Catholic Health Australia

Social Inclusion and Catholic Health Care

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From the Gospel of Matthew

"For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me.'…

'I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me.'

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About Catholic Health Australia

Twenty-one public hospitals, 54 private hospitals, and 550 aged care services are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

Introduction

The passage from Matthew's gospel above is a clear description of social inclusion; it is also a foundation text for Catholic involvement in health and welfare. This paper contributes to the discussion around social inclusion that is currently shaping Government policy, priorities and actions by broadening the parameters of the discussion in new directions and from a perspective that is held by a major provider of services within the health and welfare sector. In addition, it is articulated within a framework that reflects the beliefs, goals and aspirations of significant numbers of the Australian population.

Social inclusion is intrinsically linked to the concept of social exclusion.[1] The two concepts are often associated with notions of poverty, deprivation, disadvantage, integration and powerlessness and strategies designed to eliminate or ameliorate these disadvantages. Usually the discussion is framed through a sociological lens. This contribution to the debate is framed in the context of the Catholic ethos and, especially, how that ethos is applied in health care. Using this approach is not a critique of a sociological stance; it is presenting an equally valid analysis from a very different, value rich and faith-based context.

One challenge that confronts any debate about social inclusion is that it is possible to turn to methods of alleviation rather than structural reform to address the causes of exclusion and disadvantage.[2] In the field of health, community and aged care, the response to immediate needs can often build in an automatic alleviation mechanism. That is, the 'acute' need of the patient, client or resident for treatment, assistance or caring shelter can become a limited focus for the provider of care, whether an individual or a facility. This is also built into structures around health and aged care: the mechanism of 'fee-for-service' and, in aged care, 'bed occupancy' funding that mitigate against systemic reform and attempts to move to holistic wellness and independence models of care. The Catholic tradition, largely due to the view of the human person at its base, has always tried to balance the duty to care for those in immediate need with a larger obligation to address the reasons for the disadvantage.

Consistent with the Catholic tradition in health care and social teaching, a contemporary social inclusion agenda will, in terms of health care, consider the following issues: access to quality health care; mental health services; disability services; palliative care; aged care; and, community care. In order to develop a truly social inclusion perspective on these issues it is necessary to first establish a theoretical framework for social inclusion from a Catholic viewpoint. This framework will promote a focus on building community rather than a narrow attention to particular outcomes. An outcomes focus all too often leads to attention being paid to dollars and hours committed rather than on the more foundational matter of human flourishing through relationships.

Part 1: Social Inclusion

Any understanding of social inclusion relies on an understanding of the very nature of society and, obviously, for this reason will be heavily influenced by the context of the nation or community. In terms of social theory, a social contract perspective will deliver one set of answers, while a communitarian view will generate yet another. Regardless of the theoretical or philosophical underpinnings, all understandings of society rely on four essential pillars:

- a conception of the good;
- an understanding of the human person;
- an understanding of the nature of the relations between the persons within the society;
- a perception of the goal to which society aims.

The quotation from Matthew's Gospel at the beginning of this paper is crucial to understanding a Catholic perspective on social inclusion: those who are most vulnerable – the socially excluded – have genuine, tangible needs and it is incumbent on societies and individuals to reach out to help these people in their needs.[3]

Gerry Arbuckle, in the Catholic Health Australia publication *Preferential Option for the Poor,* identifies two types of assistance to those in such need: emergency and developmental.[4] In other words, immediate alleviation of hunger, thirst, homelessness etc; and structural reform that seeks to ensure that vulnerable people are not continually outside the 'system' looking in. The parable cited above calls on those with the means to alter the situation for those in need. The obligation here is a personal one: ultimately, in the face of human need we have only a single choice – either we embrace the other who is in need or we reject them.[5]

The concepts of acceptance or rejection, building relationships with those in need are vital to understanding social inclusion and social exclusion: those who are embedded in networks and communities of meaning are more likely to be sustained in terms of their physical, mental and social well-being; those who are isolated and separated from others are likely to have significant social, health and economic deficits as well. The Australian Social Inclusion Board's recently released *National Mental Health and Disability Consultation Findings*, reports that isolation and loneliness are more serious causes of disadvantage than economic disparities and that the more challenging the economic situation the more imperative the need for interpersonal connections and community integration.[6] Health care, like other forms of intervention, can have a tendency to focus on the alleviation of immediate need, but the vision of health and wholeness that is part of Catholic health care is not satisfied with such an approach.

In contrast to many models of health care, in Catholic health care palliative care serves as an archetype of all health care. Here the focus is not on cure, as such, but on health, wholeness and human flourishing. The situation of the terminally ill means that palliative care facilities and carers operate out of a quite different paradigm – focusing on that which ensures life is able to be lived to the full. Considered more generally, health care is a response to the human experiences of suffering, illness and injury arising from a commitment to our common humanity. The various models of health care, types of intervention, uses of technology and innovations derive from this initial response to the human condition. Palliative care, the care we offer when we have no hope of cure or prevention, is the basic structure for health care and it is the basic model for human community.[7] It is such an approach which is truly inclusive and in which the vulnerable other is embraced by the community.

Catholic health care has a very long tradition; central to it has been the embrace of those who are in need, particularly the sick and dying. Over the last fifty years, responding to changes in community structures and the needs of people, Catholic

health care organisations have entered into aged care. In this way the response of those who have institutional priority for Catholic health and aged care organisations has been not only to care for those with particular health needs, but also to actively seek out those who need to be included. With this tradition as the central motivation, the priority for the future needs to be developing responses to the impact of the social determinants of health. Levels of education, employment, early nutrition, quality housing and community resilience are all key aspects of social exclusion/inclusion and they have direct impacts on health care.[8]

The understanding of social inclusion and the proposals that follow are founded on that experience of Catholic health care and the vision provided through the *Parable of the Last Judgment* from Matthew's Gospel. In those we encounter through health, community and aged care, we are encountering Jesus, who has identified himself with those who are most vulnerable – the isolated, neglected and excluded. The positive relationships developed with those in need are always relationships of faith and hope.

What is 'social Inclusion'?

The term social inclusion is relatively recent in socio-political literature but is well established in philosophy. It is implicit in liberal political philosophy which championed the idea of a social contract. Thinkers such as John Locke and Thomas Hobbes made use of it in their assumptions about the necessary pre-conditions for social contracts to exist.[9] Classical liberal philosophy then has two necessary preconditions for its understanding of the social contract: that all people in a given society are equal in power and they are free to negotiate the nature of society with the other free persons who seek to live in the society.[10] Social inclusion is assumed while social exclusion cannot be acknowledged within such a framework. Hence, those who hold view consistent with classical liberalism often tend to demonize those at the margins of society. Social inclusion while it must be assumed, cannot actually be a priority within such an intellectual framework; to identify

social inclusion as a need is to render the existing social contract null and void.

Social inclusion has become a distinct theme among Governments in Europe, the UK and Australia. While the process has a decade-long history in the EU and UK and a lengthy history in South Australia, it is a more recent focus of national concern in Australia. Social inclusion in these contexts focuses on increasing the participation of the marginalised within society, often in areas of particular priority, such increasing workforce participation or integration or improving educational outcomes or in relation to particular health needs. The priority areas across jurisdictions share two concerns: improved integration/participation in society and improved and sustained economic outcomes.

In the Australian health care context it is helpful, as an initial position, to adopt the view of social inclusion developed by the Australian Government through the responsible Minister, Julia Gillard. In a speech entitled 'Social Innovation, Social Impact: A New Australian Agenda', Ms Gillard established the parameters of social inclusion in the Australian context:

"...to be socially included, all Australians must be given the opportunity to:

- secure a job;
- access services;
- connect with others in life through family, friends, work, personal interests and local community;
- deal with personal crisis such as ill health, bereavement or the loss of a job; and
- have their voice heard."[11]

These parameters are further solidified if Ms Gillard's comments to the Australian Council of Social Services Annual Conference in November 2007 are considered. In this address, Gillard highlights the necessity of linking the moral and economic imperatives for social inclusion and she alters the language of government about intervention to assist the excluded:

> …our social inclusion initiatives will not be about welfare – they will be

an investment strategy to join social policy to economic policy.[12]

Catholic health care facilities are businesses that arise out of and exist to give expression to a particular mission – the healing mission of Christ. While there is always tension between the fiduciary responsibilities of operating a business and the moral responsibility to prioritise and operationalise the mission, the two elements –business and mission – are two sides of the same coin, not fundamentally separate. This is effectively the same point that Ms Gillard

makes: social inclusion is foundational to optimal economic activity.

Social inclusion in the Australian context then focuses on opportunities, access, relational networks, resilience and participation.[13] This perspective stands in stark contrast to the historical philosophical legacy of the liberal tradition and in contrast to the more economically focused stance that predominates in some of the literature.[14]

Part 2: The Four Pillars of Social Inclusion

Social inclusion, as noted above, relies on particular understandings of society. For liberal contractarians, society is a group of autonomous rational individuals, equal in power and status, and seeking a common set of good outcomes; by way of contrast, for Marxists, society is a collective of workers, prizing equality and seeking to share the bounty of their labours.

There are other conceptions of society, however. One that is central to this paper is the perspective articulated by Catholic social teaching. This perspective is foundational for the Catholic understanding of health care. Catholic social teaching understands that society is essential for human development and flourishing. Indeed, society is essential for human existence. Moreoever, Catholic social teaching gives a specific place to those who are oppressed, who suffer, who are poor; it calls on all people, especially those of faith, to solidarity with those who are vulnerable. In terms of public policy, Catholic social teaching demands that we pay attention to René Girard's insight that for probably the first time in human history we are beginning to consider victims.[15]

This view of society generates a particular view of social inclusion. All people are members of society due to their inherent relationality; the family is the fundamental building block of society, recognizing that communities are formed firstly from individuals, families and small groups entering into networks of interest. Social inclusion in such a view is not an added dimension to Government practise, it is the fundamental purpose of government. As obvious as this comment appears, it requires further clarifications. All members of society need to be included in the workings and operations of our society but there is a special obligation to reach out to those who are most vulnerable – those who are the victims of oppression from any source. This perspective is a key concept for Catholic involvement in health care.

Social inclusion not only rests on certain assumptions about society; it also requires a number of other dimensions. Underpinning the various assumptions, there are four foundations on which any understanding of social inclusion must rest:

- a conception of the good;
- an understanding of the human person;
- an understanding of the nature of the relations between the persons within the society;
- a perception of the goal to which society aims.

These pillars underpin social inclusion and from the perspective of health care, especially in the Catholic tradition, each has a definite meaning.

A Conception of the Good

A major difference between most views on social inclusion and that proposed in this paper is that the intellectual stance, the rational argument presented here is informed by a faith commitment. This does not imply an exclusivist or sectarian perspective. Others will find synergies and convergences between a Christian view and their own, but the faith commitment will influence how social inclusion is understood. A particular faith commitment will result in a particular understanding of the good. While the idea of the good is a universal concept, any instantiation of it will require a particular way of looking at the world, understanding humanity, the role of health care, etc..

Thomas Aquinas argued that the task of practical reason is to realise 'the good'; the good is realised through action. This is in contrast to theoretical reason, which has as its task the determination of how things are (the truth) and that this results in belief. In terms of practical reason, the basic premise is that "good is to be sought and done, and evil to be avoided".[16] Social Inclusion is clearly a good to be sought and done; contrawise, social exclusion is an evil to be

avoided. There are two reasons for this: the goal of human existence is flourishing[17] and for humanity to flourish it is necessary that we live in society.[18] Human flourishing is not possible if society is exclusionary. Those who are excluded cannot flourish. Their exclusion forces them into the position of being victims. In turn, societies characterized by exclusion of certain categories of persons are failing in their object and not operating effectively or efficiently. Unless people's lives are characterized by positive experiences, some measure of success and achievement, and personal sense of worth, they cannot be said to have flourished; nor can governments be said to have been successful or have served their communities if there are significant portions of the community for whom flourishing is not possible.

In short, the conception of the good that motivates Catholic health care is one of human flourishing: encouraging a sense of wholeness, self-worth, and capacity to enter into life. Any conception of the good prompts a further question: the good for whom? Hence, Catholic health care rests on a particular anthropology or answer to the question, what is a person?

An understanding of the human person

Catholic health care shares the Christian vision of the human person – an interpretation of humanity in the light of God's self-revelation in Jesus Christ. Ultimately, for Christians, human life does not primarily consist in a set of doctrines or beliefs, but in following Jesus.[19] Christianity has articulated its understanding of persons in a variety of ways over the centuries but all formulations of answers to the question, 'what is a person?' that emerge from the Christian tradition can be described as transcendent. This means that 'humanity' is defined with reference to something beyond humanity – in the case of Christians, Jews and Muslims, with reference to God.

Historically, within the Christian philosophical framework, persons have been understood in philosophical terms as a metaphysical substance within the framework of Greek philosophy and natural law.[20] In a more contemporary secular setting, persons have been viewed more functionally as solely rational, self-determining individuals.[21] Recent years have seen a return to the concept of *relationality* and the development of a relational theology of personhood. This view is a transcendent one that broadens the context, especially by explicating the communitarian dimensions of human life and conduct. The human person in this perspective is one who is created, formed and only has existence within relationships.

The human person is, in a sense, always indefinable.[22] The path to personhood is never finished. This is crucial when considering the situations of children, the infirm, the disabled and the unborn. If "personhood" is constructed as an ideal of some kind, say, a fully functioning rational adult, then all who fall short of the ideal must be excluded. This has been a very strong tendency in the modern world of the last thirty years. Increasingly people feel defined by their capacity to contribute in economic terms. Women who are predominantly involved in child-rearing and family support roles are undervalued in our society and government policies frequently reinforce this status. Those who are chronically ill or disabled are simply excluded from our society. The clear message that society conveys to these people is that they are not worthwhile; often that they are a drain on community resources – this was captured in government policy in the term, mutual obligation. Any attempt at social inclusion must begin with embracing those on the margins of society, those who are excluded, those who are victims, those who are powerless and in need.

On the other hand, a contrasting view of persons based on their relational nature and which understands that they are beings in the process of becoming, will not simply exclude those who do not meet the usual ideal. In this conception, those who do not meet the social ideal in terms of rationality, sociability, economic output must have a special role in interpersonal relations, since they are among the most vulnerable. In them, for Christians, we meet Christ, but also through them all people – those of any faith or none - are called forth into a deeper

understanding of how we belong together in a personal world, subject to limitations, yet with the capacity for self-transcendence.[23]

In terms of health care, conceptualising persons as relational beings has a dramatic impact on the context of social inclusion and health care. The emphasis is placed, not on a pathological case, not on what the individual can do or contribute, but on the person. When persons so interact, a transformation of all parties can occur, even if, medically speaking, a cure ceases to be possible. Admittedly, this entails risks and its own kind of stress. Once health care professionals – or for that matter any other person, even a politician – recognise themselves and the suffering other in an interpersonal, relational mode, then the obligation to reach out to the other, to include the other, cannot be ignored.

By stressing the relationality inherent in personhood, it is possible to understand the importance of community and social relations for the development of personal existence.[24] The person is "someone", yet the potential to realise this uniqueness lies in actuating an endless field of relationships. Modern paediatrics has demonstrated the way that even very early embryos respond to the world around them and develop in particular ways in response to changes in their environment.[25] Likewise, Jean Vanier's work with the profoundly disabled is based on the centrality of a relational framework in his remarkable ministry.[26] For Catholic health care, then, the person is a relational being. To be in relationship with others means that social inclusion is inherent – to the extent that we exclude another we diminish them, but we also diminish ourselves and we diminish the society in which we live.

For this reason, the relational person is the foundation of an understanding of society.

An understanding of the relations between the persons within the society

As indicated above human persons are relational beings. These relationships are not transactional or linear. Instead they form networks or webs of interaction through which we establish meaning, a sense of self-

worth and identity. For this reason, Catholic social teaching focuses not on society but on community.

The concept of community is larger than an ensemble of individual relationships, as is sometimes implied by the term society; it also includes the quality of the communication that is occurring in the field of interpersonal relationality in question. Genuine community recognises and affirms the persons involved, as each unique Other affects the self-identity of all.[27] In this an ultimate goal is envisaged – to draw all into unity through a common participation. In terms of social inclusion this common participation is to achieve human flourishing.

The concept of community, then, goes beyond that of society and the interactions that make it up. For being in community transcends the social situation of rivalry, violence and fear, to find its expression in active and loving relations between the persons.[28] John Macmurray uses the metaphor of mother-child relations as an archetype of all human interaction,[29] not in any sense reducible to biological relations but in terms that all human communities are formed from networks based on one-to-one interactions characterised by nurturing. It is a relation characterised by personal mutuality, linking the self and the Other in the nurture of a shared life.[30] The mutual transformation enacted in the relation is more fully expressed in the relationship between lovers. In such an encounter, there is a notable intensity which moves the self to embrace the Other, in a communication that transforms both parties.[31] The self is newly experienced as being both for, and from, the beloved Other.[32] Community, understood in this way, does not imply the loss of self, nor absorption in the other, but the realisation of the true self through the affirmation of the unique other.[33] The term community can apply to large, geographically separated, culturally and linguistically diverse groups of people, but it is most appropriately applied to those networks in which persons live, work and socialize.

This emphasis on community and relationship does not undermine the unique reality of the persons involved. It is not a matter of promoting an amorphous

collective, but of recognising both the ontological basis of personhood and the experiential importance of relationships in the psychological constitution of persons. Entering into a relationship with the other neither dissolves nor constitutes the unique reality of the "someone" who the person is. For health care, especially Catholic health care, this insight has profound implications which transcend the commonly defined boundaries of health care and seek to address the social determinants of health.

This perspective is foundational to the Catholic view on the sanctity of life: this is more than preserving life and rejecting practices which have as their object the killing of another person. Fidelity to the sanctity of life must include enabling life to be truly lived in a manner that promotes human flourishing. Unless the social determinants of health are attended to, the possibilities of human flourishing for individuals or communities is limited. For this reason, as noted earlier, palliative care is an important model for all health care. Social inclusion is always important but in health care, particularly the care of the dying it is vital. Reaching out to those in need is a fundamental marker of the health of a society – this is so regardless of efficacy of a particular response. Unless the Australian social inclusion agenda adopts such a perspective it will not truly address the needs of all Australians.

The goal of social inclusion is to build communities and through this means maintain and enhance the prosperity of Australia. This is similar to the fundamental goal of health care: to promote human well-being; human flourishing through the care of the biological, mental and psycho-social dimensions of persons. *Inter alia* this is a social inclusion agenda which is a central goal to which society aims.

A perception of the goal to which society aims

The central goal of society, clearly, is human flourishing – in the context of the Australian community this means ensuring, to the maximum extent possible, that individuals are able to attain their personal goals, the goals of those they care about, and that community goals are also achieved. In order to ensure this, strategic focus needs to be given to local communities. In line with the principle of subsidiarity, community networks are best established at the level closest to the participants. In addition, communities are effective when they form organically. As the United States landmark study, *Hardwired To Connect*, demonstrated human beings are not only relational in nature but they are intrinsically oriented to form communities. These communities are built around common interests, common values and a shared purpose.

For social inclusion to be achieved, the Australian community must aim to be "a social and political environment characterised by an emphasis on equal worth and respect…"[34] Such an emphasis is not sufficiently attained without the inclusion of all members of the community being considered. Societies that emphasise functionality, economic achievement and measurable contribution, fail on the social inclusion agenda. Recently, the media have highlighted the provisions in Australia's migration regulations that require permanent residency to be denied to those people deemed to have an expensive health status. The standard for rejection is that a person is deemed to be likely to cost $21 000 over a five year period (over 3 years if the person is aged over 75 years).[35] In these cases the economic cost of care requires the rejection of a permanent residency application and appeals processes are unable to address the moral basis for the original decision. The only remedy open is appeal to the Minister which then enters into a political process. As was observed in one article, while it may be that the Minister will intervene when the applicant is in a position of power due to family connections, other cases when the need for the applicant may be greater are not routinely overturned.[36] Government policies of this kind, although economically responsible and politically palatable, are contrary to the intent of social inclusion. Social inclusion requires that society must aim to be;

> …founded on mutual respect, on a recognition that we have a responsibility collectively and individually, to help each other on

the basis of each other's equal worth.[37]

The views expressed by the then British Prime Minister Tony Blair translate quite easily into the Australian context. As Lin Hatfield-Dodds has argued, social inclusion requires a vision of and for a society;

>…that actively enables the participation of all citizens through integrated policies that underpin healthy communities, a healthy environment, and a healthy economy. Social inclusion does not happen by accident, or overnight. It requires sustained political commitment and government leadership, including the building of partnerships across government, business, the community sector and local communities.[38]

Likewise, the Catholic health sector recognises the need to build partnerships and networks, both formal and organic, to found the social inclusion agenda and to ensure it is capable of sustained action to bring about change, especially for those most in need.

Social inclusion, then, is the goal to which society aims. This goal is attained only when people are empowered to enter into relationships with each other based on the need to care for others, to reach out to those who are vulnerable and to join with each other in solidarity.

To this point, this paper has addressed the theory and foundations of social inclusion, albeit from a health care perspective. Now the task is to consider specific issues in health care in the light of the political call for a social inclusion agenda and the gospel call that is the foundation of Catholic health, community and aged care.

Part 3: Relevance for health care - Some key issues

Parts of the health care system in Australia have become so systematically impersonal that economic considerations of measurable outcomes of success predominate to the detriment of personal care and the complex of relationships that affect the human person in health and in sickness. Lisa Sowle Cahill's recent work has been critical of these emphases in American health care[39] while Melvin Konner has presented a wide ranging and prophetic critique of contemporary Western medicine covering Australia, Britain and other health care systems that reflects similar concerns.[40]

The justification for increasingly expensive technological innovation necessarily relies on publicly measurable successful outcomes in surgical repair and the cure of disease. As a result, the person who receives such care can often be reduced merely to the status of a success or failure in the process. Furthermore, the crisis-medicine which is the business of acute care, especially emergency departments, and the ability to respond to major accidents and natural catastrophes, is not structurally capable of pausing over the significance of the individual person's experience: the system's ability to respond rather than the individual's personal experience of threat or injury is rightly the main consideration. However if health care is uncritically intent on curing a condition through surgical or other intervention, or largely taken up with crisis-responses to accidents or catastrophe, it becomes increasingly desensitised to the personal reality of those it is designed to serve. This is currently being demonstrated in Australia with a number of regionally-based health systems being overstretched and the number of publicly (politically) unacceptable errors mounting.

The chief *systemic* failure is not a lack of expertise or deliberate choice to avoid meeting known needs. It is a failure to adequately recognise the needs of the persons involved in the various health situations, staff or patients. In short, the pathology, a reification of the person and the consequential exclusion of the person becomes the focus, rather than the care of persons at their most vulnerable, in their experience of the situations of isolation, powerlessness, suffering, and the risk of death. As a result, the understanding of health as wholeness leading to human flourishing can easily slip from view, even if the wholeness in question may vary, as with those who have lost a limb, those afflicted with Down's Syndrome or who are in palliative care, compared with those who require surgical intervention to ensure a return to somatic equilibrium. Specific treatments will vary, but the central goal of wholeness, inclusion and integrity will not.

These physical, biological goals of medicine are necessary, but they need to be pursued in the context of the persons who are the subjects of health care, especially by acknowledging the multiple and multi-faceted nature of the relationships in which the human person exists. There are genuine limits to biological existence that must be recognised, along with the transcendent character and orientation of the human person. To ignore any of this results in a truncated sense of the wholeness and integrity of the persons who are the subject of health care. Social inclusion is fundamental to health care since in its absence persons are rendered impersonal; their care becomes functional; and the possibility of flourishing is limited – both for the individual and for society as a whole.

Hans-Georg Gadamer stresses the need for a much more integrated and inclusive approach, arguing that health care is misdirected when "the individual patient is objectified in terms of a mere multiplicity of data",[41] so that the unique value of the particular person is unrecognised and even discounted. He goes on to make a telling point, "[I]n the vast technical structure of our civilization, we are all patients".[42] Gadamer highlights something vital for an understanding of the intersection between theology and health care, namely, that we

are all "patients"—in a more radical sense, "sufferers". For all persons are vulnerable, and they are especially vulnerable when in the grip of illness, injury or diminishment. What the *Catholic* vision fundamentally offers to health care is the reminder that the promotion of personal existence is central to the goals of the activity, even as the pathological conditions involved look to healing and cure. It argues for social inclusion as a fundamental way to ensure flourishing for individual persons and for society.

It is precisely in this regard that the Catholic perspective can assist health care to understand its own goals more fully, to be ever alert to unique value of each person and the breadth of considerations implied in such a recognition. Appreciation of this dimension of the social inclusion agenda will enrich the socio-political debate and policy outcomes. For Catholic health care participation in this debate is important – it is the public face and argument for the activity undertaken.

Discussion of Social inclusion has the capacity to be either a lofty ideal or a pragmatic necessity. The Federal Government has argued that it is not an ideal but a pragmatic necessity: sound economic policy demands that social inclusion be pursued and achieved. Catholic Health Australia supports the social inclusion agenda and proposes six areas of particular need in the field of health care:

- Access to quality health care funded adequately and located suitably
- Improved mental health care
- Health care and services for those living with disability at a level which reflects their membership of the Australian community
- Increased access to and funding of Palliative care services
- Increased Aged Care funding (see blueprint)
- Priority given to community care

Each of these targeted areas reflects distinct needs in the Australian community which constitute barriers to social inclusion and economic prosperity

Access

Unlike many countries in the world Australia offers universal access to high quality health care. However, not all Australians have access to the same level of services within a reasonable distance of where they live – 4 hours travel to oncology services, for example is not uncommon. Access to quality palliative care services either at home or in hospitals is patchy; as is access to gynaecology and obstetrics specialists outside major population centres. Those members of the Australian community who do not have access to such services are among the poorest and the most vulnerable in our community. They are often those who are already subject to significant social exclusion due to unemployment, geographical isolation, disability status, lack of education and paucity of access to a range of services. Limiting the access to quality health care for people living in such circumstances diminishes their already compromised capacity to participate in and enjoy the benefits of living in a very wealthy community.

Succeeding in the social inclusion agenda must include improving access to a broader range of high quality health services for all Australians. To accept that the tyranny of distance means that some Australians will not have access to essential health services also means accepting that the goal of social inclusion is unachievable.

One means of addressing the shortages of services is to utilise a greater mix of public and private delivery mechanisms to ensure both quality and availability in a range of locations. It will also require preferential funding of specialist services in areas that are currently without access to high quality health care or where such access is very limited. Clearly government funding is only one avenue of funding this increased level of services. Another is to demand a greater level of funding for services by health insurance funds. This would mean both an increase in the benefits paid for services rendered and a community benefit obligation that would require health funds to increase payments for services in rural and remote locations to ensure that people in these areas are afforded the same access to and

quality of health care as those living in our best serviced areas. No doubt health funds will argue that such a requirement would threaten their viability.

A second measure would be to drastically reform health care funding from a fee for service model to one which promotes holistic health care for patients. This would mean focusing attention not on the activity of the health care provider but on the outcomes for patients. Increased emphasis on the health of Australians rather than on the treatment of various pathologies would be more in keeping with the goals of health care and with the Government's own research findings.[43]

Ensuring that 90 per cent of Australians have access to equal quality of health care services within four hours of where they live may be expensive; however, as we begin to more accurately count the costs of diminished health care for significant numbers of Australians it is clear that inaction brings dire economic losses. Failure to adequately meet the health needs of Australians does not just limit the effectiveness of the social inclusion agenda, it actually promotes social exclusion throughout the whole society. When we fail to build relationships with others we actually destroy the fibre of our society and undermine prosperity for all. Health care plays a vital role in enabling members of the Australian community to participate in society, to build relationships of meaning and to flourish.

Mental Health care

The excellent work carried out in recent years by various community and research groups in the field of depression has had a major impact in the Australian community. Not only is depression better understood in the community but its insidious reach into almost all aspects of society is now acknowledged.[44] The economic cost of mental illness in the US is estimated at $100 billion.[45] In Australia, it is suggested that the true costs are unknown. Depression alone costs the Australian community $3.5 billion[46], while the Australian Institute of Health and Welfare suggests that over 26 million working days are lost each year as a

result of mental illness; this is in addition to the significant numbers of those who are unemployed and unable to find work due to their mental health status.[47]

The Australian Social Inclusion Board, in its recent report on the National Mental Health and Disability Consultation Findings, has noted that mental illness increases social exclusion and leads to overlapping and compounded disadvantage.[48] In other words, not addressing or sufficiently addressing mental health issues has major consequences for the Australian economy because it is detrimental to the capacity to build a cohesive society.

What is required is greater levels of mental health care and that services are more widely available. However, this is not just a matter of more. As well as increased funding and access to professionals, to adequately respond to mental illness an integrated approach to care is required. Again this means making use of all our resources; not simply government health care agencies. Non-government agencies have had considerable success in assisting those with mental illness but they are hampered by short-term funding and the strategic weakness of fee-for-service approaches to mental health projects.[49]

Given that close to 30 per cent of the Australian population will suffer from some form of mental illness,[50] focus on this area of health care is long overdue and must be central to the social inclusion agenda. To bring about significant change in this area, improved funding of services will be necessary, but it will also take a quite different paradigm of health care delivery. Mental illness will require much greater levels of community health care. For this to be achievable, there needs to be better training and a more integrated approach to knowledge and skills acquisition in undergraduate medical, health care and allied health professions degree programs.

Those who suffer from mental illness are burdened by their health status, but also suffer due to isolation and social stigma. Access to adequate mental health services needs to be improved and is the result of poor funding, poor access and historically

low levels of awareness. The personal isolation that many people with forms of mental illness experience exacerbates their health condition since it has been established both in Australia and internationally that only through building strong links within communities and networks are people able to overcome the barriers established through mental illness. Social inclusion must reach out to those who have need of good clinical services but also who have need of friends. Building strong communities is a necessary pre-condition of high levels of mental health. Confronting our need for adequate funding and models of care in this area promises substantial economic benefit – as well as being a key means to attain high levels of social inclusion.

Disability Services

The Australian Social Inclusion Board (ASIB) has identified the need for greatly improved services to assist those living with disabilities and those who care for them. This reflects both the Australian situation and the international research.[51] Proposals to more effectively integrate services, employment and government funding are to be welcomed. The ASIB report suggests that approaches need to be well resourced and flexible to meet the needs of those living with disabilities. It may be that adopting a case management approach would be more appropriate to overcome bureaucratic obstacles and to ensure appropriate levels of support in terms of health, social, educational and workplace needs.

Again a stronger, more focused and better integrated approach to disability is required in pre-service professional training. Such training should also include an interdisciplinary focus to ensure that more holistic approaches to meeting the needs of those with disabilities is the hallmark of our society. The care of those living with disability is a mark of whether social inclusion is a serious notion or simply an election catchphrase.

Social inclusion must embrace those most in need and whose very existence is constantly under threat through: tacit community and government encouragement to terminate

pregnancies in which there is a suggestion of disability; poor levels of support – especially for those whose disability gives rise to chronic health problems; poor access to high level health care due to discrimination on the grounds of disability status; poor levels of support for those who care for people living with disability; and poor standards of institutional care when that is necessary. This is not going to win votes in the short term; it will be expensive – but it is a mark of our humanity.

Building social cohesion and empowering communities to be self-sustaining takes time and commitment. Governments can provide incentives, information and services that encourage community initiatives whether through business, non-government agencies, social groups or simply in changing attitudes. Such initiatives when focused through a social inclusion lens can have a major impact. For example, it has been reported that, due to the increased level of community services for those living with disability and their carers in Britain, the marked decline in the birth of children with Down's Syndrome has been reversed between 2000 and 2006 for the first time in over 30 years.[52] It may be inferred from this report that, when community support services are available; when those who will care for the disabled know that they are not on their own, that the community will support them in their need, the choice to accept disability is seen to be realistic. Such an inference would be supported by other reports, most notably *Hardwired To Connect*.[53] The goal of social inclusion must also include the recognition that each person has their own health needs, their own level of disability and their own contribution to make to the social fabric. Denying this fundamental human reality, especially through lower levels of service and care for those living with disability, tears at the ties that bind us, leaving the fabric in tatters.

The Parable of the Last Judgement cited at the beginning of this paper is not just a religious treatise; it is a political tract that seeks to remind all people that service to those in need is not something to be left to professionals. Systematic professionalisation of services has brought

many positive benefits to those with special needs but it has also enabled the community to ignore the obligation to care for others. Instead of rendering the kind of basic human care which builds communities and strengthens relationships we have increasingly allowed ourselves to be lured into leaving all care only to professional carers.[54] Correlative to this has been the loss of visibility and voice of those who live with disabilities in public discourse and in public life. Social inclusion must aim to increase the visibility and the voice of those with disabilities.

World class disability services should be available to all Australians regardless of socio-economic status or geographic location. Moreover, not only should it be available, but it should be known to be available. No society that rejects disability and rejects those who shoulder the burdens that come with significant levels of disability can call itself inclusive. Social inclusion cannot focus on those who are easy to include: the young well-educated, skilful, employed, who are full of vigour. It must reach out to those who are in need, whose contribution is less visible but no less significant. Unless Australia gains a reputation for being the world leader in disability support services, in welcoming those with disabilities into our community, social inclusion will be relegated to the archive of failed government policy.

Palliative Care

The provision of palliative care services is haphazard: quality of service is inconsistent; availability of services is unreliable. Understandably, the lack of availability of high quality palliative care, more than any other factor drives the euthanasia debate. The prognosis of a terminal illness leaves all people, no matter how personally secure, financially stable or relationally connected, in a situation of extreme vulnerability. This is even worse for those who are already on the periphery of society in some way: the unemployed or underemployed, the aged – especially those who care for others in need, members of rural and remote communities. In such a situation everyone should be assured of the best of care in their dying. Palliative care offers a completely different model of health care: cure is not the focus; rather it is the person and their living well to death.

Catholic health care knows the value of high quality palliative care. The leading Australian centres providing palliative care are within Catholic facilities – we know well the benefits that come from assisting people to die well. Yet the challenges in this field of health care are huge. Under current funding models, each palliative care facility is a financial drain on the broader hospital or health care group. Because the Catholic tradition has a preferential commitment to those who are dying, this is core business and part of the reason for our health care ministry. From the perspective of Catholic health no society can be inclusive if it tacitly refuses support to those who are dying. The severe limitations which are in place on palliative care reflect indifference to the plight of the dying and a rejection of their contribution to society as a whole. It is when the chips are down that we know our value to others. The failure to provide high quality, universal access to the full range of palliative care services is fundamental to social inclusion. Yet, not all Australians have ready access to such services when and where they need them; nor do they have access to the kinds of service they would like, especially community based palliative care.

Palliative care resources need to be increased and made more prevalent throughout the Australian community – especially in rural or remote areas. Greater levels of funding, a stronger focus on community provision of palliative care and more specialist hospices are required. We cannot claim to be inclusive and reject those who are dying. The poor level of palliative care services available to many Australians is not just an indication of exclusion for those in need; it has a multiplier effect throughout the community. The care of the most vulnerable and most in need of community support is the hallmark of a community. It is what separates the objective reality of a society from the subjective experience of a community. When members of society know that those who are among the most vulnerable are excluded it has a negative impact on our

connectedness. It is as though the message received is that, 'no matter what I contribute, no matter my need, at the end of the day I am on my own – unsupported, unwanted, unloved'. This feeling of isolation destroys communities through weakening the ties that bind us together. It has an impact on our social lives, our working lives and on our fundamental sense of self-worth. It suggests that a person's economic value is all that counts, they have no innate dignity. Catholic health care offers an alternative vision: it is the fundamental dignity of the person that is the basic building block for communities. For this reason, palliative care is the bedrock of Catholic health care. The Second Vatican Council noted that the dying have the first call on all the resources of the Church: economic, spiritual and, especially, human.[55]

Care of the dying is core Catholic business, whether in health or other aspects of the mission, but it is also the universal human reality. Each person will face death. Building communities relies on the knowledge that support is available when need is most acute. Social inclusion demands better palliative care services (funding, location, access). The social and economic impact of such services is much greater than the financial outlay involved. High quality palliative care for all Australians will (a) enable people to remain in employment for longer -- (b) require lower levels of overall care -- (c) result in fewer and shorter hospital admissions -- (d) lower levels of stress and co-morbidities among carers -- (e) enable those who are dying to do so peacefully and with dignity.

Aged Care

Along with other Western nations Australia is encountering a new demographic trend: an ageing population at time of increasing life expectancy and decreasing capacity of families to care for aged relatives from their own resources. This scenario means that any model of social inclusion must include a clear strategy to respond to the demographic reality of an ageing population.[56] The priorities in this area are that,

- older Australians receive the care they need in the accommodation of their choice, whether in their own home, in the community or in a residential facility,
- demographic based funding will be oriented to ensure the delivery of excellence in person-centred, compassionate care, and
- the funding framework will ensure that the care of older Australians is delivered by an appropriately skilled and qualified workforce.[57]

Over the next thirty years Australia will need to secure a sustainable model for aged care based on the ageing of the population resulting in increased demand for aged care services at the same time as there is a decreasing workforce base. This will have an impact on Australia's economic prosperity.[58] It will also have a significant impact on the structure of Australian society.[59] Social inclusion policy will encounter significant challenges in addressing ageing and the multifaceted issues which arise as a result. In terms of health care new structures, funding models and approaches to professional and informal care are required.

The generation that will be among the aged of 2020 ('baby boomers') have historically altered the patterns of decision-making, government policy and economic activity throughout their lives. It is highly likely that this will occur again as this section of the population ages. It seems likely that increased consumer choice will be a hallmark of aged care into the future. While 'retirement communities' will continue to grow, many will increasingly choose to remain in the more general community too. However, due to the rapid increase in numbers of people aged over 80 who will also have significant levels of disability, the need high care residential aged care beds will also increased markedly.[60] The call for greater levels of government funding, especially for those in need of high levels of care, must be heeded in terms of justice and social inclusion.

The social inclusion agenda will need to respond to the demographic changes facing Australia. Responses must include higher levels of government funding for high care facilities but will also require innovative measures for ensuring that older Australians remain a vibrant part of the communities they have shaped. This will be important not just for those who are older and in need of some degree of care, but also for their carers. Bittman et al analyse the economic impact for carers in terms of reduced income levels, participation in the workforce and career options. They also note the growing impact for industry of being unable to source appropriate staff due to the increased prevalence of the need for carers.[61] Carers are become isolated from their communities due to the demands of caring. Participation in community life whether that is through employment, community service, membership of community and sporting groups or even simple attendance at community activities and events is important both for older Australians and those who care for them.

The distinctions between profession care and informal care are less stringent than in the past; however, this has not been an entirely positive outcome. While it is generally accepted that those offering informal care are becoming more 'professionally competent', more educated and more skilled in offering such care, this has not resulted in higher public recognition, greater flexibility or higher levels of support. Instead, the professional workforce that is focused on aged care has become less visible, have lower levels of pay than comparable professionals and lower levels of support.[62] Instead of supporting informal carers to ensure higher levels of community participation and cohesion, Australia has increasingly burdened those who care for older people, whether professionally or informally, with exclusion from the community themselves. Social inclusion in aged care must rectify this situation by genuinely valuing older Australians not simply for their past contributions but for their present role in sustaining the fabric of our communities. Carers will also benefit from such a change in priorities.

Another priority for social inclusion will be a more systematic and sustained approach to community care. As the baby boomers increasingly choose to remain in their homes and communities throughout their ageing,[63] community based models of care will increase their capacity to participate at the optimal levels they desire in their communities.[64] This will also have a number of positive economic effects but will require clear vision and leadership and systematic government intervention to dramatically alter the nature of health care in Australia.

Community Care

Community care is a growing area of health delivery and requires significant improvements in funding. Community care will be the predominant model for health care in the latter seventy years of this century. Only a community care model of health delivery is capable of genuinely responding to local community need while still implementing a preventative health strategy.[65] Substantial investment is required now to ensure that community care is high quality, multi-valent and consistently delivered across Australia.[66] This is an absolute priority because only through quality community care can Australia's health care system be made sustainable.[67] The need for community care is evident through increasing demand for health services where people can access them:

- older people desire to stay at home as long as possible
- community based aged care services
- earlier discharge from acute care
- greater support required for those living with disabilities
- focused and sufficient support services for carers.

Those who specialise in community care models of health service delivery indicate that this is responsive health care that can genuinely lead to preventative medicine as being a reality.[68] Only when health care professionals work closely with communities can they genuinely know the needs of particular communities and the members of such communities. Case management

approaches are integral here but rely on strong and integrated communities. [69] Social inclusion, at its base level, must have the intent of securing and nurturing communities. Supportive communities have stronger social ties, but also generate the relationships necessary to overcome social disadvantage.[70] Health care must cease to be a function of society that removes one from the community and become the heart of community activities: community care is the only way this can happen.[71]

Community based models of health care are cost effective and promote stronger community networks. It is also more consistent with the goals of health which has care primary and cure as secondary. Such models call for a complete re-envisioning of how health is structured, provided and funded. As Menadue notes recognising this is relatively straightforward, implementing it is the challenge – for the community and for governments.[72]

Conclusion

This paper has addressed the public debate on social inclusion with respect to health care within a Catholic perspective. It began by considering theoretical frameworks for thinking about social inclusion and highlighted that social inclusion requires four pillars to sustain it: a conception of the good; an understanding of the human person; an understanding of the nature of the relations between the persons within the society; and, a perception of the goal to which society aims. This section of the paper argued that understanding that persons are relational beings who live only in relationships with each other must be foundational to social inclusion. The second part of the paper turned to specifically focus on the requirements of the health care sector in terms of social inclusion. Here it was proposed that there are six areas of central concern in terms of social inclusion: access to quality health care; mental health services; disability services; palliative care; aged care; and, community care. These issues are all urgent and must all be priorities for the social inclusion agenda. Those in need of health care are among the most vulnerable of our society and, if the social inclusion agenda is to be meaningful, they must be the principle beneficiaries of altered government policy and community action. The Parable of the Last Judgement calls on all people to recognise in those most in need make a fundamental call on our resources, whether financial, social, emotional or simply human. In formulating the social inclusion agenda this is not the goal it must be the starting point.

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