in the detail of this complexity, but in the future some of us will need to be more involved or through a qualified delegate. I would welcome your advice and guidance on how best we can achieve this—I do not have the answer—and in the spirit of us building the Church of God together, we must find this answer.

Many bishops look to Catholic Health Australia in this regard, and in the future, we might consider how to enrich the channels of communication, both formal and informal, to ensure bishops and Catholic health and aged care organisations can strengthen their partnership in both pastoral matters and in matters of public policy, but also in ensuring the effectiveness of this wonderful ministry of Catholic health and aged care as it responds to new models of financing and delivering care. It is important to maintain strong and fruitful relationships with the local bishop and the Bishops Commission for Health and Community Services. What then might our guide for the future be? Again, Perfectae Caritatis offers a path. It outlines several principles to inform the renewal of religious life, which can today inform the ongoing renewal which is seeing lay people excel in roles once the sole domain of religious sisters and brothers.

In Perfectae Caritatis we are invited to make the following of Christ the highest rule. Today, this obligation is unchanged, and faithfulness to Christ’s call must be the root of all our ministries. Perfectae Caritatis suggests a religious order should honour the spirit and special aims of their founders. Today, as successor organisations are being developed by religious orders, they too should continue the aims of their founder’s traditions, but do so in the context of the times and in a way that allows the original charism to evolve, grow, and flourish.

The Holy See reminded religious institutes that they should share openly the life of the Church. As Church ministries embrace their necessary changes, they too remain part of the fabric of our wider Church. This message is centrally important—we are one Church built to fulfill Christ’s vision, and it is only as one Church together that we can remain true to his word. Adaptation to the social conditions and times within which we live was the fourth principle outlined. The call was to “judge current events wisely”. This call to remain contemporary, to remain relevant, and competent in the delivery of mission is now passing to our many wonderful lay leaders who have and are assuming the leadership of Church works.

The final, and perhaps most important call expressed in Perfectae Caritatis, was the recommittance to live a life “following Christ and to be united to God through the profession of evangelical counsels ... animated by a renewal of the spirit”. Perfectae Caritatis said, “even the best adjustments made in accordance with the needs of our age will be ineffectual unless animated by the renewal of the spirit, and that this must take precedence over the active ministry”.

Here we are reminded that prayer, discernment and nourishment of the spiritual life are the ground of all our activity. I encourage a deep commitment to the practice of prayer and theological reflection grounded in scripture as the basis for the emergence of a community and culture that genuinely witnesses to the Gospel.

God’s faithfulness to the Church can be found in the many lay people coming forward to continue the works of the Church that were once the domain of the religious sisters and brothers. Our duty as bishops, your duty as religious, and the duty of all lay people, is to remain true to the call, and to work collaboratively within our one Church. Together, we must remain true to the call of the Gospel, to see the love God has for all brought to life through our Church.

Together we must remain true to the call of Christ in the Gospel.
Sr Anne Derwin rsj
president catholic religious australia

Archbishop Philip Wilson, CHA Chair Tony Wheeler, and the many friends and colleagues gathered to share wisdom and experience and a real desire for the best future for the works of the Church. I commend Catholic Social Services, the National Catholic Education Commission, Caritas, St Vincent de Paul, and CHA for together initiating this gathering of Catholic leaders.

I thank Archbishop Wilson for his generous and informed words. He has articulated clearly the times in which we find ourselves and offered a path for our future, a path built on dialogue. I’d like to speak a little of the context of religious life in Australia—who we are today, the role of religious in the Church generally and the situation we face today in terms of stewardship of our ministries before suggesting what is important at this stage in terms of future stewardship of the works that had been entrusted to us as religious institutes.

Before Christmas last year, Catholic Religious Australia (CRA) published a report on the 2009 survey that CRA had commissioned on religious life in Australia. The report was published under a title taken from the prophet Isaiah, See, I’m doing a new thing! I understand CHA has been good enough to make the survey available on the CHA website with the other papers that are being presented at this important governance conference.

CRA commissioned the survey to gain a realistic picture of religious life in Australia today given that the previous survey had been done over thirty years ago. Needless to say much has changed since 1976. The survey captured data from 161 of the 180 congregations, orders, societies and associations which belong to CRA. Unfortunately 19 congregations did not for some reason or other respond to the survey although we tried hard!

The data indicates that
• There are at least 8,422 religious sisters, brothers and priests in the country—compared to 17,029 in 1976. We rejoice that there are over 8,000 religious, 70% being women, still faithfully living their commitment to Christ in this country.
• The median age of religious is now 73.4 though only a quarter of religious define themselves as retired. We rejoice that there is great vitality in the religious of Australia despite age.
• Only 6% of religious are today involved in primary and secondary schools compared with almost 50% of women religious, 80% of brothers and 21% of religious priests involved in the 1976 survey. The 1976 survey showed a considerable decline from 1966.
• The face of religious life now reflects the multiculturalism of Australia with the quarter of religious born overseas and born in 75 different countries.
• Religious are living and ministering in every diocese of Australia and reflect the percentages of Catholics in each diocese with the exception of Sydney which has almost double the proportion of religious (22.8%) compared to Catholics (11.6%).

The second half of the survey dealt with organisational change. Although this section tapped into some of what is happening for religious congregations in terms of organisational change I don’t think it tells the complete picture. In hindsight I believe this section of the survey needed to be done differently from the first section. If we had the chance and the funds to do so I know we could tell a much richer story of how congregations are already in the midst of organisational change or are preparing to be.

Vatican II affirmed the role of religious life as being a prophetic one. Prophets are called to give witness to
God’s dream for humanity. They are called to do so in circumstances where that vision has somehow been lost, reduced, or distorted. This understanding implies that a prophet is immersed in a particular historical place and time, and connected to the challenges that beset a particular culture and people. It implies that a prophet is alive to, and grounded in, an alternative vision to that which the mainstream community has adopted.

Prophets see with fresh eyes the experience and reality in which others are immersed and take for granted. They recognise how things ought to be and, in spite of personal shortcomings, they don’t shrink from sharing their vision. They don’t conform to expectations or quietly keep their perspective to themselves. They usually challenge the status quo, making those around them feel uncomfortable. They may even end up being crucified, literally or metaphorically.

Religious life has taken on the prophetic role needed by God’s mission for different times in history from its beginnings in the 4th century with the hermits living lives of solitude and sacrifice; to its monastic form in the 6th century in the west when religious began to witness to life in common with a daily schedule of prayer, work, spiritual reading and rest; to its mendicant form of the 13th century engaging with secular city life; to its apostolic form of the 19th century providing specific works of schools, hospitals and new missionary enterprises around the world.

We see the beginnings of this apostolic form of religious life in Mary Potter’s encounter with the poor on the streets of London; in Catherine McAuley’s instruction of poor girls and visitation of the sick in Ireland’s slums; in Mary Aikenhead’s care for the poor in her home town of Cork and in her order’s beginnings in Dublin; in Edmund Rice’s concern for education of poor boys in Waterford; in John of God’s comforting of the afflicted, sick and dying in Granada; and in our own land in the determination of Saint Mary of the Cross to bring the poor out of poverty particularly in the isolated parts of Australia. This apostolic form of religious life, beginning in Australia with the arrival of the Sisters of Charity in 1838 has contributed enormously to the Australian Church.

Many religious institutes came to our shores at the invitation of bishops. Bishops responsible for the pastoral care of their people saw enormous needs in the colonies of the 19th century and depended on religious to attend to these needs. They came or were founded here to provide education, health care, care of the aged, homes for the homeless and other services to the community.

I think of Bishop Matthew Gibney for example sending a request to various orders overseas, one of them being the Sisters of St John of God in Ireland, for help to alleviate the pastoral and social needs of the people entrusted to his care in the vast territory of the diocese of Perth. And we know the great legacy that grew from the first eight sisters who arrived in 1895.

We stand in awe that bishops and religious women and men had such vision and worked together for the sake of God’s mission in our land. Our Church today has inherited an incredible legacy because of this vision and the continued commitment of bishops and religious over Australia’s history. The apostolic form of religious life has served God’s mission well in our country. It seems that God is now doing something new with religious life, though we don’t quite know what that is. Whatever form it takes it will still be a life unreservedly free as Jesus was for the sake of God’s mission and it will still have its prophetic role in the Church.

Until the new emerges the religious institutes of Australia will continue to give witness to the Gospel among the needs of today’s people—among refugees and asylum seekers, with Aboriginal and Torres Strait Islander
peoples, with prisoners, with those subjected to human trafficking. Our immersion in God compels us as religious to seek and be for those who are poor, isolated, vulnerable, disadvantaged and to go where no one else can go.

Thirty years ago religious institutes in Australia began planning for the future by incorporating their apostolic works, providing more surely that the works would continue and acting out of the belief that the laity had a place in decision making within works of the Church as Vatican II had proclaimed.

For the sake of the mission of God, bishops, religious and laity must work together in trust, a trust that can be nourished through ongoing dialogue and a trust that can be secured by what we do in partnership to ensure that the right elements are put in place in new canonical structures. With fewer religious and priests perhaps we the Australian Church can finally make real Vatican II’s affirmation of the rightful place of the laity. It is time for us to have an attitude of delight that the laity of the Church of Australia are now, not only leading the mission and pastoral aspects of most of the ministries of the Church, but that they are, thanks to new structures being established by many religious institutes, able to take on the ownership and the governance of many of the Church’s works. The transition in which we are involved, with new partners and evolving structures, towards new ways of witnessing God’s compassionate presence, will challenge our inventiveness and courage. Walter Bruegemann reminded us, “God trusts us with our moment of history”. God’s own Spirit is indeed our guide.

We must trust the laity to take the Church’s works where they need to go for the sake of God’s mission and allow the laity to contribute their own gifts, their own professionalism and their own passion for the healing, teaching, empowering ministry of Christ.

I love the line from the 16th century poet Basho which Joan Chittister often quotes— ‘We do not seek to follow in the footsteps of those of old rather we seek the things they sought’. By trusting in new structures led by the laity we are also trusting in the emergence of new prophets, prophets who bring new experiences and gifts. As today’s scripture reminds us when God says to Abram: “I will establish my covenant between myself and you, and your descendants after you, generation after generation”.

At the time when God spoke to Abram, Abram and his wife Sara had been unable to conceive children. How odd it must have sounded to be told they would be followed “generation after generation” when up until then they had thought themselves incapable of bearing children. Today, in a different time, this covenant God offered for “generation after generation” offers inspiration that our task, to enable the ministries that were once the domain of religious alone, can evolve with God’s love to continue service in new and different ways to “generation after generation”.

Now it is not only the governance but the ownership of apostolic works that is changing hands—either through partnerships or new canonical structures—to the laity.

I heard a line in a Bob Dylan song the other day in the car which spoke to me about the situation religious institutes find themselves in today with regard to the future of these ministries: There’s no going back, all roads have led to here. All roads have led to today for the bigger religious institutes of Australia as they continue their good stewardship of the works entrusted to them by ensuring that these works are not lost to the Church.

I had the privilege of serving on the governing board of the first of these new PJPs established in the country— St John of God Health Care. My five year experience was one of being firmly situated in a ministry of the Catholic Church, of deliberating with the most professional and knowledgeable of people, of being formed spiritually through a rich Gospel and the John of God story, of being educated in Church tradition, Church history and Church law, of being guided by the vision articulated over and over to the board by the trustees and of being part of a large, vibrant truly Catholic community across Western Australia, Victoria, New South Wales and New Zealand. This was an opportunity I relished and I know my fellow board members did too. What a gift to be invited to be part of such a lively part of the Church’s mission.

In order for the works of the Church to flourish I suggest we work together on the following. If we as the bishops and religious of today are to have the vision of our 19th century predecessors in being able to respond to the vast needs of the people of God we would be rejoicing that structures like PJPs are allowing the laity in the Australian Church to contribute so significantly to the work of the Church.

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"It is time for us to have an attitude of delight that the laity of the Church of Australia are now ... able to take on the ownership and the governance of many of the Church’s works."
We must be in continual dialogue so that trust can be maintained in the beginnings and in the establishment of the new structures. The status of the PJP—diocesan or pontifical—certainly needs dialogue with the bishops concerned early in the piece. Perhaps our bishops are more concerned when the status is pontifical and their concerns are similar to those of the bishops of the colonies who did not want the Sisters of St Joseph for example to be a Pontifical Congregation! This is a really important point that needs dialogue—bishops listening to why religious institutes believe this is the best for the ministry and religious listening to why some bishops might favour diocesan status.

As religious institutes and bishops we must support the laity in the new structures to nurture their gifts and engage with them as equals in the fulfillment of God’s mission. We know that our bishops on the whole felt secure when Catholic schools and hospitals were run by religious because they knew formation, ongoing renewal, professional development and a life of prayer, despite all our weaknesses, were integral to their being. As religious we need to keep in dialogue with the bishops so that they are confident that solid formation programs and ongoing renewal opportunities are given priority in the new canonical structures.

It makes sense to work together as ministries of the Australian Church when it comes to formation, not replicating what is already in place but identifying gaps and trying to respond in a practical way to meet the needs of the laity who juggle family life, working life and the spiritual life all at once. I believe our CRA members who have already set up PJPs, or those thinking about doing so, are investing great energies in ensuring that Gospel values are centred in the hearts of these new entities and that the work of these PJPs are definitely works of the Church.

Religious institutes and the lay leaders within the new PJPs are together ensuring that formation of owners, trustees and governing board members is given high priority. This level of governance is mandating that similar formation and ongoing opportunities are integral to the life of the senior executives of the work. Senior executives are ensuring that appropriate formation for any staff member involved in the work of the Church is happening. The rich stories of religious institutes as living out of the Gospel provide a context for today’s lay leaders to explore and develop their own spirituality and so reflect their own contemporary context. If we could work out how to ensure that successive generations of trustees and boards of the PJPs would be as formed as the current generation I think we could alleviate one of the concerns of the bishops. Perhaps this is something we could as bishops, religious and the current laity in leadership work on together. This conference might commission a group to see what could be put in place so that our bishops particularly feel secure that the ministries of the future are as Catholic as they are today.

It is the spirit that the scripture writers call parresia—courage and innovative boldness, the spirit willing to suspend conventional thinking and to try the previously unimaginable. It is the spirit that looks beyond instinctive reasons, seeks to respond in deepest attentiveness to the whole picture, and which thus charts a different way forward, full of risk, full of possibility.

The spirit of parresia lay at the heart of Jesus’ ministry. It was the spirit that enabled him to suspend standard patterns of thinking and to dream and announce something new. Parresia is the spirit which also enabled Jesus the courage to let go, to not to be in control, to recognise that the dream to which he is committed neither originates in him nor is exhausted by his own efforts.

By way of conclusion I encourage us all—bishops, religious and the laity in the words of our Australian theologian David Ranson as he talks about the spirit we all need to face the future:

"The transition in which we are involved ... will challenge our inventiveness & courage."
Catholic Health Australia (CHA) recently announced the awarding of the inaugural “Catholic Health Australia Sr Maria Cunningham Lifetime Contribution Award”. The first recipient was, appropriately, the inspiration behind this new award—Sr Maria Cunningham rsc OAM (refer CEO Message and cover pic).

The award recognises those who over the course of their life have given extraordinary service to the Catholic Church’s health and aged care ministry. And, in the spirit of this new award, the following stories—contributed by CHA members—seek to “shine a light on” those who in their daily work in Catholic health and aged care make a unique and inspirational contribution to our ministry.

**man of vision and courage**

Chris Rigby, first and founding managing director of Catholic Healthcare Limited, retired in March 2011 after 16 years of service.

In this period, Chris saw to the establishment of the infant organisation and oversaw its growth so that today, Catholic Healthcare owns or operates over 45 residential aged care services, 10 retirement communities, provides services to over 6,000 persons in the community and operates three healthcare services. This commenced with the establishment of Hawkesbury District Health Service, which remains the only Catholic public private partnership hospital in Australia.

Chris’ leadership has created a vibrant organisation that has at its core a passion for the care of people, particularly for those who are most vulnerable.

It is difficult to overstate Chris’ contribution to the Catholic healthcare sector in the past 16 years. Because of his vision, many existing Catholic ministries have been supported and encouraged to thrive, while many new initiatives have also been given life. In one sense, “promoting life” is what Catholic Healthcare is all about. These words are at the heart of the Catholic Healthcare mission statement and reflect the organisation’s commitment to the greatest good of each and every resident, client, patient and staff member.

Faithful to this mission, Catholic Healthcare will continue to participate in the healing ministry of Jesus Christ into the future. Thanks to Chris Rigby, the organisation will be able to do so from a strong base and with a fervent commitment to compassionate, quality care steeped in the Catholic tradition.

**deep commitment to catholic health leadership**

Dr John Ballard joined Mercy Health in April 2000 as Chief Executive Officer. Since then he has driven significant performance improvement, widespread infrastructure renewal and growth, intensively focused on quality of care, teaching, training and research and launched significant staff attraction and retention strategies that have positioned Mercy Health for further growth and long term sustainability.

This was recognised in 2008, when he was awarded the “Leading CEO for the Employment of Women” by the Equal Opportunity for Women in the Workforce Agency (EOWA) and in 2009 the “Lynda Gratton CEO of the Year” by the Australian Human Resources Institute. John has many skills and vast strategic vision which has been put to great use for Mercy Health and more broadly for the Sisters of Mercy. He has over 20 years experience in the health and aged care industries and is company secretary, public officer and designated key personnel for Mercy Health’s 10 associated legal entities. Prior to his current appointment, John worked for eight years in senior executive roles with the Sisters of Charity Health System.

It is, however, in the area of Catholic health leadership, mission, vision and values that John has brought an absolute focus and commitment. John has an extraordinary knowledge and understanding of what is Catholic and the Gospel, much deeper than many of us. Coupled with this is John’s great ability to teach what this means in our health ministry.

John recently announced his resignation from Mercy Health. He has been a wonderful leader and will be greatly missed at Mercy Health and Catholic Health.
embodying the spirit of mercy

Gemma Holmes is the dementia support specialist for Mercy Aged Care Services, Brisbane. She has worked in this role since 1999 and was instrumental in the establishment of the services’ integrated model of dementia care.

Key elements of the model include a dementia day centre for residents, family pastoral support groups, outreach and transition to care programs, dementia education for all staff and education and support for cognitively sound residents. The model is based on the maintenance of resident capacity, social skills and social networks and has a particular focus on outreach, relative support and pastoral care.

Gemma also works with people with an intellectual disability who are ageing and has particular expertise in responses to dementia in this group. Care for this group is centred on a lifestyle planning and case management model. Gemma has been influential in supporting staff in the implementation of this approach. She facilitated the introduction of the successful “music and movement” program for this client group, and assists in the delivery of the organisation’s person centred care staff development program.

The organisation has been recognised by the aged care standards agency for its practice in dementia care and the effective management of challenging behaviours and has been invited to present at three agency sponsored “Better Practice” events in Queensland and interstate.

Gemma embodies the spirit of mercy through her work with the most disadvantaged and vulnerable groups in our community. She often works out of hours particularly with relative support and pastoral care, and represented the organisation at the mercy pilgrimage to Dublin in 2010.

total commitment to the healing ministry

Maureen Colgan, a former nurse and passionate supporter of Catholic health care is currently a Board Member of MercyCare, WA. Maureen’s tireless efforts and organizing support for programs and events are well known within the Catholic community in Perth.

However, it is for one of her least well known roles that we honour her commitment to Catholic health care—Maureen retires this year as Chair of the MercyCare Ethics Committee after 11 years.

Maureen’s background in nursing and her deep Catholic faith has led her to generous voluntary engagement within the church across many years. However, most of the long list of her passionately embraced engagements, though intense, were for a shorter period of time, and perhaps did not rely as heavily on Maureen’s sharp mind and total commitment to excellence as did her very responsible role as Chair of the research ethics committee.

Maureen joined the Committee in 1998 and was appointed Acting Chair in 1999 and has remained Chair until this year, 2011. Over these years Maureen was responsible for leading the establishment of the Human Research Ethics Committee under NHMRC standards, as well as for ensuring sound ethics governance practice in areas other than research, and for organizing ethics education.

In 2010, almost singlehandedly, she completed the requirements for certification under HoMER (Harmonisation of Multi-site Research Ethical Review). Maureen was also very aware of the need for collaboration within Catholic health care. She partnered with the St John of God Health Care (SJGHC) Ethics Committee on a number of major projects.

One of these was the setting up of the Mamreh Counselling Centre for pre and postnatal counselling which has now matured into a comprehensive service within SJGHC’s Raphael Centre. Most recently Maureen took a leading role with SJGHC in the development of processes and guidelines for the introduction of Advanced Health Care Directives in WA.

The taking on of such a substantial role across this period of time has been witness to Maureen’s total commitment to the healing ministry and the caring environment on which MercyCare’s commitment to health care is built. Her collaborative spirit, her enthusiasm for best practice, her willingness to take on whatever would enhance clinical outcomes and contribute to a better outcome for patients, whether at Mercy or in other health settings, has been outstanding. We thank and congratulate her.
Thirty five people gathered at Sydney’s Polding Centre in mid-June for the annual CHA Mission Leaders Forum.

Inspiring and thoughtful input was provided by keynote speaker Fr Richard Leonard sj on “fostering a new vision for the mission of Catholic healthcare”. For anyone who has ever heard Fr Richard present, you’ll know him to be an engaging speaker. His message focused on three critical elements of effective mission: witness to the Gospel by word and example; inculturation or taking our cultural context seriously; and a message of liberation through faith and service.

The CHA forum’s purpose was to allow mission leaders working in Catholic health and aged care from around the nation to identify and share their priorities as leaders in the area of mission and identity in the context of significant challenges facing both the Church and human service delivery.

Key to the forum’s agenda was mission leader engagement on how their work and the work of other mission leaders could be fostered and supported through collaboration and networking. The forum proposed a work agenda be established to consider collaborative projects to:

- establish a new dialogue with the Bishops Conference and other arms of Church on issues affecting mission and identity
- produce a publication highlighting characteristics of Catholic culture through practical examples
- establish a shared library of reflective practices and resources for healthcare professionals
- create a shared resources bank for liturgy and faith celebration
- set up a mission blog for use by mission leaders in Catholic health and aged care
- develop resources for formation of middle managers
- enable the “good news” story of the Church’s activities to be told
- provide statistics that support the “good news” story of Catholic mission in action
- advocate for low paid workers in aged care to enhance their dignity
- facilitate social determinants of health research to move from theory into concrete programs for those experiencing systemic injustice
- communicate the value of Church documents in relation to the work of multi-disciplinary teams
- develop a national succession strategy to foster the development of future mission leaders
- develop a national approach to training and development of mission leaders
- consider a baseline post graduate qualification for mission leaders
- articulate skills and competencies for mission leaders linked to qualifications and awards
- provide resources for continuing professional education in theology, scripture, ethics, spirituality, ritual and liturgy
- create contemporary resources for ethics: applied ethics including scenarios, education tools, discussion notes and papers.

With these options now under active consideration by the CHA Education and Formation Committee, the input of other mission leaders and health and aged care professionals is invited to set priorities for future mission leader resources and programs. To have your say, or to obtain further information, contact CHA’s Director of Mission Strategy Susan Sullivan by getting in contact with the CHA office.
In December 2010 the CHA General Meeting and the Stewardship Board endorsed the development of a shared statement of purpose.

The statement is intended to express the shared goals and vision of Catholic services across the sector as well as capture the essence of our unique Catholic identity and point of difference.

CHA has developed a paper outlining the background and process for the initiative which can be accessed online at www.cha.org.au/MembersOnly/CHASharedPurposeStatement

We hope to receive input from as many people as possible, representing the broad range of stakeholders and levels of participation in the Catholic health and aged care ministry.

You can contribute your ideas by responding to the short survey which is also available online at the above site.

Further information can be obtained by emailing Susan Sullivan at susans@cha.org.au
The work of pastoral care practitioners and chaplains is essential to our mission to bring the healing ministry of Christ to all, especially those most in need. To have someone listen empathetically to you as you struggle to make sense of an illness and all that it means can be a very healing experience.

For a dying person to have someone journey with them in care and compassion through the last stages of life can be a source of great comfort and can help revive their spirit. The sacramental ministry of our Catholic chaplains is a powerful reminder of the presence of the risen Lord drawing people into the fullness of life. Such is the important work of our pastoral care practitioners and chaplains and the contribution they make to the holistic care of our patients and families is invaluable.

But how do we ensure that our facilities and our people continue to provide excellent spiritual care alongside excellent clinical care? Achieving best practice in pastoral care depends upon our ability to train and develop appropriately qualified people. The development of agreed standards and educational prerequisites is a step in the right direction. Our facilities need to demonstrate in their policies, reports, celebrations, artwork and use of space that the pastoral and spiritual care of patients is integral to the services provided and resourced adequately. All of these areas require constant review and evaluation. Working in specialized areas (e.g. aged care mental health, palliative care) and with people from multi-faith backgrounds requires ongoing education and skill development. Training modules are needed to help with this.

Alongside our colleagues in other professions, pastoral services departments need to be accountable for the services provided and be able to demonstrate this through accreditation processes. We need to look for opportunities to promote pastoral care and chaplaincy, to educate and inform others. There is no substitute for telling the stories.

Undertaking research into the effectiveness of our services is also an increasing priority and this will require collaboration with others to enable this to happen. In all of this, we should not lose sight of the importance of nurturing the spirituality of our pastoral carers and chaplains so that they can continue to be sources of life and hope for the people they meet.

The pastoral care provided in Catholic healthcare for all people regardless of their spiritual traditions, is informed by hope as understood within the Catholic tradition. It is patient centred and promotes the human dignity of each person.

If hope is the cornerstone of all pastoral care offered, then several challenges ensue—finding appropriate language to communicate hope, doing so ethically, and being able to research the impact of such pastoral engagement. What does “hope” look like for patients and families from a variety of spiritual traditions? In our post modern age, with its unspoken expectation that illness and disease can be overcome, hope is often aligned with good outcomes—restoration and healing. This expectation—combined with conviction in the power of positive thinking—frames hope to be the assurance of a “good” outcome. For pastoral care, the ethical challenges are to respect the person’s perspective, not to collude with any “false” hopes, and to enable a broader understanding of hope.

If hope is to include a “quality of being in the face of vulnerability” (Sullivan, Health Matters, Issue 57 Autumn 2011; p.8), then the pastoral carer will need to model such hope in pastoral encounters.
the paradoxes and challenges for pastoral carers in aged care
sister mary lynch, catholic healthcare

The position of pastoral carer in residential aged care is a very “fragile” one which requires on-going support and promotion. The reasons are many.

• It is a position, which in the wider work place, lacks clarity. It is unlike a hospital where there is usually a chaplaincy department.
• It is a lonely position.
• It is a position which makes huge personal demands and where the employee requires supervision. In aged care this is not at all common.
• There is a lack of trained persons applying for positions.
• There are not many suitable courses available.
• It has no career prospects even after two or three years of study.
• The salary is low when compared with a similar position in areas such as education.
• Usually it is a part time position.

In country areas the challenges are even greater. Access to gaining qualifications is difficult, costs are trebled with travel and accommodation. Here as well, the service will probably be smaller and the position part-time.

What a dismal picture I present of paradoxes and challenges. Yet, pastoral carers make an enormous contribution to an organisation. Managers find that they are a valued support, able to care for residents, families and staff. Once a manager experiences having a pastoral carer in a facility, they will not be without a person in the position.

Skills around the areas of grief and loss, the ability to be with the dying and assist the living, to be able to pray, prepare prayer across the more traditional religions and to cater for the non-believer, to work with the challenges of people with dementia, to arrange welcomes and assist with funerals, these are the gifts of the pastoral carer.

Have I mentioned the paper-work? The person needs to be self-motivated and whilst in a team, often works alone and is sometimes rashly judged as “just sitting and chatting”. We need to be promoting this role. It is a special and a privileged one. Networks of support need to be set up, short courses/workshops need to be available closer to the worksite.

To the Pastoral Carers I work with, I say in the words of St Paul “I thank my God each time I think of you and when I pray for you I pray with joy” (Phil 1:3).

Space needs to be given to enable people to voice their fears, hopes, and concerns. In healthcare today, space for such reflection is often not present or discouraged. Pastoral care needs to find more effective ways to encourage reflective and robust conversations, to ensure that people make considered choices and are not swept up in the system.

Pastoral conversations also require language that enables connections grounded in hope. Pastoral care in Catholic healthcare can still evoke fear of being only religious and from a Catholic perspective. A Vietnamese Buddhist family feared that when their baby died that her funeral must be conducted in a Catholic way. This fear existed despite several discussions with a pastoral carer, who had asked a Buddhist monk to assist them with the funeral.

The challenge is to find language that communicates respect for the variety of spiritual traditions, to enable the person to find meaning, and to create rituals that begin to honour their experience. Such care is vital and requires much time and professional sensitivity. This care can be diluted when others in the multidisciplinary team determine that they can provide specialist spiritual care. This is a challenge for pastoral care as other disciplines have a growing interest in spirituality.

Critique of practice and research are vital if pastoral care is to maintain a distinctive role in the provision of spiritual care within healthcare. This is a challenge due to funding limitations and the serious lack of appropriate personnel.

Most pastoral carers come into the profession in the latter half of their career. Whilst they are deeply committed to pastoral care practice, most prefer to work part time, and do not engage in policy writing or research. It is incumbent upon the pastoral care leaders to ensure that education and research continue to evolve so that pastoral care maintains an effective voice within healthcare.
the sector speaks
aged care and ministry: a glimpse into the world of our frail aged and the thoughts of some of those who care for them

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St Vincent’s Hospital, Sydney

Sr Margaret O’Sullivan rsj
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St Vincent’s Hospital, Sydney

Holism and working together is the very essence of care vital to the frail aged in our communities. Consideration of organised aged-care, is arguably, a rather modern phenomena and, in many developing and poorer countries more of an idealism.

Living longer, increasingly beyond 85 years, brings with it worries about the cost of getting older, particularly around housing to meet both social and health care needs. Other concerns are about loneliness and aloneness, not being able to care for oneself and the ardent wish not to be a burden on family. This article will just glimpse into the world of our frail aged, their worries, but also their peace, to finish life’s journey with a flourish.

The presence of pastoral ministry in aged-care enables individuals to participate in religious worship, and for many, to share spiritual concerns about the life already lived and, the passing from life to come. The need to provide holistic care in a variety of housing and health care contexts is compelling to enable good quality of life for older Australians and, what we wish for ourselves.

Erikson, a psychosocial developmental theorist, considers this life-stage, from 65 years through to the end of life, a conflict of integrity versus despair (Erikson 1968). The individual seeks reflection on life’s accomplishments as well as the regrets. The theory holds that a positive experience of this reflective period brings greater wisdom, and a sense of integrity, peace and hope even when confronting death.

The alternative, more negative experience brings personal bitterness, loneliness and despair. Erikson considers religious and spiritual guidance to be important influences in the life-stage of old age, resolving the conflict with integrity rather than despair (Erikson 1963).

Acute and residential aged-care services bring together nurses, pastoral carers, patients and families often in distressing and joyous circumstances, 24-hours a day, and seven-days a week. The typical case-story below will bring a deeper understanding of the transition into aged-care for the final journey of life. Specifically, this story highlights what is most important and most feared about this major life event for patients and carers. Names have been changed to maintain confidentiality.

Case story of Kathleen
Kathleen is a widowed 94 year-old lady and has been admitted for the second time in the last year to an acute aged-care facility. She presents with an exacerbation of congestive cardiac failure, a urinary infection, weight loss and a minor injury resulting from a recent fall at home.
Kathleen has been living at home with her children—Annie, her 74-year-old daughter who has health problems and David, her 71-year-old son who has had long-standing mental illness. Kathleen has been reluctant to accept that her health care needs are beyond the capacity of her children and has resisted all efforts of community assistance. Following a family meeting with the health care team, a recommendation is made that Kathleen will require placement in a residential aged-care facility. Kathleen is distressed about her deteriorating health and has difficulty coming to terms with this decision.

**what is pastoral care for Kathleen?**
(by a Josephite sister)

Critical to transition and adjustment to residential living is the participation of Kathleen in the decision-making process. Allowing time to consider the information and then to make her decision, helps dispel thoughts and anger about family rejection and the notion of being “dumped-in-care”. Reassurance about her ability to maintain social connections and communication with family members also helps with acceptance.

Kathleen will require support with issues of grief and loss, and the sense of bereavement as she leaves her friends and social networks behind. Other important aspects of pastoral care for Kathleen are the hospitality of presence given with an open heart. Companionship is also appreciated; often “empty-handed” just to be alongside, walking together with awareness and acceptance of personal stories without judgement, but with love and compassion. Pastoral care offers religious and spiritual communion as Kathleen prepares to finish life’s journey.

**what is important in health care for Kathleen?**
(by a nurse in aged care)

Initially care involves collecting an oral history from Kathleen and her family, followed by multiple assessments to ensure health problems are treated. A simple treatment plan is developed for the transfer of care aimed at preventing the distress of another admission. Listening and talking together, Kathleen and her family with the healthcare team, about the family’s capacity to provide care at home is vital. These conversations are particularly important to help Kathleen accept her situation and then ultimately the decision to be placed in residential care.

Important to nursing is to optimise Kathleen’s independence in residential care, absolute respect for her circumstances and to sure advocacy and dignity in all aspects of care. Emotional support will be offered to Kathleen’s family dealing with guilt about letting go of the physical aspects of caring for their mother. This involves the team’s pastoral carer and social worker supporting the transition including the emotional realisation for Kathleen, and her family, that she is approaching her end-stage journey in life.

Pastoral and health care are integral to holistic care and are brought together skillfully and gracefully in the day-to-day care of elderly people and their families. Pastoral caring is about spiritual health and emotional support to finish life’s journey with integrity, peace and grace. An awareness of the needs of the frail aged, and the part each of us can play to ensure their final journey in life is a positive experience, can enrich the lives of those left behind and assist them with their journey.

Being able to be a supportive presence for people in this situation, and their family, may be seen as frightening or ultimately as a privilege that can bring serenity and inspiration. In the words of Jean Varnier, “The challenge is to maintain death as the last great act of human life, a final human act through which we can still find meaning and, I suggest most importantly, pass on to others”.

**References**

new research shows patient education can reduce hospital falls by up to 50%

background

Preventing falls is a high priority for older people and their health care team as unintentional falls are the leading cause of injury-related hospitalisations in Australia. In Australia, 91% of hip fractures are associated with a fall and one year following hip fracture approximately half these patients are unable to walk independently.

Clinicians and researchers are now aware that falls are the most common adverse events reported in hospitals with Australian and UK research showing that one third of reported patient safety incidents are due to slips, trips and falls, with older patients significantly more likely to fall. When older people fall over in hospital up to 30% sustain a physical injury, compared to falls-related injuries sustained in the community where approximately 10% of falls cause injury.

Falls in hospital are also associated with other negative consequences including increased length of stay, increased costs and poor outcomes such as decreased function and increased risk of institutionalisation, which may then in turn lead to litigation.

A recent meta-analysis that was conducted by the Cochrane Collaboration examined trials that tested falls prevention interventions for hospitals and nursing homes. This review of trials to date concluded that multifactorial interventions reduce falls and risk of falling in hospitals in patients who stay longer than three weeks. However the reviewers were unable to isolate the individual components of the interventions to provide clinical recommendations for any individual component of these programs.

the world’s largest RCT into falls prevention

I was fortunate to recently be part of an international project team that conducted the largest randomised controlled trial (RCT) worldwide to investigate a single falls prevention intervention—namely patient education. The results of this successful multi-site RCT (which enrolled 1206 patients) have recently been published in Archives of Internal Medicine. The project team was led by Associate Professor Terry Haines of Monash University, Victoria and was funded by a grant from the NHMRC (Australia).

My role involved managing the WA project site where my doctoral research, which was conducted through The University of Queensland, also focused on investigating the effect of providing multimedia patient education on preventing falls in hospital in older patients, the problem of falls after discharge from hospital and evaluating the efficacy of falls reporting systems in hospitals. I was awarded a Menzies scholarship in Allied Health Sciences from The Menzies Foundation for 2009–2010 to conduct my research program.

The RCT demonstrated that providing multimedia patient education with trained health professional follow-up reduces falls by almost 50% in cognitively intact older patients. The intervention is not effective in reducing falls in the sub-group of patients with cognitive impairment. Importantly, the results also demonstrated that providing patient education materials alone, including a written booklet and a DVD program is not effective in reducing falls and that individual trained health professional follow-up is required.

Patients were assisted during these follow-up sessions to develop individualised strategies for reducing their falls risk. These sessions were conducted by myself in WA and Dr Steven McPhail (Queensland University of Technology) at the Queensland site. This has important implications for clinicians as it suggests that older people in hospital require high quality falls prevention education materials and that these materials must also be delivered in an individualised manner by a trained health professional.

Results of the falls reporting investigation identified that hospital reporting systems captured only 75% of falls events and that events captured do not provide a complete representation of falls—for example, falls that occur during the morning are less likely to be reported in hospital reporting systems. This is the first published Australian research demonstrating that measuring falls events using hospital systems alone will not provide complete results and that multimodal methods of measurement are required. These data have international implications for falls researchers and hospital practice and are published in Journal of the American Geriatrics Society.

The period after discharge from hospital is recognised as a hazardous time for older people with an increased risk of adverse events such as unplanned readmissions to hospital, functional decline, reduced health-related quality of life, and hip fracture. My research identified that older people have low levels of knowledge about falls prevention strategies when they are at point of discharge.

The sector speaks
In summary, this large RCT found that falls in hospitals can be reduced in cognitively intact patients by providing a high quality multimedia education resource that includes trained health professional follow up. Therefore this single intervention has strong implications for cost savings for health care systems.

However more work is required to investigate how to reduce falls for older patients with impaired cognition. Older people with intact cognition who are admitted to hospital should be alerted to the risk of falls and provided with strategies to reduce their falls risk. Older people can take action to reduce falls when admitted to hospital by discussing suitable strategies with their health care team.

This research also highlights that health care teams that work with older people may need training to deliver suitable patient education for falls prevention, as current programs may not deliver the type of tailored education provided during this trial.

In addition, results of the falls reporting study strongly suggest that hospital reporting systems will not capture all falls events and that hospitals should prioritise staff training in the area of falls reporting and examine the quality and consistency of collected hospital falls data.

At this stage multimodal methods of collecting falls data are recommended for researchers and quality improvement programs to ensure that collected data accurately reflect the clinical situation of a particular setting, and further, that these data can be compared across different clinical areas and hospitals.
the sector speaks

new research shows patient education can reduce hospital falls by up to 50% cont.

About the author: Anne-Marie has now completed her doctoral studies and is currently working on developing the healthy ageing research program at UNDA in the Institute of Health and Rehabilitation Research. This includes development of a research program to examine providing education and working with older people to prevent falls and regain functional ability after admission to hospital. There are limited data about patient safety and falls prevention in the immediate post discharge period and this research will investigate how older people can engage successfully with models of health care and the influence of patient safety systems on the prevention of injury in older populations.

Anne-Marie is especially interested in investigating patient safety from the perspective of older patients themselves and thereby empowering older people to take an active role in their own health care. She has over 20 years experience as a clinical physiotherapist working in aged care and hopes to inspire other researchers and students to work in this rewarding area.
Ethics

catholic hospitals: public monies, whose ethics?

On the 7 Mar 2011 the Clinical Unit in Ethics and Health Law, School of Medicine and Public Health, at the University of Newcastle hosted their third Annual Seminar on Ethics and Religion—“Catholic hospitals: public monies, whose ethics?” Following is the paper presented at the seminar by Bernadette Tobin.

Ethically good research which involves the participation of human subjects must give due scope to people’s capacity to make their own decisions. This requires that the people who participate in a clinical trial do so as a matter of voluntary choice, which is based on sufficient information and adequate understanding of both the proposed research and the implications for them of their participation in it.

If the drug to be tested in the clinical trial is one which is known to cause birth defect in animals, then potential participants in a clinical trial of the drug must be informed of, and understand, the need not to become pregnant whilst participating in the trial. Must the information sheet instruct the potential participants on how to avoid pregnancy? Different answers to that question have prompted tonight’s seminar on the wider issue of the public funding of Catholic hospitals in Australia.

In order to clarify the basis on which I take part in this seminar, the title of which was coined by those who invited me to participate, I will begin by recalling a couple of points made by the Oxford philosopher John Finnis in an article in which he addresses the topic of the participation of Catholic Church and its members in public policy debates. Professor Finnis pointed out that, though there are some religious propositions which are not accessible to natural reason, there are others that are. On the one hand, many religious propositions are not accessible to anyone who is unaware of the particular set of historical realities which were the revelation culminating in the life and teaching of Christ. An example is the proposition that there are three persons in the one God.) On the other hand, many religious propositions are accessible to natural reason.

An example is the proposition that it is always wrong to enslave a human being. In fact, the Catholic Church proposes to Catholics to accept in faith a good number of propositions that are accessible to natural reason. Indeed, as Finnis notes, that there are such propositions—ones which are accessible to natural reason—is itself a proposition of faith!

So, when we are talking about religious beliefs, doctrines, ideas, claims, propositions, it is important to be clear about these different types of relationship between faith and natural reason—for clarity about these two different kinds of relationship between religious belief and natural reason helps us to avoid some common mistakes about the contribution of a Catholic to deliberations about public policy.

For instance, it is often thought that any proposition which is proposed by the Church for acceptance by Catholics is, by virtue of that very fact, “religious” in the sense of not rationally grounded or compelling: that is a mistake. And, again, it is often thought that any proposition which is proposed by the Church for acceptance by Catholics is, by virtue of that very fact, held by Catholics only as a matter of “faith” and not as something that they are authentically willing to defend as a matter of natural reason: that too is a mistake.

“... there is nothing unreasonable about a Catholic hospital maintaining its own standards with respect to the conduct of clinical trials ...”

And so I speak as a Catholic who contributes to tonight’s discussion of the reasonableness of continued public funding of Catholic hospitals in Australia without appealing to religious propositions which are not accessible to natural reason as the grounds for what I say.

One last preliminary. It is sometimes said that the only propositions which may legitimately figure in deliberations about issues of public policy are those “plain truths which are now widely accepted”: for only they, it is said, are truly “public” reasons. This seems to have been the view of the American philosopher John Rawls.

I see no reason to follow him in this. The wrongness of slavery is accessible to reason. But the truth of the claim that slavery is wrong has been variously accepted throughout history: by only a few people, by some people, by many people, by most people. The variations in actual acceptance depend on variations of culture, the historical epoch, etc, and on what Elizabeth Anscombe once called the endless twistiness of the human mind. The important point is that accessibility to reason is independent of the facts about actual acceptance.

Why should Australians continue to endorse the public funding of Catholic hospitals in the full knowledge that the
services Catholic hospitals offer, and the manner in which those service are offered, reflect their religious beliefs as these are expressed in the Code of Ethical Standards for Catholic health and aged care services in Australia. I’d like to suggest three reasons why a secular, liberal, pluralist society, committed to the separation of church and state, should do so.

First, a liberal society is committed to freedom of thought, freedom from coercion with respect to what one believes. Indeed, freedom of thought may be the most precious value of political liberalism. Of course, freedom of thought is one thing, and freedom of conduct another. Even a genuinely liberal state must acknowledge limits to freedom of conduct, limits set by the necessity to protect peace and social order in a society. But state neutrality with respect to religious belief at least precludes any argument which says: the state ought not to fund Catholic hospitals because these institutions are informed by a distinctively religious code of ethics.

Second, secular, liberal societies greatly benefit from the existence of Catholic hospitals. The Catholic Church has a long history of pioneering the provision of health care not only to all members of the society, regardless of colour, creed, gender, etc, but also with a special attention to the care of the poor, the vulnerable, and the socially disadvantaged. Indeed, the commitment to providing health care to all, and in particular to the poor, is both recognized and valued by the Australian community. Patients, their families, medical and nursing staff who are not Christians (let alone Catholics) often advert to the appreciable difference it makes to them to be in a Catholic hospital. That this is still said in the Australia of today, more than twenty years after Medicare’s public funding of healthcare for everyone regardless of their means, ensured that the poor and the disadvantaged have access to first-rate health care in government-sponsored hospitals, is remarkable.

Indeed, non-Catholic patients, families and staff seem to regret the decline in the presence of the religious, particularly women religious, in Catholic hospitals just as much as Catholics do. And yet Australians still register and appreciate a discernible difference in the atmosphere and ethos of Catholic hospitals. I have no doubt that that discernible difference arises from something other than a striving on the part of Catholic hospitals to be technically and humanely the best hospital, that it arises from a Christian conception of health care as an expression of the goodness of siding with the poor, the sick, the disadvantaged, what Catholics call the “preferential option for the poor”.

Thirdly, for reasons elaborated by the great 19th century English philosopher of modern political liberalism, John Stuart Mill, it is socially useful to Australian society to have different conceptions of what is ethical in the provision of health care in competition with each other.

Remember Mill’s four reasons for maintaining free speech and opposing censorship: a censored opinion might be true; even if it is literally false, a censored opinion might contain part of the truth; even if it is wholly false, a censored opinion can prevent true opinions from becoming dogma; and as a dogma, an unchallenged opinion, will eventually lose its meaning.

The Code of Ethics which informs the provision of health care in Catholic public hospitals, and which explains why Catholic hospitals do not provide terminations of pregnancy, euthanasia, assisted suicide, in vitro fertilization, etc, offers a conception of healthcare which is in competition with the conception of health care which informs other parts of the health care system. Though there is no essential conflict between the best of secular medical ethics and Catholic religious ideas about health care, the ideas in that Code of Ethics form a worthy competitor, in the marketplace of ideas, to the dominant conception of what constitutes basic healthcare.

They provide rationally-grounded grounds, reasons accessible to and disputable by anyone, to explain the range of services Catholic hospitals provide and those they don’t. So, I maintain that for the reasons that Mill gives, it is useful to a liberal society to have its dominant conception of justice in the distribution of health care constantly challenged by a different conception, one to which Catholic hospitals are accountable.

Of course, there are limits to what Catholic hospitals can reasonably expect from a secular liberal society in maintaining their own religiously-informed ethical standards and integrity. It would be unreasonable of Catholics to expect to maintain their own standards if their

“Optimists amongst Catholic commentators think it is still possible to conduct Catholic hospitals according to their religiously-informed ethical standards.”
standards failed to respect the rights of others, if they failed to respect public peace or the preservation of public morality and social order.

But—and here we come to the arrangement which prompted today’s seminar—there is nothing unreasonable about a Catholic hospital maintaining its own standards with respect to the conduct of clinical trials, and in particular with respect to informing potential participants in a clinical trial about the seriousness of the need for participants not to become pregnant without endorsing those particular ways of avoiding pregnancy which Catholic teaching holds to be unethical.

These standards in no way fail to respect the rights of others (whether clinician researchers or prospective participants). Indeed, it might be argued that, in encouraging potential participants to discuss their proposed participation in the clinical trial with their own doctor, they hold researchers to a higher conception of informed consent to participation in a clinical trial than does one which simply lists the forms of contraception to be used.

Of course, it should go without saying that Catholic hospitals have an ethical and a social obligation to be utterly transparent about the scope of, and limits to, the services they offer, and the conditions under which their services are offered. And, on rare occasions when issues arise in Catholic hospitals in country towns, the Catholic hospitals have to work collaboratively with the state, which after all is the institution with the responsibility of providing health care to all, to resolve matters in ways which are both true to their own ethical standards and in accordance with the law.

Secular, liberal societies are becoming increasingly intolerant with respect to the religiously-informed provision of health care. Increasingly, it is asserted that individual doctors and collective institutions have an obligation to provide whatever treatment or service their consumer-patients want. Optimists amongst Catholic commentators think it is still possible to conduct Catholic hospitals according to their religiously-informed ethical standards. Pessimists fear that the mission may be becoming impossible. It would be a loss of a great Australian public good if the pessimists turn out to be right.

“Pessimists fear that the mission may be becoming impossible. It would be a loss of a great Australian public good if the pessimists turn out to be right.”
people & places

clinical school opens in ballarat

The Ballarat Rural Clinical School—an innovative partnership between the University of Notre Dame Australia (UNDA) and St John of God Health Care (SJGHC) to provide training for medical students in a rural setting—was officially opened on the 4 February.

The new school will host 10 of UNDA’s medical students, who will spend their 4th and final year of study gaining vital clinical experience at St John of God Hospital Ballarat. These 10 students will be joined at various times throughout the year by a group of 32 students from other UNDA clinical schools who will be undertaking four week rural rotations.

To help increase the availability and viability of Australian rural health services in the long-term, the Australian Government is providing funding to universities to maintain and develop rural education and training networks through the establishment of rural clinical schools. The Commonwealth has provided $120,000 of capital funding for the Ballarat school and ongoing recurrent funding.

st vincent’s private receives internationally acclaimed quality award

St Vincent’s Private Hospital Sydney achieved a major milestone in its 100 year history by becoming Australia’s first private hospital to be designated as a Magnet facility—Magnet Recognition is considered internationally to be the ‘gold standard’ and most prestigious of quality awards, recognising excellence in patient care services.

The Magnet Program requires organisations to meet 88 stringent quality and safety based criteria that cover four main areas: transformational leadership, structural empowerment, exemplary professional practice and new knowledge innovations and improvements.

Feedback from the Magnet Program appraisers particularly commended the work of staff in reaching out to the community as well as the ways in which the hospital recognises and rewards its nursing staff and empowers them through their involvement in decision-making.

SJOG ferns house comes out of the shade

March 2011 officially marked the start of a new location, new name and new era for the St John of God Counselling Centre Fremantle, with the opening of St John of God Murdoch Ferns House.

The centre, which provides counselling and group work for people experiencing depression and anxiety, moved from its original location to larger and more versatile premises in order to better meet the needs of clients.

Murdoch Manager Social Outreach and Advocacy Peta Wootton explained that over the last seven years the centre had seen 2600 clients from across the south metropolitan area. “In addition to continuing to provide services for our clients in the community, we look forward to building on our relationship with the University of Notre Dame,” Ms Wootton said. “Counselling student placements and social justice hours for medical students will be welcome at Ferns House.”

The building was named St John of God Murdoch Ferns House, after the diocese in Ireland where the Sisters of St John of God began their mission.

Commissioner of Mental Health Eddie Bartnick; St John of God Sister Gratiae O’Shaughnessy; Murdoch Manager Social Outreach and Advocacy Peta Wootton
Cabrini Health, St John of God and the Mater Hospital in Sydney all rated among the best providers of private maternity care in Australia, according to the Medibank Private Maternity Experience Index.

The Medibank Private Index evaluated the experiences of over 2000 patients who had recently given birth in private hospitals across Australia, allowing parents to rate hospital performance, environment, staff and support throughout the pregnancy, birth and early parenthood. Cabrini Health was ranked Victoria’s number one maternity hospital and second nationally. St John of God hospitals at Subiaco and Murdoch were rated Western Australia’s top hospitals for maternity care, with their Bendigo and Ballarat hospitals ranked in the top three in Victoria. And in NSW, The Mater Hospital, North Sydney was named that state’s best provider of private maternity care.

WA’s largest ever private health sector investment

St John of God Health Care is investing $234m at its Murdoch Hospital, significantly increasing the hospital’s capacity to provide high quality health services to communities in Perth’s south.

The redevelopment will add 165 beds, eight theatres, a medical clinic and a comprehensive cancer centre by 2015, enabling an additional 25,000 patients to be cared for each year. In addition, around 200 jobs will be created in stage one for clinical and support staff.

Building will commence in early 2012, with new services coming online from 2013 through to 2015, coinciding with the opening of Fiona Stanley Hospital in 2014.

$6.6 million investment into mercy health and aged care

The Minister for Health and Ageing, Nicola Roxon, has announced funding of $6.6 million for Mercy Health and Aged Care Central Queensland to support major infrastructure developments.

“The $6.6 million provided by the Gillard Government to the Mater will enable construction and fit out of two new operating theatres in Rockhampton,” Ms Roxon said. “A third operating theatre will be built as a shell so it can be fitted out in future as the need arises.” In addition, 24 patient and family accommodation units will be built—12 at Mater Rockhampton and 12 at Mater Bundaberg.

The Mater projects are being funded from the Health and Hospitals Fund (HHF) regional priority round.

Mercy Health delivering more residential care beds to shepparton

Mercy Health commemorated the beginning of the $4.98 million expansion of its Shepparton aged care facility, Mercy Place Shepparton, with a sod turning ceremony April—the extension will see the facility expand from 66 to 96 beds. Monsignor Francis Marriot, Diocesan Administrator of Sandhurst, turned the first sod in the company of the Sisters of Mercy, Mercy Health executives, employees and residents, those involved in the construction process, and invited guests.

Mercy Health Chief Executive Officer Dr John Ballard said the redevelopment, which incorporates the latest aged care innovations, will help to meet the region’s growing aged care needs. The project is due for completion late this year, with the first residents expected to be welcomed in early 2012.

Survey ranks CHA members among the best maternity providers in australia

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L to R: St John of God Health Care Group Chief Executive Officer, Dr Michael Stanford and St John of God Hospital Murdoch Chief Executive Officer, Mr Peter Mott.
The Sisters of Mercy have a long history of reaching out to people in need and identified the need to support the health care of refugees and asylum seekers by filling the gap in refugee health care in Brisbane.

The sisters provided initial support with in-kind funding to help establish a refugee primary health care clinic. Mater Health Services now operates an initial health assessment service for all newly arrived refugees and an extended care service for people of a refugee background with complex health issues—Refugee Health Queensland plus a dedicated antenatal clinic for women of a refugee background. In 2001 when refugees from Afghanistan, Iraq and Iran were being released from detention centres on temporary protection visas, Mater Health Services responded by providing clinic accommodation for a group of volunteer GPs to provide health care to people without Medicare eligibility. This clinic developed into an extended care service and since its inception has provided integrated, coordinated and culturally sensitive care that is now part of Refugee Health Queensland.

Refugee Health Queensland is a state-wide coordinating service that organises health care services for refugees across Queensland and provides a health assessment service for newly arrived refugees.

In late 2004 and early 2005 refugee camps across Africa were being closed, culminating in large numbers of people being relocated as humanitarian refugees across the world, with many people from Sudan, Ethiopia, Liberia and Burundi settling in Brisbane. The arrival of new communities to Queensland brought with them new and complex health issues not usually encountered by health care workers in Australia. To accommodate this new area in health care, Mater Mothers’ Hospitals and the Sisters of Mercy collaborated on a project to support a Refugee Community Worker. The aim of the project was to identify a best practice model to support appropriate health care, psycho-social support and resources for women of a refugee background birthing at Mater Mothers’ Hospitals.

The outcomes of the two year project which benefited from extensive community participation, informed Mater’s organisation-wide efforts to improve its cultural responsiveness, as well as established a specific antenatal clinic for women from a refugee background which commenced at Mater Mothers’ Hospitals in November 2008. The model of care which emphasises culturally appropriate continuity of care comprises a multidisciplinary team including a lead obstetrician, dedicated midwife, social worker and interpreters.

The midwife and social worker team provide each woman and her family with individualised care as well as linking with appropriate community agencies to ensure ongoing support during pregnancy and the post-natal period. Language services have been streamlined within the clinic with interpreters clustered into language groups specific to the needs of the women. Since 2008 the Refugee Maternity Service has provided maternity care to 511 women and their families.

Mater Health Services celebrates Refugee Week with the sharing of food from different cultures and the opportunity for staff to listen to a choir made up of people of a refugee background. Members of Mater’s Cultural Diversity Network use the week to inform staff of the diversity of patients of a refugee background accessing Mater’s services along with providing education sessions throughout the year related to the refugee experience.

Sr Sandra Lupi, Congregation Leader Sisters of Mercy Brisbane and Lavinia Yor, originally from Sudan, at Mater’s 2010 Refugee Week Celebrations.
calvary refugee mentoring program

The Little Company of Mary Health Care values of hospitality, healing, stewardship and respect guide the provision of compassionate and consistently good care for people in need.

The Refugee Mentoring Program (RMP) is a part of Calvary’s Community Benefit Program to serve and empower the disadvantaged and marginalised people in our society. It is a tangible expression of our values in particular healing, hospitality and respect and is an opportunity for mutual engagement for both the refugee and the staff mentor.

The aim of the program is to provide individuals with an asylum seeker or refugee background, with a positive and individualised workplace related experience by providing opportunities in an Australian workplace, counselling and career guidance and by facilitating community integration so that participants may be better prepared for career, study or employment.

Calvary staff members, who become mentors, also gain the opportunity to share their skills and expertise, to provide psycho social support, to understand cultural differences and generally to learn the stories of others and to walk in their shoes. The RMP helps to improve cross cultural communication, interaction, treatment outcomes, and quality of services and well-being of the patient. It challenges the myths that have negatively stigmatised other cultures and helps us to examine our own current practices, stereotypes and interactions with other communities.

As the RMP coordinators, Calvary works closely with agencies such as Canberra Refugee Support, CIT, Catholic Care, the Red Cross and MARS as well as our Refugee Mentoring Program Advisory Group. The advisory group is made up of 12 members from outside agencies that provide oversight and expertise in the ongoing delivery of the Calvary RMP in order to maintain its relevance and responsiveness to the needs of refugees. Since its inception in June 2008, the RMP has had over 50 participants enrolled in the program with eight participants currently active and over 20 staff Mentors. Three past participants have gained employment at Calvary as a direct result of their experience in the RMP.

We are proud to be participating in World Refugee Day 2011 with past and current participants, mentors, the RMP Advisory Group and other agency members to acknowledge the plight of refugees across the world and celebrate the successes and futures of those who have now chosen to call Australia “home”.

social justice statement

each (refugee) is unique

Their experiences and the particular circumstances of their joys and hopes, griefs and anxieties are likely to be just as diverse.

But through this amazing diversity, we are all sisters and brothers of this world – created in the image and likeness of God.

The life we share is sacred and our human dignity is to be respected ...

One of the blessings of living in a free and confident nation is that we have the opportunity to develop our gifts and contribute to a better world for those without the same gifts or opportunities.

People, societies and nations that are free and secure are well positioned to build a better world in which others will also have peace, security and opportunity.

(Social Justice Statement, 2007)
Today Cabrini Health, Victoria’s largest Catholic private health service, employs approximately 3,800 staff and the successive waves of migration to Australia are evident in its workforce.

The Italian and Greek migrants who arrived with their families in the 1940-50s, Vietnamese and Chinese refugees of the 1970s and more recently, the Horn of Africa refugees. There are approximately 70 nationalities among Cabrini Health staff and embracing cultural diversity resonates deeply at Cabrini Health. This was reflected in joyous celebrations held across the health service during Cultural Diversity Week 19-27 March 2011.

Francesca Cabrini, who founded the Missionary Sisters of the Sacred heart of Jesus in 1920, was canonised Universal Patron Saint of Immigrants 60 years ago and 2011 has been declared by the MSC “Year of the Immigrant”, calling on the Cabrini Community to reflect on the challenges and difficulties experienced by people who leave their homelands in search of a better life, especially migrants, refugees, displaced and itinerant peoples around the world.

“As a daughter of Mother Cabrini, it gives me great joy to see the current staff is young, diversified in origin and culture, professional, talented and evidently happy and proud to be part of this great organisation,” said Sr Patricia Spillane msc, Superior General, of her visit to Cabrini Health in March 2011.

The staff of the Cabrini Linen Service, a commercial laundry producing 120 tonnes of linen per week, represents 30 different cultural groups.

Stories of success are shared and celebrated at Cabrini Health, such as a young Vietnamese refugee who started as a laundry hand and, with career development and educational support, recently achieved his career goal when appointed Production Manager for the Cabrini Linen Service.

This year, in celebration of the Year of the Immigrant, the life stories of staff from across the organisation are being collected and these will be published during National Refugee Week in June 2011 to provide insight into the journey that many have taken to arrive where they are today.

Staff pictured in the main kitchen at Cabrini Hospital Malvern during 2011 Cultural Diversity Week celebrations—they wore national costume and shared food from their country of origin.

SJOG refugee playgroup for children from refugee backgrounds

St John of God Subiaco’s Social Outreach and Advocacy Department has partnered with ASeTTs (Assisting Torture and Trauma Survivors) to provide a coordinator and other needs for a playgroup to address attachment issues between parents/guardians and their children from refugee backgrounds—the age range for the group is 0-5 years.

ASeTTs provides services to people who are humanitarian entrants or are from a refugee background and who have experienced torture or trauma in their country of origin, during their flight to Australia or while in detention.

The playgroup came about when ASeTTs staff recognised that many of their counselling clients were struggling with raising young children and that there were no programs to which parents/guardians with no or limited English could be referred.
MercyCare, Perth WA offers a range of holistic and integrated programs at its friendly and supportive Mirrabooka office to assist refugees and migrants settle into Australia and lead productive and fulfilling lives.

Many clients have become independent, self-determining contributors to their local communities through participation in MercyCare’s services. Eligibility conditions apply for most programs funded by government.

The Workforce Development Centre is designed to assist Culturally and Linguistically Diverse (CaLD) clients of any age (secondary school and above) and at any point in their life to make educational, training and work choices.

The Settlement Grants Program provides information, referral, advocacy and casework services for refugees and humanitarian entrants in the region. Life skills sessions are delivered on topics including • employment • education and training • health • housing • budgeting and finance • credit traps • internet security • family and relationships • security and safety • budgeting and finance.

A free 4-day Rental Ready program is delivered to help clients secure rental property. Included is a practical course in cleaning, with skills gained being transferable to job opportunities.

The Community Support Program helps clients and communities build capacity through engagement, discussions and development of programs that are relevant to their current needs. Social inclusion activities such as art and craft, yoga, conversational English and understanding Australian citizenship are offered on an ongoing basis.

The Mercy Addiction Support Team (MAST), a drug and alcohol counselling service, provides short to medium term addiction counselling for those who are experiencing drug and alcohol problems, or those affected by another’s drug and alcohol use.

The First and Second Click Computer Training provides basic training for those who have never used a computer before. Increased social inclusion and independence is gained through the ability to use internet, email and search engines.

Mercy Lending Services offers affordable and manageable interest free loans to help clients build a better life for themselves and their families. Clients can borrow from $100–$1000 to be used for a range of employment, training and education items including driving lessons, training courses, work tools, computers.

Anjali Mukund, the Manager of MercyCare’s Mirrabooka office where the services are located, is continually advocating for refugees and migrants, and constantly seeking new opportunities for programs and extra funding.

The team at Mirrabooka is focused and dedicated. MercyCare is proud that we are able to contribute to the well-being of those who arrive in Australia needing support, skills and advocacy.
comings & goings

new southern cross homes CEO

Mr Paul McMahon has been appointed as the new CEO of Southern Cross Care (NSW & ACT). Paul will take up his role on 25th July 2011, with the longstanding CEO John Ireland to retire on 12th August. Paul is currently the CEO of Thomas Holt Village which is a not-for-profit, community based organisation offering residential aged care, community care and independent living. Paul also worked for Uniting Care Ageing NSW & ACT for eight years and the Commonwealth Department of Health & Ageing including a number of years as the NSW Manager of the Aged & Community Care programmes. Paul is currently a Director of Mercy Health and Aged Care Central Queensland Ltd, so is well known to many in the Catholic community.

notre dame appoints new dean of medicine

Following a wide ranging international recruitment process, Dr Christine Bennett has been appointed as the new Dean of the University of Notre Dame Australia’s School of Medicine, Sydney.

Dr Bennett completed her MBBS at the University of Sydney in 1979, her Masters in Paediatrics at the University of New South Wales in 1987 and became a Fellow of the Royal Australian College of Physicians in 1987. She has worked in the New South Wales Department of Health, including time as General Manager for the Royal Hospital for Women, Director of Clinical Services and Population Health at the South Eastern Sydney Area Health Service and CEO of Westmead Hospital and Community Health Services.

Over the last nine years, Dr Bennett has worked for Bupa Australia and Bupa International Markets (previously MBF), most recently in the role of Chief Medical Officer and Director of Healthcare Leadership. Dr Bennett chaired the National Health and Hospitals Reform Commission in 2008–09, and continues to chair Research Australia Ltd and is a board member of Obesity Australia and HeartWare Inc.

eastern focus for st john of god’s new appointee

St John of God Health Care (SJOGHC) has appointed Mrs Tracey Burton to the position of Executive Director, Eastern Hospitals—a new role which has line responsibility for the organisation’s nine Victorian and New South Wales hospitals, and for any future developments in the eastern states of Australia.

Tracey brings a wealth of experience to the role, having worked in the health services management sector for the past 26 years. Most recently, she held the position of Chief Executive Officer, St George Private Hospital in Sydney.

Tracey has undertaken and overseen master planning and facility developments at multiple hospital sites—including the 130-bed Hawkesbury hospital development, $30 million Mater Private Clinic, 60-bed Mater Redlands hospital development and $18 million expansion at St George Private Hospital—including both brownfield and greenfield developments.

Commenting on the appointment, CEO Dr Michael Stanford said, “A person of Tracey’s professional calibre and demonstrated expertise in health management is a rare commodity, and we are thrilled to welcome her into our organisation.”
As this edition of Health Matters arrives around the country we will be celebrating the great Feast of Pentecost. This Feast is really a celebration of the birth of the Church. It was the coming of the Spirit promised by Jesus that released the courage and other gifts the disciples needed to go out to the world and share the Good News of Jesus.

So in this sense Pentecost is the celebration of the birth of our mission too—our mission to bring about in the world around us, the circumstances that make Jesus’ presence and love for us known.

Images associated with Pentecost and the presence and activity of the Spirit are fire, wind and breath. At a recent e-Videoconference sponsored by the Broken Bay Institute, the Holy Spirit was depicted by presenter Fr Denis Edwards as “the dynamic energising power of God”—the “Breath” expressed in the “Word” making God visible, but in ways that are never complete.

There is a lot about Pentecost that speaks to our present circumstances in Catholic health and aged care. The clear message resonating throughout CHA’s recent Reconfiguring Catholic Governance Conference was the reality that something new is happening among the ministries of the Church.

Scripture and our faith tradition remind us unfailingly that the Spirit is recognised in the emergence of the new. Each time we find ourselves in the context of new challenges that stretch our old ways of being and doing, we can take heart that we are actually immersed in an experience rich with opportunity to encounter the Spirit. And it is openness to the Spirit that will lead us to respond to new contexts in creative ways, to seek life-giving directions that reflect our unique tradition and faithfulness to our mission.

So, just as Easter reminded us that we are Resurrection people in the disposition we bring to our relationships and commitments, so too we are Pentecost people especially in our approach to our challenges and crises. Often expressed in the voice of someone who speaks from the fringe, who challenges our ways of seeing and doing things, the Spirit is always calling us to re-vitalise ourselves and our efforts. Do we have the courage to listen?

Come, Holy Spirit, fill the hearts of your faithful; and kindle in them the fire of your love. Send forth your Spirit and they shall be created, and you shall renew the face of the earth.
Registrations NOW OPEN!

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National Conference 2011
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for more information and to register visit
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