Church and Health

CHURCH OF NORWAY
National Council

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Preface

National Church, Institution and Congregation

The Church of Norway has a varied and qualified engagement in the area of health. Through a wide variety of diaconal institutions and through the activities of local Churches, an extensive range of services related to health and care assistance is made available. The community-building work of local Churches can contribute to strengthening public health and can provide the experience of belongingness and can enhance the meaning of life. The diaconal institutions represent one of the most important expressions of the Church in the public arena. Their health and care services provide a broad contact net with the population at large. These institutions have and will continue to have a central role in realizing the Church´s mission in the world. This same mission is pursued through the health-related work of local congregations on a health promotion level, through care giving and pastoral counseling, and through conversations, rituals and community and culture-building activities.

Changes in both Church and society create a need for more attention to the subject of Church and health. The changes that take place at a time when the Church of Norway is reorganized also make it important for the Church to clarify its mission and role in society.

On all levels, questions regarding health play an important role for the Church:

- Every living person has a body and a state of health. Disease and changes in the body and health situations affect us continuously. This actualizes the need for good health services and good communities that provide assistance and care for one another and that meet the need for interpreting one´s own life according to worldview and faith.
- The preaching of the Church is often based on texts that center on healing and stewardship. How do we understand these texts theologically and how do these texts challenge us to take responsibility?
- Many congregations provide extensive diaconal and health-promoting activities. How can this be developed further within a framework that boosts new boldness and creativity?
- We live in a society where questions of health dominate in the media and in heated political debates. For the Church, it is important to participate in these difficult conversations with wisdom and professional knowledge.
- The large diaconal institutions must constantly redefine their role, strategy and self-understanding in relation to changes in society, economic constraints and national health policies. How can the Church of Norway support and help in these processes?

The General Synod of 2015 was challenged to think through and clarify the health related work of the Church in all of these areas.

A Broad Perspective

This document is a slightly revised edition of the agenda paper presented to the General Synod for consideration. It explores the Church´s health related services from a broad perspective: as health promotion, as help in coping with life, as medical treatment and as care for the sick. In the document, the concept of health is discussed in relation to contemporary perspectives and understanding of health issues. The intention is to establish a deeper and more affirmative understanding that we as a Church share the vision of providing this important service to the world. The study brings forward theological insights and takes up professional health-related challenges. In this way it can serve as a common reference for the different aspects of the Church's health work. The study serves as a resource that can contribute to increasing the cohesion between the different types of work and to give inspiration to the work.

The document has been developed through a work process that has included several seminars, consultation with different specialists and dialogue in the Contact Forum for Health and Church. Many thanks to Kjell Nordstokke who has been the primary author.

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1. Introduction

1.1 Background for the Document presented at the General Synod 2015

In this introduction, we will present the goal for the document and explain some of the reasons that *Church and Health* was chosen as a theme for the General Synod meeting.

The question of the health mission of the Church is actualized both through the context of the society and the context of the Church[1], of which we are a part. The first relates to the understanding of this mission today and to the kind of health services and activities for which the Church should have a shared responsibility. Is this kind of engagement relevant within the framework of our welfare state? Shouldn´t treatment of the sick and needy primarily be a task for the state? Or is the rich heritage of the Church in the area of health, based on the mission given by the Lord of the Church, still relevant? If this mission still has validity, how should it take form in the concrete efforts of the local congregations and diaconal institutions?

The term «folk Church» indicates a vision of the Church as rooted in the public arena. This includes being prepared to take on tasks that will contribute to strengthening that which is good, true and fair in society. Based on the historical role of the Norwegian Church, health and care are such tasks. This is not coincidental, but is in accordance with the belief in a compassionate God who cares about people in need and who restores the rights of the weak and marginalized. The stories about Jesus have the same focus. On the basis of this, the disciples were given the mission to heal the sick and provide care. Through the centuries this has inspired what we could call the diaconal *«cantus firmus»* (TN: Fixed Chant) in the Church, as concretely expressed thorough different types of health and care services.

How can this *«cantus firmus»* be played in the realization of the Church's mission in today's society? In the development of the Church of Norway as a «folk Church», it is important to direct focus to the Church's role in society that in a way will renew the commitment and shared responsibility for appropriate services in the public arena. There are valid theological arguments for the Church to take on such a role and to become what, in some places, is called *public Church*[2]. From the perspective of the First Article of Faith, this could be understood as God's caring for all that is created. Further, it calls upon all of us to serve wherever we meet our fellow man. In the perspective of the Second Article of Faith, we are challenged by the stories about Jesus: He served in the public arena, in everyday life, and there he healed the sick and practiced care. Even the Third Article of Faith points in this direction: When the disciples at Pentecost received the Holy Spirit, they were empowered to leave closed rooms and, in words and practice, to witness about the great deeds of God.

Thus, the health-related services of the Church could be understood in light of the holistic mission of the Church and it´s role in the world. Diakonia is an integral part of this holistic mission, and health-related services are a central part of the diaconal tasks. The *Plan for Diakonia* in the Church of Norway confirms this understanding by emphazising that diakonia is Gospel in action, and that an overarching perspective for the diakonia of the Church is to «join efforts with all people of good will in order to safeguard the basic values of society»[3]. Good health, but also good treatment and care when health is failing, are values the Church is challenged to promote, both in words and deeds.

The health mission of the Church can thus be justified internally, based on a theological reflection on the mission of the Church in this world. However, there are also external reasons, in particular, reasons connected

[1] The Church of Norway is the primary reference for this document; nevertheless, the document should be read from an ecumenical perspective where we, as a community of Churches, share a common mission of health
[2] Cynthia Moe-Lobeda (2004): Public Church: For the Life of the World. Minneapolis: Augsburg Fortress.
[3] Church Council (2008): Plan for Diakonia in the Church of Norway. Oslo: Church Council p.13

to the changes we see in today´s society with new challenges within the health and welfare sector. Thus, this presentation will look closer at important trends in Norwegian health care today and some of the new health reforms that are currently being implemented. In particular, the *Coordination Reform Act,* the *Municipal Health and Care Services Act,* and the *Public Health Work Act* challenge the civil society, including congregations and diaconal institutions, to renew their efforts. There seems to be an expectation that the Church should be on the pitch and take on new tasks, in particular to promote public health.[4] This is connected to the increased importance of health promotion work in the development of national health policy. There is an understanding that health is related to quality of life, mental and physical capacity and well-being, and that each individual and the social settings in which we participate, are important factors for the promotion of health.

When we, in this document, speak of the health mission of the Church, we are including health promotion work, services for medical treatment, and care activities for the needy. That these are presented as one mission reflects an understanding that the health mission of the Church is both a divine and a public mission. This understanding is founded in the biblical presentation of health and healing, emphasizing that we are created to wholeness and relationships, and that the Church is called by the Lord to practice caring love of one's neighbor. This part of the mission corresponds to what, in English, often is referred to as the healing ministry of the Church, a formulation that makes explicit that these services have, as a focal point, to heal; in other words, to make life whole. At the same time, the health mission has a public aspect. The Church has a thousand year old tradition in cooperating with public authorities in this matter, and the population expects that the Church should play an active role in society, in particular within the health and social sector.

In other words: The Church is challenged to get involved, to an even greater degree than just a few decades ago. This is due to changes in society and what, today, is causing «unhealth». In the book *Helse på norsk* (TN[5]: Health in Norwegian), the authors refer to how hardship, cold, and hunger threatened the health of former generations. They suffered diseases that medical science today, to a large degree, knows how to treat. The authors claim that the threat today has moved to the

[4] «Public health work is the effort of society to influence factors that directly or indirectly promote the health and well being of the population, prevent mental and somatic disease, prevent injury or sufferings, or that protects against threats to health, and works to achieve a more equal distribution of factors that directly or indirectly influence health.» http://helsedirektoratet.no/folkehelse/folkehelsearbeid/sider/default.aspx.

[5] TN: Translator´s note: Translations of titles, names etc. by the translator. TN is used as an abbreviation for such translations in the text.

psychosocial life world, where people are struggling to «succeed in the competitive economy, to get recognition in the performance society, and to find closeness and community in the lonely society in order to realize oneself in the society of opportunities».[6] This is a fight where many are struggling and carry a heavy burden. This is part of the context where the health mission of the Church should find credible expressions.

Background and Process

The question of how the health mission of the Church should be understood in the world today has received particular attention in the *Contact Forum for Church and Health* (established in 2010). This forum gather professionals in the areas of health and diakona, a member of the Norwegian Parliament, a director from the Diakonia Leadership Forum, the Director of the Norwegian Association for Church Employers (Kirkens Arbeidsgiverorganisasjon), and the Director of the Church Council.

The work of this forum is based on two documents (report to the Department of Health from the Church Council and KA, 1999; and the Parliamentary White Paper, *Values in Norwegian Health Services*, 1999), and three yearly conferences involving participants from the higher echelon in the Church and national health services. The contact forum has been involved in developing the document, *Church and Health* and, in relationship to this, has arranged several seminars and meetings with leaders of diaconal institutions, deacons, hospital chaplains and professionals from different diaconal settings.

Several of the executive leaders of the largest diaconal institutions, through their stakeholder meetings in the Diakonia Leadership Forum, have been extensively involved in developing the ideology and profile of the diaconal institutions. They have explicitly asked for recognition from the Church of the health mission they have taken responsibility for on behalf of the Church

1.2. Overview of the Content of the Document

The following document consists of three parts with an introduction discussing the concept of health.

The first part has as a goal to present the theological foundation for the health mission of the Church. This is a presentation of how health and healing is understood in the Bible and how the Gospels tell about the miracles of Jesus. These texts are also discussed in light of the issue of their validity when interpreted today.

Further, it is described how the disciples understood the call to serve and how they practiced this call when providing for care of the sick and poor. There is a short presentation of how the call to serve has been practiced through the history of the Church and through to today. Here, the modern diaconal movement is presented, including a description of how it got a foothold in Norway from second half of 19th century.

The second part has as a theme the societal context within which the Church exercises its health mission. It starts with a presentation of the Norwegian welfare model, how health and care services are organized, and the role that diaconal service providers have within this model. There is a description of some of the challenges health-Norway is facing today, including trends that characterize the current health debate. Further, there is a presentation of several recently enacted health reforms, in particular those that challenge the Church and its health mission. The emergence of alternative and complementary medicine is explained, as is the development of more openness as related to the spiritual dimensions of health and, consequently, spiritual care. This part ends with a wider view of global health.

The third and last part has as a goal to make distinct the health mission of the Church based on the two earlier parts. The focus is both on the local congregation and diaconal institutions, on the multitude of resources that the Church already manages in this field and on the potential for more collaboration with partners, including those outside the Church. The call to serve consists of both words and deeds: words in the form of preaching, Christian education, critical presence in the public debate, and activities within a broad specter of services, from mobile activities in the local congregations to highly specialized health services.

The intention with all of this is to establish a broad platform that affirms that we as a Church share the vision of performing a health mission in the world.

[6] Per Fugelli og Benedikte Ingstad (2009): Helse på norsk. God helse slik folk ser det. Oslo: Gyldendal akademisk, s.227. (TN: Health in Norwegian. Good health, the way people see it).

Hopefully, this will inspire an effort to design joint strategies, more collaboration and above all, renewed commitment.

1.3. What do we Understand by Health?

Health is a popular theme, both in the public debate, as well as in everyday life. The tabloid press brings almost daily news and reports about what can promote or damage health. At times we see a tendency to present health as the most important of all values and thus the most important condition for a good life.

There exist many perceptions about health.[7] To some, health is foremost an issue of being healthy, as opposed to being sick. Given this understanding, health is a question of biomedical normality, often perceived as the condition of a human being when not having a diagnosis. Others perceive health in a wider sense. For them, health is about prosperity and well being, about quality of life in meaningful relationships - family, friends, neighbors and work colleagues.

The difference between the biomedical and the subjective perspective on health is often described by the two English words, *illness* (conveying the subjective experience of an ailment) and *disease* (pointing to a more exact and measureable ailment). Sometimes, there occurs a tension between the subjective perception of health, how healthy or sick a patient feels, and the biomedical assessment made by the doctor. A patient who feels unwell may be told by the doctor there is nothing wrong. That same distinction permits people who are chronically ill or suffering from a disability, to say that their health is good. In English, the word *sickness* is also used to say something about society's response to a disease, at times creating a sense of distance to what is considered «sick», with the consequence that people may be marginalized and excluded.

In the presentation of the Church' mission in this area, we will take into account ailment as *illness*, *disease* and *sickness* and will have as a perspective that it is important to pay attention to each of these in the practice of health and care work. At the same time, the Church will have as a primary concern to confirm the connected-

[7] John Gunnar Mæland (2009): Hva er helse? Oslo: Universitetsforlaget. (TN: What is health?)

ness between these dimensions, not the least in order to emphasize that each individual is subject to their own life and should not be reduced to a diagnosis.

The World Health Organization (WHO) has defined health in the following way: «Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity».[8] The definition has been criticized for promoting a utopian perception of health. How should health authorities approach the expectations this gives when transformed into actual health and care services? When do we experience «complete well-being»? The World Council of Churches has formulated an alternative definition of health: «Health is a dynamic state of wellbeing of the individual and the society; of physical, mental, spiritual, economic, political and social wellbeing; of being in harmony with each other, with the material environment and with God».[9] Here, several issues are included; it becomes clearer that health is something dynamic that is experienced in the relationships of people's lives, including the relationship to God. In this way, the theme of health is firmly connected to existential questions, to foundations of values and the concept of being human and to the expectations we have for happiness and the meaning of life.

The German-American theologian, Paul Tillich, claims that the life we live as human beings consist of a multitude of dimensions that together make a unity, and that these dimensions are mutually dependent (the multidimensional unity of life).[10] That means, for example, that mental illnesses often have physical and social consequences. It also means that the spiritual dimension could have an effect on physical and mental functioning, for better or worse. Strength in one area could lead to better coping in other areas. This is an important perspective to keep in mind when reflecting upon the health mission of the Church. This makes it possible to distinguish between being healed and being cured and, at the same time, see the relationship between the two.

Wherever the Church is engaged in health promoting work, the efforts will be characterized by the Christian view of being human that upholds both the human frailty and its greatness. This is the background for understanding health as something dynamic, in the tension between the presentation in the Bible of human beings as «dust» and at the same time created in the image of God. In the midst of this tension, the value of each person is ascertained as absolute and indisputable, regardless of social status and life situation. Dignity is not something that one must wrest or something that is a result of other people's friendly recognition. It is given by virtue of God's goodness. A mark of quality is put on each one created in the image of God. It is also important that this task is an asset: the Latin concept of *dignitas* that is connected with the understanding of the value of the human, could also be translated to capability. To confirm people's dignity means, therefore, to confirm their basic right and ability to master life and to live fully, in good and meaningful relationships.

The good life, *eudaimonia*, as it is called in the tradition from Aristotle, is in our time rewritten to human flourishing, that is, to flourish as a human being in a multitude of relationships and dimensions. This understanding is according to the Christian understanding of health. It means that that the health mission of the Church must be understood in a broader perspective as health promotion work, as help to coping with life, as medical treatment, and as care for the frail and sick. In all of these missions, the goal is to promote human dignity and quality of life, especially in contexts that require effort to struggle for these values.

[8] WHO 1948
[9] World Council of Churches, 1989.
[10] Paul Tillich (1963): Systematic Theology, volume 3. Chicago: University of Chicago Press, p. 12-17.

2. Theological perspectives on health and the health mission of the church

2.1. Health from a Biblical Perspective

The word «health», as it is used in health care today, is unknown in the biblical texts. Thus, it is no need to a Bible concordance to find out what the Bible has to say about this issue. We have to look for further contexts and, in particular, statements about what it means to be a human being and what gives quality to life.

Nevertheless, we find the word «health» used four times in the Norwegian Bible translation, each one occurring in the Old Testament, three of them in the Proverbs: «This (fear of God) will bring health to your body and nourishment to your bones (3,8); «For they (my words) are life to those who find them and health to a man's whole body (4,22); «A cheerful heart is good medicine, but a crushed spirit dries up the bones» (17,22). It is clear that these are words of wisdom, pointing towards the sources of the good life. The former Norwegian translation of 1978 uses «helsebot» (TN: «good for health») in the first two of these references, the English translation of the NIV[11] uses healing on these two occasions and good medicine in the third.

This shows that the focus of the biblical perspective is dynamic and holistic in a way that links it to the understanding of what it means to be a human being: On the one hand, humans are created from the dust of the earth and because of this are vulnerable; on the other hand, humans are created in the image of God, created to good relationships with the Creator, with fellow human beings, and with nature. It is in the tension between these basic dimensions that human beings are exposed to disease and pain, but at the same time experience the blessings of the good life. Humans know that to dust they will return (Ps. 90,3), but trust in God who «remembers that we are dust» (Ps. 103,14).

In the biblical sense, health means wholeness and wellbeing, and that all good relationships are intact. This is what lies in the word shalom that in our Bible is translated to «peace». We see this, for example, in the story about Josef when he asks his brothers about how his father is doing (Gen. 43,26). In this story, the Hebrew Bible uses *shalom*, whereas the Jewish translation to Greek (The Septuagint) uses «Is he healthy». The relationship to the extended family and to the immediate family is of fundamental importance.

The Norwegian word health also has a linguistic connection to that of being whole and to the processes that lead to wholeness (healing is another word for the same). This holistic perspective emphasizes that a human being is more than a body and that health therefore includes the mental, social and spiritual. At the same time, it does not undervalue that human beings are bodies. On the contrary, the Bible is clear in presenting the physicality of human beings as a basic condition of life. Thus, it is the body that most clearly tells us how we are doing. If anything happens to the body, other dimensions of the individual are also likely to be tipped out of equilibrium. Therefore, health is not perceived as static, but is conditioned through dynamic processes. These could be negative if a person lives in a way that leads to negative consequences. Sin could result in disease. In the Old Testament, the people of Israel are warned against violating the Commandments. Should they do so, then God would punish them through disease and illness (Lev. 26, 14-16, Deut. 28,22). At times, the impression is given that disease is always caused by sin or disobedience against the will of God. However, the picture is not clear-cut. The Bible also tells about people who have become ill without there being anything sinful about them; on the contrary, they are seeking comfort and help from God. Thus it is written: «The Lord will sustain him on his sickbed and restore him from his bed of illness» (Ps. 41,3). On the other hand, the Biblical view of human beings will always hold an acknowledgement that human weakness has the potential to harm relationships. This recognition

[11] *The New Revised Standard Version,* published 1989.

leads human beings to turn to God and ask for compassion. Compassion is shown through God´s forgiveness of sins; that is to say, broken relationships are restored, and the sick are healed (Ps. 103,3).

Therefore, a great deal of emphasis is placed on hindering and preventing disease (Exod. 15,26; Deut. 7,15). The 215 health regulations in the Law of Moses have as their goal to promote wellbeing and peace in accordance with the covenant of peace God made with his people: «Though the mountains be shaken and the hills be removed yet my unfailing love for you will not be shaken nor my covenant of peace be removed says the Lord, who has compassion on you» (Isa. 54,10).

Questions about wellbeing and health are therefore related to expectations about the care of God and salvation. This is the key message on the fourth occasion where the Norwegian Bible uses the word *health* (TN: In Norwegian «bringer helse»). The context is that the prophet portrays a vision he has received about the new time to come: «Fruit trees of all kinds will grow on both banks of the river. Their leaves will not wither, nor will their fruit fail. Every month they will bear, because the water from the sanctuary flows to them. Their fruit will serve for food and their leaves for healing» (Ezek. 47,12).

In the poetic literature, the theme of body and health is a recurrent theme. Gratitude and joy to God who has raised people up from disease and misery is expressed in songs of praise and worship. In lamentations, people describe their distress and despair. There is no cover up or rationalization of the distress. Typical for the tradition of lamentations is a detailed description of the distress and the insistence that our entire world of experiences is a concern of God. Questions related to body and health has always been important in people's religiosity. Changes in body and health as related to the process of aging are also described poetically (Eccles. 12, 1-8).

The stories about Jesus in the New Testament are presented as the fulfillment of this promise of food and health. This will be dealt with more extensively in the next chapter. Here we wish to state that the Gospel reflects the Jewish understanding of health as holistic and dynamic, although it is now presented in Greek language. The common Greek word for health, *hygieia*, is not used in the New Testament; on the other hand, the verb *hygianein* (to get well or to recover) and the adjective *hygies* (recovered) are used, as when Jesus asks the invalid at the pool of Bethesda, «Do you want to get well?» (John 5,7). When these words have been used, it can be in relationship to the «getting well» of separate body parts or of the whole person (Matt. 15, 31; Act 4,10). The greeting of peace in 3 John, 2 makes it clear that this is about wholeness, wellbeing and relationships; «Dear friend, I pray that you may enjoy good health and that all may go well with you, even as your soul is getting along well».

In the broadest sense, health involves being included in the context social context of life as well as to partake in faith, hope and love. Thus, there is no coincidence that the last book of the Bible, Revelations of John, ends in a manner that resembles the vision of the prophet Ezekiel, but in this case with reference to «The throne of God and the Lamb», where the leaves on the tree of life are «for the healing of the nations» (Rev. 22, 1-2). Statements like these reflect the biblical view of man in their emphasis that health is about wholeness and relationships. This is an important perspective to include in the health mission of the Church. It can contribute to an extended, but also more realistic, understanding of health. In our dealings with the concept of health, there must be room for both good and bad days, for the belief that it is possible to master life, and that wellbeing and wellness are possible, even when everything is not perfect. From this perspective, health is perceived as a gift and is therefore meant for enjoyment. At the same time, it provides us with a view of health as something we are responsible for preserving and promoting, knowing that the gift of life is more than good health.

2.2. Healing from a Biblical Perspective

Just as the Bible understands health from a holistic and relational perspective, healing is also presented as a process that restores coherence and wholeness. Therefore, being sick is about more that being stricken by a distinct disease that can be defined by the help of a diagnosis. Equally important is the subjective experience of pain as well as the experience of physical, mental, social and spiritual incapacitation.

The words used in the Bible to describe sickness and disease focus on the conditions of the sick and the consequences of the illnesses, rather than on the diagnosis itself. In the New Testament there are a variety different words that in Norwegian are translated to the Norwegian word for «sickness». The Greek concepts point in the direction of what it implies to be sick: wound or injury (Greek: nosos - Matt. 4,24), affliction (Greek: *basanos* - Matt. 4,24), fatigue (Greek: *asteneia* - Luke 13,11) and weakness (Greek: *arrostos* - Matt. 14,14).

Healing is bringing to wholeness again what the disease has caused of wound and injury. In the same way that the writers of the Bible relate health and wellbeing to God, trusting in God's care, they also connect expectations of healing to God: «For I am the Lord, who heals you» (Exod. 15, 26). The former Norwegian translation, from 1978, reads, «For I, the Lord, am your doctor?» in line with Luther's translation to German in the 15th century. This translation could give the readers the impression that God is the doctor to whom the believers should relate and that there is no need to consult other doctors. That would have been an error; furthermore, the translation is not precise. The Hebrew word that is used here (*refusha* of the verb *rafa*) means to remedy, to sew together and to make whole. The image of God that heals brings one´s thoughts not in the direction of a miracle doctor making other doctors superfluous, but of a compassionate Creator who gives vitality to the sick in order for them to again become whole.

Does this also imply physical healing? There is no doubt that people believed that God could bring an end to physical ailments. Nevertheless, there are surprisingly few stories about this type of healing in the Old Testament. The four best-known stories are all rendered in Kings and are connected to the activities of the Prophets. The first two stories are about the dead being awakened: Elijah and the widow's son (1 Kings 17, 17-24), and Elisha and the son of the Shunammites's woman (2 Kings 4, 8-37). In addition, we have the story of Elisha and of Naaman who had leprosy. Naaman was sent away with the greeting «Go in peace» (2 Kings 5, 1-19). There is also a story about Isaiah and King Hezekiah (2 Kings 20, 1-7), told in Isaiah 38.

In all these texts the emphasis is as much on the relational and holistic as on the physical. The Prophet´s ability to heal comes as a result of being sent by God. Thus, the Naaman King of Aram confesses: «Now I know that there is no God in all the world except in Israel». (2 Kings 5,15). The same attitude is expressed in the Psalms when it is said, «Oh Lord my God I called to you for help and you healed me. Oh Lord you brought me up from the grave, you spared me from going down into the pit» (Ps. 30, 2-3). God is the God of life, the Creator that gives life and who restores life and who delivers from the forces of death.

It invokes the fear of God: «But for you who revere my name, the sun of righteousness will rise with healing in

its wings» (Mal. 4,2). That leads Jeremiah to ask if God has rejected his people when it they are exposed to hunger and disease: «Why have you afflicted us so that we cannot be healed?» (Jer.14, 19). Does that mean that sin and disobedience are causing people to become sick? This is a question that is repeated throughout the Old Testament, a question we encounter again in the story of Jesus' meeting with the blind man when the disciples ask, «Who sinned, this man or his parents, that he was born blind?» Jesus categorically rejects this way of thinking when he says, «Neither this man nor his parents sinned» (John 9, 2-3). For Jesus, the story of man who was born blind is not an illustration of what sin can lead to, but rather is a sign of the salvation he was sent to deliver; «But this happened so that the work of God might be displayed in his life. As long as it is day, we must do the work of him who sent me». This statement can be read as a call to refrain from judging why some are affected by disease and sufferings, and rather as a call to become a part of the greater «we» of Jesus´ disciples who show compassion and do such deeds that Jesus was sent to perform.

Healing of the sick has a prominent place in the practice of Jesus as presented in the Gospels. Its prominence can be seen in the sheer volume of stories related to healing in Matthew and Mark (40%). In Luke the volume is 35% and in John, 33%. All together, 26 stories are about individuals being healed. More than half of these stories are told in the three first Gospels. In 17 cases, the stories tell about healing from physical afflictions, 6 refer to deliverance from demons, and 3 tell about awakening of dead. In addition, there are 12 collections of stories such as this one in Matthew: «Jesus went through all the towns and villages, teaching in their synagogues, preaching the good news of the kingdom and healing every disease and sickness» (Matt. 9, 35).

There is reason to assume that Jesus was perceived as a folk healer similar to others common to his time. These «healers» were lay healers and were therefore different from the doctors (Greek: *iatros* – Mark 5,26) who belonged to a higher social class. The art of medicine at that time, especially that based on Greek and Hellenistic background, was closer to philosophy. The doctor would teach about diseases and how they could be treated. The doctor did not touch the patient, but rather could use a slave to treat the patient. This slave was the guilty party if the treatment failed. The *folk healers* however, touched their patients, opening for the risk of becoming unclean. Jesus, too, behaves in this way. He lays hands on the sick (Luke 4,40: 22,51), both on his own initiative and when he is asked to do so (Mark 6,56). He uses spit in the healing of both a deaf-mute man (Mark 7,33) and in the healing of a blind man (Mark 8,23). This common, everyday side of the healings of Jesus did not attract much attention. On the other hand, the things that he said and the fact that he healed on the Sabbath, did attract attention.

This is illustrated in the story of the healing of the paralytic man who was lowered by his four friends from the roof of the house to the place where Jesus was standing (Matt. 9,1-8; Mark 2, 1-2; Luke 5, 17-26). It attracts attention when Jesus tells the paralytic that his sins are forgiven and then asks the man to get up, take his mat and go home. «We have never seen anything like this!» exclaim those who were spectators to the event.

Should this be understood that disease is a result of sin and that forgiveness is a prerequisite for healing? Would this not be contrary to what Jesus said in his encounter with the man who was born blind? Not necessarily. What Jesus rejects is a direct cause-effect interpretation that strikes the man who was born blind as an individual and that justifies religious and social sanctions against him. This does not prevent Jesus from interpreting disease and disability according to the understanding of his own time as an expression of the power of evil and sin over man. Thus, to heal means to be set free from the domination of evil and from the sinful sphere it brings upon man. Disease and disability are not perceived as a diagnosis, but rather as a metaphysical condition that excludes the person from both the religious and social community.

This understanding of healing is expressed through the words that are used. The story of the woman who suffered from bleeding for 12 years, said to herself, as she approached Jesus, «If I only touch his cloak, I will be healed» (Matt. 9, 21). The Greek word soozein that is used here is translated in Norwegian as «get well», but in English is translated as «be healed»; it could as well have been translated to «become whole» or «be saved». This we see in the continuation of the story. Jesus uses the same verb when he addresses the woman, but this time the Bible translators have chosen to translate

differently by writing; «Your faith has saved you» (Matt. 9,22)

There is a similar way of thinking that underlies the statements of lepers who have been cleansed (Greek: *katharizein*- Matt. 8,2), a word that Paul uses in a broad sense about being purified «from everything that contaminates the body and spirit» (2 Cor. 7,1). Another word Paul uses is to «be released» or to «be set free» (Greek: *apolyein*). In his encounter with the crippled woman, Jesus says, «Woman, you are set free from your infirmity» (Luke 13,12).

This holistic perspective is also included in the use of two other Greek words meaning ¨to heal¨ (Greek: *iaomai and therapevein*). For example, we find the first one in the story of the woman mentioned above when she touched the cloak of Jesus; «She felt in her body that she was freed from her suffering» (Mark 5,29). Her suffering included much more that the physical: the bleeding had made her unclean both socially and religiously. It was a pain she had carried for 12 years. Nor does the other verb, the one that we recognize as the modern-day word, «therapy», limit itself to what we perceive as medical treatment. This we see, for example, in the story of the boy with the demon, where Jesus makes it clear that it is his spiritual authority that forces the demon to leave the boy in peace (Matt. 17,18).

When we read these Biblical stories about healing today, a fundamental problem is revealed. What Matthew describes as a boy with a demon, would likely today be perceived as a case of epilepsy. In modern medicine, we speak of diagnoses about physical and mental diseases. We do not interprete these illnesses metaphysically; that is to say, we do not interpret them within the framework of supernatural phenomena as was done in the time of Jesus, but rather within the framework of medical knowledge and the possibilities for treatment that are available within this body of knowledge.

How are we to understand these stories today? Does it give meaning to read and interpret these stories based on a modern perspective of disease and treatment? Teachers and preachers in particular experience this to be a demanding task. On the one hand, it is unreasonable to expect the audience of today to share the understanding of disease and healing that was prevalent in antiquity. Our horizon of interpretation is shaped by modern science with it´s extensive knowledge of both why people become ill and of how to treat diseases. Christian teachers and preachers cannot put this aside. On the other hand, it is not reasonable for us to restrict the stories to the spiritual aspects of disease or to limit the stories to telling about man's relationship to God. The stories do indeed tell about human suffering (physical, mental and social), and about humans who receive help in their distress. Jesus of the Gospels cares about these human beings; he sets them free from that which binds them and gives their life a new beginning.

What is the validity of this message today?

The first point that can be held as valid is that when we interprete a story about healing, God cares about the whole human being, not just the spirit or the soul. This must have consequences for the health care mission of the Church. Throughout the history of the Church, God´s caring for the person as a whole has been an inspiration to serve the sick and helpless. We will look more closely at this in the next chapter. At times, a spiritualized understanding of Christianity has led to a weakening of this tradition. It may appear at times that the Church has distanced itself from the issues of health and wellbeing, issues about which the Church should be concerned and to which it is called. The stories of Jesus meeting sick and marginalized people challenge us as a Church, not the least the local congregations, to have an eye out for people who are struck by disease and grief, and to show our caring through concrete diaconal activities.

The story of Jesus casting out demons can also be interpreted within this framework. At that time, people believed that they were surrounded by a dangerous world of demons and that demons could inhabit human beings. Even today there are people who believe this, and some Churches have rituals to cast out demons.

This is often related to people with mental disorders, disorders that we understand in quite another way and for which we have other possibilities for treatment than at the time of Jesus. We now know that people with mental disorders can be exposed to even more suffering if they are labeled as being possessed by demons. The Gospels understanding of reality takes as a given that demons exist and that they can be hurtful to individuals. The main message in the stories of the Gospels is

not to give reasons for believing in demons, but rather to proclaim that the forces of evil, regardless of how we perceive them, are subject to the mighty rule of Jesus. They have been cast out. This happens as a result of the appearance of Jesus in the midst of the brutal everyday life where people are affected. That Jesus is casting out demons can be interpreted as liberation from all the incomprehensibilities we feel can threaten us, and from the prejudice and stigmatization towards those who are suffering. We don't need to be educated about demons in order to see the relevance of these stories today. These stories challenge us to have faith in Jesus and in his power of salvation in the midst of all human misery. Further, they challenge us to follow his example by showing care for people that have been overpowered by forces they are not able to control.

The second point that can be held valid is that these stories about healing allow us see illness and suffering as multifaceted. People experience that they fall short and that they become isolated and that they need help to cope with life when they become ill. Care and solidarity may have a healing effect on many people, as was expressed by an African woman when her friends from a women's group came on a home visit when she said, «I was healed, even if I was not cured».

This holistic perspective brings us to the third point, that the stories of healing have a critical undertone because they reveal prejudices and discriminatory practices. Jesus faced opposition from the religious establishment when he was criticized because he healed on the Sabbath. The order of religious life was considered more important than people's sufferings. When Jesus heals it reveals his prophetic mission of restoring the right of the weak and marginalized and to defend their dignity and place in the community.

Thus, the Gospels claim that the stories of healing is connected to Jesus' preaching of the kingdom of God. This is the fourth point in understanding these stories. In this respect, His wonders are unique and are an expression of the messianic authority He has been given by his Heavenly Father. Jesus is sent by God and, as such, represents God's unique power of creation and will for salvation. This is what is illustrated by the stories and what the Prophecy has promised as reflected in Luke 4, 18-19; «He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to release the oppressed, to proclaim the year of the Lord's favor». A sign of this new reality that Jesus brings to us is the story of the man by the pool of Bethesda who, after having been sick for 38 years, could readily stand up and walk away (John 5, 1-9). It is only Jesus who can do this. At the same time it is a sign wherein the kingdom of God is brought close to us through preaching and diaconal service that witnesses to the victory of life over the forces of death.

2.3 The Mission of the Disciples

It is clear that the Gospels present the healing acts of Jesus as unique and connected to his messianic authority to set people free from the ties of sin and evil. It is equally clear that Jesus hands over this mission to the disciples as an integral part of their call in the world. «He called his twelve disciples to him and gave them authority to drive out evil spirits and to heal every disease and sickness», Matthew tells us and adds that they were sent out with clear instructions to, «Go and preach: The kingdom of heaven is near! ´Heal the sick, raise the dead, cleanse those who have leprosy, drive out demons. Freely you have received freely you give» (Matt. 10, 1-8; Mark 6, 7-13; Luke 9, 1-6). Luke has an additional story about 72 disciples who were sent out two and two (Luke 10, 1-12).

The stories in Acts show that the first Christians took this mission seriously. Here it tells about the sick who were healed (Acts 3, 1-10; 9, 32-35; 14, 8-11; 28, 8-9), of driving out demons (16, 16-18) and of the dead who were awakened to life (9, 36-42; 20, 9-12). The readers should be aware that the «new time» that Jesus brought with him, continues also after He ended His life on earth: The apostles carried out «wonders and miraculous signs» (2,43; 5,12; 6,8) that above all witnessed to the Lord's presence and care (14,3). Paul denies categorically being perceived as a miracle man when the spectators who had witnessed him healing a sick person, began fantasizing that Paul and his companions were gods who had turned into human beings: «We too are only men, human like you» (14,15). It is the Gospel and God's generosity that allows those who are powerless to rise up again.

Therefore, Paul talks about the gift of healing (*charismata iamaton*) when he answers questions from the

congregation in Corinth, where some clearly had the idea that this was a supernatural art of miracle making that one could acquire (1 Cor. 12). First, this is about a gift, and it is the giver that makes it effective. Secondly, it is an expression of the grace of God, wherein people can experience that God cares about the sick and the suffering. It is for their sake that some have been given the gift of healing.

God gives the gift of healing to whomever God wishes. However, it is necessary that the congregation organizes itself so there is room for this gift of grace. In the letter of James this is presented as a task for which the elders (leaders) have a special responsibility, that is, that they should visit, anoint and pray for the sick (James 5, 13-18). Both here and in other places in the New Testament an impression may be given that sickness comes from disorder in the congregation. For example, Paul suggests that a believer who attends communion without recognizing that he is receiving the body of the Lord, «eats and drinks judgment on himself», claiming, «that is why many among you are weak and sick and a number of you have fallen asleep» (1 Cor. 11,30). This is not to be understood as a cause and effect between sin and sickness, but as encouragement to fully live the life of faith. Paul knows well that not everybody who is sick will be healed. He himself has a «thorne in my flesh» to remind him not to become conceited, and instead to put his trust in God's grace and to the power that «is made perfect in weakness» (2 Cor. 12, 7-10). As we have seen, the Greek concept asteneia that is translated here as «weakness» is also used about being sick. There is, therefore, no contradiction between sickness and the experience of joy and strength.

To be whole, or if we choose the concept of our time, «health», in it´s widest sense, is therefore about maturing in faith and wisdom (Col. 1,28; Eph. 4,13). Paul expresses something similar when he asks God to bless the congregation in Thessaloniki: «May God himself, the God of peace, sanctify you through and through. May your whole spirit, soul and body be kept blameless at the coming of our Lord Jesus Christ. The one who calls you is faithful and he will do it» (1 Thess. 5, 23-24).

2.4 The Healing Ministry of the Church

We have seen that healing was an important aspect of Jesus' ministry and also an integral part of the mission he further gave to the disciples. Ever since, this ministry has been part of the Church, from the first congregations that grew as a result of the missionary work of Paul and others and until today. In English, this is called the *healing ministry of the Church*, a wording that is not easily translated into Norwegian because «healing» could be understood as supernatural and spectacular and therefore many would understand this as a problematic concept. Some also associate *healing* with communities that want to be seen as alternative health services (as opposed to modern medical services), or to faith communities with preachers who promise healing if one believes strongly enough. Thus, the New-Norwegian word «heiling» will function better, because it refers to making whole that which has been damaged.[12]

It seems that the holistic understanding of healing that is fundamental in the Bible, is more easily conveyed in the English language than in Norwegian. At the same time, using the concept of *ministry* implies that this is a permanent mission, one that is grounded in the Gospel of Jesus Christ, in such a way that it demands structure and roles. *Ministerium*, the root for the word *ministry*, is the translation to Latin of the Greek word *diakonia* as found in the New Testament. It refers to Jesus' diaconal ministry and to the ministry of the Apostles (2 Cor. 3,6), but also to a defined ministry in the congregation (Acts 6, 1-6; 1 Tim. 3, 8-13).

In the early Church, the healing ministry of the Church was expressed primarily through hospitality and visitation services. The lonely and the needy were included in the community of the congregation. They were taken care of and given their righteous place as valuable limbs of the body. Both deacons and widows had important functions. None was so poor that they were not accommodated at the table, with food for both body and soul, and at the table their equality as brothers and sisters in faith was confirmed. Therefore, it is no coincidence that hospitality is emphasized as a Christian virtue, both in the everyday life of the congregation (Rom. 12,13; Heb. 13,2) and as a quality in the recruitment of a leader (1 Tim. 3,2).

[12] TN:There are two official written Norwegian languages called «bokmål» and «nynorsk» (nynorsk translated here to New Norwegian).

Visitation services were equally important. The deacon brought food from the communal meal to the sick and to those who could not attend. In this manner, they continued to be a part of the community. This care did not only include the congregation's own members, but all those who suffered. During times with plagues, it attracted attention that Christians were caring for the sick and making sure that the dead were given a dignified burial without regard for their own health.

The parable of compassionate care for the hungry, the thirsty, the naked, strangers, the imprisoned and the sick, and the importance of such behavior on Judgment Day (Matt. 25, 31-46) and in other bible stories, came to shape Christian faith and service to those in need. While people in antiquity placed the sick and needy at the periphery of society, the Christians claimed through preaching and practice that all human beings have the same value and are equally loved by God, regardless of life destiny. They also claimed that Christ identified with the marginalized; to care about the sick was to care about Christ. After a time, this Christian view of human beings came to permeate the entire society, and it contributed to a new understanding of disease and other disorders.

An expression of this new understanding was the establishment of guesthouses for the sick (hospitals) and homes for orphans. This marked the beginning of what we today call institutional diakonia. When we reach the Middle Ages, it was primarily the monasteries that took on the task of giving shelter to the homeless, the old and the sick.[13] Especially well known is the Order of St. John of Jerusalem that in the 12th century built a hospital in Jerusalem. All those who were sick were cared for here, regardless of faith. The Norwegian king Sverre Sigurdsson arranged for the Order of St. John to come to Norway and, around the year 1180, the Værne monastery south of Oslo was established; this was most likely the first hospital in Norway.

The monastery hospital was often built in close proximity to the Church building, making it easy for the patients to be in close contact with the religious services. The healing ministry of the Church was holistic. It included body, mind, soul and fellowship in the community. This was in accordance with the Church fathers' presentation of Christ as a doctor (Christus medicus), a perception that is often mirrored in the religious artwork of the Church in that period.

The Church fathers called for sobriety in the understanding of healing. Origenes (approx. 184-253) makes it clear that healing cannot be used as theological evidence and that curing the sick is not divine in and of itself. Therefore, Christians should not think that they are the only ones given the task of caring for others or that the Church is given a privileged role as healer. Nevertheless, this is an indisputable mission given to the Church, not for the sake of the Church, but for our fellow man who is in need.

This was also a major concern for Martin Luther who claimed that secular authorities had the primary responsibility for the welfare of the sick and poor. Luther built his understanding on theological reasoning: First, that the care of human beings in need should be carried out for the sake of our neighbor and not out of religious motives (for example, to do meritorious deeds for God). This would be to reduce our neighbor to an instrument in striving for our own salvation. Luther also had another important concern: All Christians are called to serve God, but the call is to a place in this world, to the best for our neighbor, and not inside a religious order as had been the customary way of thinking. Based on this way of thinking, the sovereign and the city council had a special call encompassing responsibility for the welfare of everyone.

At the time of Luther the entire population was part of the Church. Everybody was expected to attend Church services and to be preached to about what it meant to be called by God, whether one was a nobleman or ordinary citizen. With time, the distinction between congregation and society became clearer. The period of Enlightenment played an important part in contributing to this development.

This made it more difficult to claim that the responsibility of the Church for healing could be realized only through individual Christians call to the world, and through the political leaders and arrangements for which they took responsibility. A consequence of this would be that the congregation as community abandons it's diaconal and health related mission. The understanding of the congregation as a community gathered around preaching and sacraments gives the impression

[13] Olav Helge Angell (2001): *Omsorg i mellomalderhospitalet.* (TN: Hospital Care in the Middle Ages). In K.W. Ruyter & A.J. Vetlesen (red.): *Omsorgens tvetydighet: egenart, histoire og praksis.* Oslo: Gyldendal akademisk, p. 128-158.

of the Church as primarily being related to the ministry of the clergy. This, in turn, could give an impression of the congregation as a passive recipient of Church services and a perception of the Church as providing limited action space for the congregation to realize the common call to serve the world, as well as limiting diaconal activities in charge of the congregation. In many ways Lutheran orthodoxy was dominated by this understanding of the Church, and we notice traces of this well into our own time.

Many in the Church experienced the beginning of 19th century as a time of crisis. On the one hand, this period was characterized by enormous misery as a result of the Napoleonic Wars and social disintegration due to industrialization and urbanization. On the other hand, there was reduced support for the Church and an emergence of ideas critical of the Church. However, this crisis also proved to be an opportunity for reorientation and action. It is in this context that the modern diaconal movement emerged through the establishment of houses for deaconesses and deacons beginning in the 1830s. Here, women and men were educated to become nurses and social workers, and a number of diaconal institutions were founded, first in Germany, and then in other countries. Everywhere, the diaconal movement came to play a pioneer role in the development of modern health care and social services. Equally important, the movement took upon itself the role of renewing the healing ministry of the Church, adapted it to the modern challenges and opportunities for action and, not the least, gave women the opportunity to realize their call in Church and society.

In 1868, Diakonissehuset Lovisenberg was established in Oslo as a motherhouse for deaconesses. It became a powerful impulse for the development of modern nursing and medical treatment in Norway and in confirming the role of the Church in caring for the sick and needy. Diakonhjemmet was established in 1890 as a house for male deacons. Here, the deacons received an education that made them qualified both as nurses and social workers. This introduced a new era in the healing ministry of the Church in Norway. However, it would be incorrect to assume that the Church of Norway, prior to this, had not acknowledged this ministry. For centuries, caring for the sick and poor had been an integral part of the ministry of the Church. Already in 1277, Church leaders took an initiative to establish Trondheim Hospital, an institution that is still operating today. Similar institutions were established in other towns; for example, Oslo Hospital was originally part of a Franciscan monastery that was built around 1290. After the reformation in Denmark-Norway the pastors and deacon (called degn in Danish), received the public responsibility to look after the sick and marginalized. In some places, citizens initiated the establishment of orphanages as, for example, in the city of Trondheim where Tomas Angell, in the middle of the 18th century spent a large part of his fortune on what we today call diaconal activities. A hundred years later, many congregations across Norway started building nursing homes, the Inner Mission movement established institutions for marginalized people, and free Churches, having by then arrived in Norway, initiated different types of health and social welfare institutions.

The centennial celebration of the Norwegian Constitution in 1914 was marked with a grand exhibition at Frogner Park in Oslo. On this occasion, a thorough study of Norwegian Church life was completed. Among other things, the diaconal activities of congregations were registered. The numbers showed an extensive engagement, in particular with respect to services directed towards the elderly, those suffering from alcohol addiction and for disadvantaged children. This engagement mobilized many volunteers. It contributed also to the development of a diversity of non-governmental organizations and the establishment of non-profit foundations. For example, only a few years following its establishment in 1908, Blue Cross could report that they had 10.000 members nationwide. It can safely be said that the healing ministry represent a rich tradition in our Church. It constitutes a rich heritage that it is important to responsibly administer in our time.

3. Today´s situation as context for the health mission of the Church

3.1 The welfare state as framework for the health mission of the Church

The first building blocks for the development of Norway as a modern welfare state were laid down in the 1930s, with public welfare regulations securing the health care and social services for the entire population. A characteristic of our welfare model is that the regulations are statutory. The welfare model is built on three basic principles: First, it is universal, all citizens have the same right to the welfare services, independent of social status and economic means. Secondly, it is financed through public budgets and not through individual health insurance as is the case in many other countries. Thirdly, governmental agencies, that is to say state and municipality, have the responsibility of organizing health care and social services.[14]

The third principle had far reaching consequences for diaconal and other volunteer organizations. Many perceived that their time was over and that the tasks they for a long time had taken on now would be transferred to public sector. This would apply to institutions like homes for elderly, as well as to services organized by local congregations such as parish nursing. The parish nurse and deacon provided health care service of a holistic nature. In addition to home-based nursing, this could include public nursing and home help services, contact with a wide network of social support agencies, and important activities in the area of general public health and hygiene. When the *Municipal Health Service Act* came in 1984, and the municipalities started to organize home nursing and other home based services, the health work of parish nurses and deacons was perceived as redundant and was discontinued most places. While there were 262 parish nurses registered in 1967, the numbers had fallen to 235 in 1975, and by 1985 the numbers were reduced to 90.

Within the Church there were different opinions regarding the welfare state.[15] Bishop Eivind Berggrav was one of the sharpest critics; he feared that this would give the state almost totalitarian control over people's health and welfare. The question was also raised as to the state's ability to show loving care for those suffering. Would the state, for example, understand people's spiritual needs?

Others welcomed the welfare state. In particular, this was the case for people involved in diaconal work. They knew how important it was to secure rights-based services for people who were sick and in vulnerable life situations, and that it was crucial that the government take responsibility for organizing health and care services. At the same time, they also asserted that there must be room for the involvement of diaconal actors, ideally in constructive collaboration with government.

So it came to be. A number of diaconal institutions were given contracts with the state and municipality and were able to continue with their work. The contracts secured access to public funding. A study from 1986 shows that 244 Christian or Church based institutions were operational, and together they represented 10 % of

[14] This welfare model is often presented as the Nordic model. In other European countries Church and non-governmental service agencies have a more central role, and the financing is often through individual health insurance (for example in Germany).

[15] Aud V. Tønnesen (2000), «… *et trygt og godt hjem for alle»? Kirkelederes kritikk av velferdsstaten etter 1945.* Trondheim: Tapir Akademisk Forlag. (TN: «… a safe and good home for everybody»? Church leaders critique of the welfare state after 1945)

the institutional services, measured by client beds, in the health and care sector.[16] Most activity was in care for the elderly, where almost 45 % of all the beds in diaconal institutions were in homes for the elderly and nursing homes, providing 10 % of total services in this sector. Another important sector was treatment and rehabilitation of alcohol and drug addictions. Here, 60 % of the total institutional capacity was operated by Christian institutions. A third important area was in the care of the mentally disabled, where 18 Christian institutions were operational, providing more than one thousand client beds. At the end of 1950s, diocesan councils and congregations established the Church Family Counseling Services. Later, this became a statutory service. Today, approximately 30% of all family counseling offices are Church related.

The introduction of the so-called HVPU- reform[17] in 1991 resulted in the closing of many diaconal institutions. Others were not able to keep up with the new governmental requirements regarding professional staffing and modern building facilities. A new study from 1997 showed that the number of diaconal institutions was reduced from 244 in 1984 to 156 in 1997. The number of institutional beds was reduced from 9.900 to 5.634 within the same time period. The reduction was most noticeable in nursing care and care giving, with a reduction from 4.500 to 2.602 beds.[18]

Most of these institutions (114 in 1984 and 77 in 1997) were run by organizations or foundations within the Norwegian Church. The greatest reduction was in the number of institutions run by local congregations (46 in 1984 to 22 in 1997). Also, institutions belonging to the free Churches such as the Salvation Army and the Pentecostal Church, represented an important group (59 in 1984 and 54 in 1997).

These numbers show that it has not been easy for diaconal institutions to survive within the framework of the welfare state. It has been a challenge for them to adjust to the demands from the government regarding professional practice, especially when this was interpreted as a requirement to soften the religious profile. Gradually, this led to a discussion about whether the adjustments were too extreme and whether the diaconal institutions were loosing their characteristic profile. The question was raised as to whether there was any difference between a public and a diaconal hospital. If not, why should the diaconal institutions continue as owners with all the demands and risks involved?

From the 1990s, the discourse regarding the characteristic profile of the diaconal institutions took a new and more positive turn. During this time, the importance of values also became a focus of discussion within public health care. A dialogue was established, beginning in 1996, between the Ministry of Health and Care, the Association of Church Employers (KA), and the Church Council with the purpose of discussing how the health services and Church together could take on the present health challenges. In 1999, this was presented in a report to the Ministry of Health and Care. The report described areas of on-going collaboration and identified areas where collaboration could be extended. The White Paper entitled, *On Values for Norwegian Health Care*, was presented in December of the same year, giving recognition to the Church and diakonia for their contribution to the development of health care services:

From ancient time the Church has had a central role in providing help to the sick. Historically, diaconal activities preceded pure health care services in many areas, both nationally and internationally, as a provider of preventative medical services, treatment, care and, not the least, education.[19]

In the continuation of this statement, the White Paper announced that «The Ministry aims at continuing this work in order to identify good collaboration between diakonia and the public health and care services.[20]

However, this positive trend in the area of ideology was balanced by a corresponding negative trend on a practical level, in particular when it came to new requirements for providing services. Inspired by New Public Management, new methods for modernizing and for making public services more effective brought with them new demands for the providers of health services. Some of the diaconal service providers were required to meet the same conditions as other commercial and for–profit businesses that had emerged in the health and care sector. When competitive bidding was introduced for nursing and home care services, the diaconal providers lost a number of contracts in the bidding process. At times, it was quite a challenge for diaconal providers to cut costs and to make their operation more

[16] Olav Helge Angell Nordeng (1987), *Institusjonsdiakoni i Noreg. Omfanget av kristne institusjonar i helse- og sosialsektoren.* Forskningsrapport 22, Oslo: Diakonhjemmets sosialhøgskole. (TN: Institutional diakonia in Norway. The extention of Christian institutions in health and social sector).
[17] TN: HVPU, short form of health care for the mentally disabled
[18] Olav Helge Angell (2000): *Kyrkjeleg forankra institusjonsverksemd i helse- og sosialsektoren. Institusjonsdiakoni i Noreg.* Oslo: Diakonhjemmets høgskolesenter, Forskningsavdelinga (TN: Church based institutions in health and care sector. Institutional diakonia in Norway).
[19] Det kongelege sosial- og helsedepartement, St.meld. nr. 26 (1999-2000), *Om verdiar for den norske helsetenesta,* s. 32. (TN: Ministry of Health and Care: On values for Norwegian health and care services).
[20] Ibid., p.33.

effective, but there was also the ethical question of how much consideration should be paid to quality and well-being, both for users and employees. The question was raised as to whether a non-profit provider with the ambition of delivering holistic care could possibly exist within the new guidelines for public administration and management.

As outlined, the Norwegian welfare state presented a number of challenges to the Church's health mission. Nevertheless, a large number of diaconal institutions managed to adjust to the new requirements, and they still play an important role in health and care services, on the whole in good collaboration with public authorities. In this role, they often receive positive recognition for their work, especially from the users of their services. Surveys show that the public image of the diaconal institutions is good, and people value their characteristic profile, in spite of the fact that people are not always able to say clearly what it is they experience. People often say, «There is a feeling, an atmosphere, that comes with the place»; it is something that is expressed through the friendliness and dignified care that is provided in these institutions.

The introduction of the welfare state had an even greater impact on the congregations. The local engagement for the sick and poor that for centuries had been an obvious task for congregational life and structure, was now sometimes perceived as superfluous. But could the congregations give up their diaconal mission and health ministry? In the 1970s there was a movement from parish nursing toward diakonia in the Norwegian Church. With this followed a discussion about the aim of the diaconal mission in our time and in a society characterized by well-developed health and care services. In 1985, the *Act of Diaconal Ministry in the Norwegian Church* came with the purpose of «promoting the Church's care for our neighbor and strengthening the work of the congregations in preventing and relieving human suffering». In the years following, plans for diakonia were developed, both locally and nationally. This contributed to new diaconal practices and new experiences that together have formed a more adequate groundwork for a stronger health-promoting engagement vis a vis todays challenges in health-Norway.

3.2 Health and Care Services under Pressure

The public health service in Norway has been extensively developed over the last decades, and there is no question that it is one of the best in the world. In 2012, Norway spent approximately USD 35 billion for health and care purposes, 85% of which was covered by public funding. This is approximately USD 7,500 per capita, more than in any other European country. This demands huge resources, both in term of human capital and economic capital. Many doubt that it will be possible to maintain this level of service in the future. The media constantly reports problems, tells of systems that are not functioning as hoped, and profiles people who have not received the treatment to which they are entitled. What happened if I have a serious diagnosis and have to wait for months before receiving treatment? The waiting time for patients, especially cancer patients, can be extremely stressful both physically and mentally.

Reports and stories such as these create an impression that health-Norway is in crisis. This can lead to a loss of confidence in the public health services to such a degree that it puts pressure on the government to initiate reforms.

Although this picture often dominates the public debate, very many patients do tell about positive experiences in their encounter with the public health services. They have received good treatment, they have recovered, they have received help to cope with their disease, they have been shown care, and they have experienced being taken seriously as a whole person. There is every reason to confirm and acknowledge this, not least the effort of all the competent and dedicated health workers. A significant number of these health care workers have received their education from Christian teaching institutions, and many of these view their work as a vocation in light of their Christian faith and ministry. Through their vocational practice they contribute to the realization of the Church's health mission, even when working in the state or municipal health and care services.

In spite of all good efforts, there is broad consensus that there is a need for reform within the health and care services. The three basic principles of the Norwegian

welfare model, referred to earlier in this document, all seem to be under pressure and thus subject for discussion.

Equal rights to health and care services
The first principle deals with the equal rights of all citizens to health and care services. Should this be applied regardless of need, or should some patient groups have priority over others? Two government appointed committees have worked with the questions about priorities in health care and have provided clear recommendations. The government has also appointed a *National Council for Quality and Priorities in Health and Care Services* with the aim of supporting a more coherent approach to issues related to quality and priorities in health and care services. It has been difficult for politicians to follow up on the given recommendations, probably because it is not popular to say in plain text which medical services should have low priority. Nevertheless, priorities are reflected in the allocation of the limited economic resources. One may wonder if there is sufficient transparency on this type of priority and if this is fully in accord with medical recommendations and political decisions.

The principle of the universal right to health care services also raises the question of who has the right to decide what kind of treatment to provide. Is it the doctor or the patient? Today patients are often well informed about alternative treatment methods and about the availability of new medicine. Is the right to treatment understood as a demand on the part of the patient for a specific treatment, and will the most articulate patients get their own way?

Financing through public budgets
The second principle refers to financing which occurs through the public budget. The introduction of a co-pay or deductible was to a certain extent a break with this principle. However, since a ceiling for co-pay was defined that provided free treatment once the ceiling was achieved (free card), then this has been perceived as an acceptable arrangement. In spite of the additional resources provided from the co-pay, the need for economic resources is ever-increasing in the health services. One effect of this is that those with the financial resources may buy medical treatment from private providers, whereas those who do not may have to wait in a queue for medical care.

Who should provide health and care services?
The third principle is about who should provide health and care services. Over the last decades there has been a softening of the attitude that characterized the early stages of the welfare state, that is, that the welfare state should be in the hands of the government and municipalities. Today, there are commercial providers engaged in what is now called the health market, having either established their own private health services or having taken over existing nursing or care institutions. This development has occurred primarily in larger cities and has not reached the level that was originally feared by some. There is an ongoing discussion as to whether this contributed to strengthening or weakening the public health services.

As indicated above, the privatization of health and care services has had great consequences for the diaconal, non-profit agencies. To a large extent, they stand on equal footing with the commercial operators, something that implies a changing in the conditions for provision of services. Thus, great effort has been made to focus on the characteristic profile and added value of the diaconal service providers, especially in communicating with politicians and health bureaucrats. Many of the diaconal institutions have been through or are currently in the midst of important organizational processes clarifying their values and basic diaconal understanding. For diaconal institutions it is important that the political bodies of the Church contribute to these processes. This is an effort that needs to be strengthened, and it is important that this takes place through constructive dialogue with the various bodies of the Church. This must be carried out in such a way that it confirms the work of the diaconal institutions as founded in the Church's health mission and consequently is an expression of the call of the Church to promote adequate arrangements and services in society.

3.3 Health Policy Reforms

The development described above is the backdrop for many of the new health reforms passed by the Norwegian Parliament in recent years. The health policy documents that the government has presented on these occasions have emphasized two key strategies in the effort to meet the new health challenges: The first strategy involves the importance of more collaboration,

[21] St.meld. nr 47 (2008-2009): *Samhandlingsreformen: Rett behandling – på rett sted – til rett tid.(TN: The Coordination reform: Right treatment- in the right place- at the right time)*
[22] Ibid, p.13
[23] St.meld. nr. 39 (2007-2008): *Frivillighet for alle* (TN: *Volunteering for all*). The aim of the proposition is:" The government wants to secure the development of a living civil society through developing a close collaboration between volunteer organizations and through facilitating voluntary engagement. Through volunteering, people can participate in meaningful and socially beneficial activites. Voluteer organizations provide invaluable contributions to society, both through their activities and services and extensive unpaid efforts. The value of this effort is enormous" (p.11).

not only between state and municipality, but also with local and volunteer actors who are engaged in health related activities. The aim here is often presented as a «seamless» health and care service, with higher quality and more holistic patient pathways across institutional, sectorial, and professional boundaries. The second strategy puts more focus on preventive health work and on activities that make it possible for people to take on more responsibility for their own health.

This is the key message in the *Coordination Reform* of 2009, presented to the Parliament as a proposition with the ambitious subtitle of «Right treatment in the right place to the right time»[21] This document defines coordination as «…the ability of task distribution between health and care services with the aim of reaching an agreed common goal, and the ability of implementing activities in a coordinated and efficient manner.»[22]

While there is no direct reference to Church, local congregations or diaconal institutions in this parliamentary proposition, it is made indirectly through the reference to an earlier parliamentary proposition, *Volunteering for all.*[23] In this document the role of the Church and religious organizations in promoting volunteerism is described in positive wording; it also refers to diakonia as a particular action area.[24] Therefore, against this background, it is reasonable to interpret the Coordination Reform in this way when it recognizes volunteer non-profit organizations because they «… represent a considerable resource in Norwegian society, also in areas where public authorities have taken responsibility and where the responsibility is reflected through provision of services to the population.»[25]

The Coordination Reform was welcomed because it opened up new possibilities for collaboration between public and volunteer actors. According to a report presented to the Church Council in 2010, the reform was considered an important force in making «the Church more aware of the collaborative responsibility that is part of the Church' diaconal mission», and the Church Council therefore made the recommendation to employers of diaconal and Church institutions to strengthen their collaborative relations with municipal health care services and to emphasize the diaconal competencies. Furthermore, municipal health care services were encouraged to pursue collaboration with diaconal actors, in both preventive and acute care, for the benefit of patients in vulnerable life situations. [26]

The intentions outlined in the Coordination Reform have since been followed up in a number of health policy documents. The official report, *Innovation in the Care Services,* was presented in 2011.[27] The description of the challenges facing the health and care sector as presented in this report is characterized by a creative and open approach to new collaborative models. The committee responsible for the report concludes that these challenges cannot be left solely to the health and care services: «These have to be solved on the basis of a public responsibility that involves most of the societal sectors and through supporting and developing new forms of engagement and participation from families, local communities, organizations and service providers.»[28]

With this as a starting point, the report announces «the second coordination reform» that aims at mobilizing resources for interaction in local communities.[29] An important key word in this report is «active citizenship», which means that people take responsibility for building and shaping community based solutions, not least as volunteer workers.[30] Another key concept is «civil society», the network of organizations, institutions and activities that is an expression of volunteer engagement and where religious actors, like local congregations, have a natural role. The report states that

[24] Ibid, p. 143-144.
[25] *Samhandlingsreformen* (TN: Coordination reform), p.143.
[26] Kari Jordheim and Kari Karsrud Korslien (2010): *Diakoni og samhandling. Diakonifaglige innspill til Samhandlingsreformen.* Diakonhjemmet høgskole, s. 5 (TN: *Diakonia and Coordination. Input to the Coordination reform).*
[27] NOU 2011:11: *Innovasjon i omsorg.* Helse- og omsorgsdepartementet.(TN: *Innovation in the Care Services.* Ministry of Health and Care).
[28] Ibid, p.14
[29] Ibid, p.17
[30] Ibid, p.54

it is necessary to rethink the interaction between the public services and the civil society. The new forms of volunteering have to be more researched, and it is necessary to focus more on alternative work methods, organization and delivery of services that encourage «active citizenship».

The committee behind the report sets as a goal that before the year 2025, twenty-five percent of the total amount of activities in the health and care sector should be organized and delivered by non-profit service providers.[31] The committee based this on a high level of confidence in the civil society and its willingness to take on responsibility for caregiving, and a corresponding expectation that the public service providers are able to adjust to new forms of collaboration. There will obviously be voices that claim this is unrealistic. In fact, as feared, the Parliamentary proposition following up this official Norwegian report (NOU), failed to follow up this goal.[32] Nevertheless, this way of thinking does challenge the Church and, in particular, diakonia to rethink its role in society.

It is not only in Norway that the Church is challenged to renew and extend its engagement within the framework of civil society. The Swedish Church has also dealt with these questions, especially following the separation of Church and State in the year 2000. In 2012, the Central Board of Church of Sweden established rules for congregations wanting to establish business activities and corporations. Furthermore, in June 2013, they adopted a platform for the role and mission of the Swedish Church in the Swedish welfare society. Here it is stated that, in addition to being an interest group and collaborator, the Church itself can be a provider of health and care services. The platform describes the conditions that have to be in place if the Swedish Church is to be a provider of health and care services.[33]

In the report *Innovation in the Care Services* there is reference to «active care».[34] Culture, activity and well-being are emphasized as central and basic elements of holistic health and care services. There is reference in the report to new ways of thinking of treatment; for example, «everyday habilitation», «As far as possible in your own life», and «Care between generations». In other words, a focus on activities that demands an anchoring in local social structures. Local congregations could get involved in much of this.

Both The *Public Health Act*[35] and the *Municipal Health Care Act*[36], both implemented in 2012, confirm this strategic direction. «The work of public health is to promote the population's health, well-being, good social and environmental conditions and contribute to prevent mental and somatic disease, injuries and suffering» as is said in the Public Health Act §1, whereas in §4 it is made clear that «the municipality shall facilitate cooperation with non-profit volunteer sector».

The text of the act shows that there has been a movement in the work of public health away from a disease perspective to a perspective of promoting public health. This is based on an understanding that health is not primarily created in the health sector, but rather in the many arenas and areas of life that in different ways are important for people's health. This gives volunteer and non-profit organizations an important role. In addition to the provision of services, there is an added value in their commitment. In this respect, diakonia is not a competitor, but a significant contributor on their own terms to the welfare services. Diakonia confirms its belongingness to a life community, a dimension to which all service providers must adhere.

Openness to diversity and participation in health promoting work runs parallel to the confirmation of a holistic view of humans. It is by virtue of the need to unfold physically, mentally, socially and spiritually that people take on the role of involved citizen, ready to make an effort to promote the interests of the community. This holistic perspective is also expressed when people are not active in the same way, but dependent on care from others. The right to exercise one´s own religious beliefs and spirituality is confirmed in regulations from Ministry of Health and Care in 2009. Here, the municipalities are required to secure that people who depend on practical and personal assistance from the municipal health care services, also have safeguarded their opportunities to exercise their own religious beliefs and spirituality according to the constitutional provision for freedom of speech and freedom of religious. *The Nursing Home Regulations* §4-6 states that «residents shall have the freedom to live according to their own faith and life stance». This is interpreted as an «obligation that the health care services have to facilitate the individual's opportunity to freely exercise their religious faith and life stance».

[31] Ibid, p.18
[32] St.meld. 29 (2012-2013): *Morgendagens omsorg.* Tilråding fra Helse- og omsorgsdepartementet 19. april 2013, godkjent i statsråd samme dag (TN: Care in the future. Recommendations from Ministry of Health and Care 19.april 2013, approved in cabinet meeting same day)
[33] Kyrkomøtet KI 2013:1 (TN: General Synod).
[34] NOU 2011:11. *Innovasjon i omsorg.* Helse- og omsorgsdepartementet, s. 63. (TN: Innovation in the Care Services. Ministry of health and care).
[35] *Lov om folkehelsearbeid* 2011 (Folkehelseloven). (TN: The Norwegian Public Health Act)
[36] *Lov om kommunale helse- og omsorgstjenester m.m.* (Helse- og omsorgstjenesteloven). (TN: The Municipal Health Care Act)

It includes «access to open conversation regarding existential questions». At the same time, it implies «a more active responsibility to become familiar with the life history of the individual and to facilitate these rights for the individual». The regulations presuppose that the municipal health care services «establish necessary collaboration with relevant religious, spiritual organizations or humanistic organizations in addition to the individual's social network, family and local community, in order to ensure the safeguarding of the individual resident's opportunity to exercise the tradition of their faith and life stance».

We see that the health reforms that have been implemented over the last years, to a large degree have opened up for local congregations and diaconal institutions to have a more distinct role as a social agent in the health care sector. It seems that public authorities expect the Church to on take such a role and preferably to get more involved. This includes preventive health work and the development of different types of service activities. In addition, we see that the health care services take more seriously the trend towards a society that is more open to spiritual diversity, and that people's spiritual need and resources are seen as assets. In this respect, there is a clear expectation that the Church and other religious, spiritual and humanistic organizations take responsibility for serving those who are in need of support and who receive assistance from the health cafe services, whether it be within institutions or in the home. This provides new opportunities for the Church's health mission, and it challenges the Church to renewed commitment and innovation.

3.4 The concept of health under discussion

As mentioned previously, expectations for health care services are rising at a faster rate than the public health care services can handle. One reason for this is that patients today are better informed than was the case only a few decades ago. They are using the internet to read about their symptoms and then present the information to their general practitioner in a way that makes it challenging for the doctor to respond. Then, when the doctor fails to immediately prescribe the medicine or treatment the patient is convinced is needed and proceeds to more thoroughly investigate the symptoms, the patient easily becomes disgruntled by what they perceive as an unnecessary delay. Health and medicine are popular topics in the media, with information at times presented in a tabloid fashion, giving the impression that health and medical treatment are subjects that are easy to monitor. Offers from commercial health providers and politicians´ statements that «money should follow the patient» may serve to strengthen this perception.

Can we trust that the patient knows what is best?
The time is definitely over when doctors in white coats could behave as absolute authorities, a time when no one dared to question the doctor´s diagnosis and recommendations. Therefore, the aim must be for a high level of collaboration that puts the patient in focus, both in terms of communication and in terms of empowering the patient, the goal being to encourage the patient to have a conscious and active relationship to their own health and a realistic understanding of the possibilities for treatment when struck by disease.

This is without doubt an enormous challenge for the public health service, something that is evident from the political focus of the government on health reforms during recent years, irrespective of party affiliation. But good answers are not easily found because the answers involve, among other things, structure, competence and economy. In addition, it is about our expectations and our basic perceptions of health and how to take care of health.

We have already pointed to the tension that may rise between people's subjective perception of health and the understanding of medical science based on biomedical normalcy. In the span between these two approaches there are many different definitions of health, depending on assumptions and interests. Some point to the importance of the individual´s own responsibility for coping with the life situation and the importance of physical activity. A well-trimmed body may seem to be the best proof of good health. Other definitions remind one of the wisdom of the old saying «a healthy soul in a healthy body», suggesting that mental training and well-being are part of the equation. All this allows us to see that health is not something absolute, but the way most of us meet the demands of daily life, or as put by Peter F.Hjort, «Health is the extra surplus we have in relation to the daily demands».[37] The question about

[37] Peter F. Hjort (1994): *Helse for alle! Foredrag og artikler 1974-93*. Oslo: Folkehelsa. (TN: Health for everyone! Lectures and articles).

health is therefore a question of where we get this extra capacity and what we do when we start loosing this capacity. Without doubt this mirrors the biblical perception of health and healing as presented earlier, that health and healing means to be whole and live in peace with oneself and the environment and, not the least, in relationship to God.

There are many advantages to having different perspectives on the concept of health. It may counterweigh a one-dimensional understanding of health, as for example the perspective that claims that all focus should be on the diagnosis and biomedical aspects of health. Critical voices claim that this has led to a «medicalization» of the health care services[38], having as a consequence that patients may be reduced to their disease. «Medicalization» reflects a belief in progress, science, and expertise and in medical science's ability to say all that can be said and to do all that can be done when one becomes ill. The pharmaceutical industry has contributed to vast progress in the treatment of serious diseases and has thus made it possible for many patients to have a better life. On the other hand, this may have led to excessive use of medicine and exaggerated trust in new medicines that promise healing and health.

In the same way, it is reasonable to criticize when health workers do not see the human being behind the diagnosis. Suffering is more than a diagnosis and health is more than the absence of a disease. Sometimes, because a doctor may not be able to diagnose a specific illness, the patient is told there is nothing wrong, thus denying the patient´s intuitive perception. This is not a way to help a sick person.

Therefore, we need an extended concept of health. However, this must not lead to the government being given responsibility for everything that has to do with health. A new problem surfaces if the expectation is created that the health care services will provide treatment every time life presents challenges or that the health care services are to blame if health is not optimal. Inge Lønning, professor of theology at the University of Oslo and health politician, reminded us that health is approximate and not an absolute state, and that one of the most important functions of a realistic definition of health is «to counteract the pressure of expectation that is built into the utopian health concept».[39] Thus, it is unethical to give promises that cannot be fulfilled. This is something that both politicians and health workers must guard against.

Many of the health concepts that exist in society today, and especially those in the media's presentation of health issues are, from a biblical perspective, unilateral and colored by a utopian and functionalistic definition of health. This may give the impression that all human beings have a right to expect perfect health and immediate medical treatment if anything goes wrong. This perception fails to take into account that humans are born vulnerable and that we all have to expect to face sickness and pain on the road through life. Death is a part of life, it follows us as a threat and a shadow from birth, and throughout life.

Health care services in Norway are organized based on primary health care services, where general practitioners and municipal care services are the first line of responsibility. Their responsibility includes looking at health from a wider perspective, both in terms of prevention and harm reduction. Medical research shows there is a correlation between prevention and risk of becoming ill. It applies not only to smoking and the risk of developing lung cancer, but also for a number of other areas. Older people who stay active, physically, mentally and socially, are more likely to cope positively with the aging process and, as a result, are better able to live a good life in old age.

It can be difficult to ask for increased resources to promote the public health. It can be particularly difficult if presented as being at the expense of patients needing extensive treatments and expensive medicines. The question of priorities in health care is not easily managed when feelings are set in motion by media reports about patients who are not receiving the available treatment to which they are entitled. At the same time, we know that considerable funds could be reallocated to such treatments if health promotion efforts had led to changes in eating habits and lifestyle.

Much has happened in the area of health and lifestyle, for example changes in people's diet have resulted in reduced cases of cardiovascular diseases. Important efforts are also being made to reduce the intake of salt and sugar, something that will lead to a reduction in the prevalence of diseases such as diabetes and a further reduction in cardiovascular diseases. People's drinking

[38] Olaug S.Lian (2012): Etter Gullalderen: *Nye utfordringer for helsetjenesten* (TN: After the golden age: New challenges for the health care service). In: Hans Olav Melberg og Lars Erik Kjekshus (red.): Fremtidens Helse-Norge. Bergen: Fagbokforlaget, s. 27-55 (TN: The Future of Health-Norway).

[39] Inge Lønning (2012): *Helse: Finnes det? Refleksjoner rundt helsepolitikkens grunnlagsproblem* (TN: Health: Does it exist? Reflections on the fundamental problems of health policy). In: Hans Olav Melberg og Lars Erik Kjekshus (red.): *Fremtidens Helse-Norge.* Bergen: Fagbokforlaget, s. 275 (TN: The Future of Health-Norway).

habits, however, seem to be a much more difficult issue to address, even though this is of great importance for public health. It is worth noticing that the use of alcohol has increased by 50 % over the last two decades. This is an unpopular issue, perhaps because it is easily perceived as anti-fun and moralizing. Drug-related problems are a major cause of disease and injuries in Norway. According to the WHO, the harmful use of alcohol causes approximately 3.3 million deaths per year world wide, and there is a causal relationship between alcohol and approximately 60 different diseases. In addition, the harmful use of alcohol has great negative social consequences for innocent third parties, often women and children, in terms of violence, neglect, injuries and inappropriate use of household income. In two out of three cases of violence appearing in the emergency room, alcohol is part of the picture.

Work is another area that is of great importance to public health. *The Public Health report 2014,* emphasizes that work may be health promoting as a source of social relationships, identity and growth, and that it contributes to economic security. It also points out that work may lead to health problems, for example, through injuries and psychosocial factors. Socioeconomic differences also contribute to differences in health. Muscle- and skeletal ailments are more common among those with low education who often have jobs that are physically demanding or monotonous. The report also says that there is reason to assume that low unemployment and high occupational participation contribute to the promotion of public health and, in particular, to the prevention of mental disorders.

Living conditions, social environment and health are connected in several ways. Most groups in Norwegian society have attained better health during the last thirty years. In this respect, the welfare policy of Norway has achieved it´s aim. However, the improvements have not been equal in all social groups. Since the 1970s, there has been a drop in mortality and extended life expectancy for those with education beyond primary school and with above average income. However, mortality has changed little among groups with low education, low income and among those who are single. As a result, the socioeconomic health differences have actually increased from the 1970s to the 1990s. Further, when it comes to health behavior, it has been documented that there are considerable socioeconomic differences, for example with respect to smoking, diet, physical activity and physical inactivity. Groups with higher education and higher income come out as best with the exception of one area: the use of alcohol is higher in this group. Nationwide, there are also considerable health differences, especially in Oslo. The risk of having poor mental health, cardiovascular diseases and COPD is higher for people living in the eastern part of the city than on the western side. Life expectancy for men in different townships in Oslo varied in 2004 between 68 and 80 years.[40] At the same time, regardless of where we live, we are all exposed to what Peter F. Hjort, professor of public health at the University of Oslo, has called «co-diseases», a collection of diseases that have to do with society. These are diseases arising, for example, from issues related to cooperation at work or relationship problems at home. According to research, 25-30% take sick leave following divorce/separation, and 1/3 of these continue on long-term sick leave. Psychosocial problems lead to various types of somatic diseases, often muscular pain and high blood pressure. According to Hjort this starts a vicious circle of bodily symptoms that worsen the psychosocial problems.

It is important to be aware of the gender dimension of health, particularly in terms of women's health. Medical knowledge and practice is often based on an unreflected male standard of normality. The Norwegian health care services function best with respect to simple and acute diseases and injuries, and do not function equally well when it comes to complex and chronic diseases such as those often afflicting women. Women's health has not had particular status among doctors or researchers; men's diseases have traditionally had a higher status. Thus, medical research is often based on the studies of men. Equitable health care means that assessment, diagnostic work, treatment and rehabilitation take into consideration that many diseases and disorders manifest themselves and develop differently in women and men. Even though some research has been carried out in this area, the health care services are still lacking knowledge. The lack of equitable treatment puts women at a disadvantage.

Children represent a vulnerable group in society, and children are often left to the mercy of their environment. Social inequality impacts on the health of children, as it does for adults. Conditions that affect children's health include diet and life style, bullying,

[40] Fredrik Nicals Piro (2008). The influence of the physical and the social environment on health: A population based multilevel study in Oslo, Norway. PhD disertation, UiO.

growing up with a parent suffering from a mental disorder, drugs and alcohol, violence and abuse. Such livings conditions will not only create a problematic and painful childhood, but will also have negative consequences for their health as adults, often leading to cardiovascular disease, mental disorders and substance abuse.

There is sparse knowledge about social conditions and health in the Sámi population in Norway. This may be changing with the establishment of the *Center for Sámi Health Research*, funded by the Ministry of Health and Care.

There are major differences in health among the various immigrant groups. Refugees have higher frequency of somatic and mental health problems, particularly as related to posttraumatic stress.

Therefore, public health is an important issue, but it is also a demanding endeavor when the goal is for individuals and families to take responsibility for promoting a health lifestyle. Strong social networks that promote a health life style and cooperation between public agencies and volunteer organizations are needed. Here, the Church can contribute both as a social agent and as a conveyor of ethical awareness. It is not always easy to balance preventive health work that encourages people to take responsibility for own life and health, with treatment and care when people fail in their efforts to live their much desired healthy and sensible life. In the community of the Church there must be room for all, especially those who struggle and carry a heavy burden in life.

3.5 Alternative Treatment

We have seen that there are good reasons for conceptualizing health and disease from a wider framework than the more limited biomedical perspective. Disease and suffering are multifaceted experiences that include existential questions and thus challenge spirituality and beliefs. For this reason, the spiritual dimension should not be underestimated. When people experience that life is put to the test, such as happens when struck by a serious disease, religious belies and spirituality may be reactivated in the quest to regain health. For Christians, prayer and pastoral counseling are natural elements of such a strategy, elements that will rarely be seen as opposed to medical treatment.

Physicians and other health workers do not always see the value of prayer and pastoral counseling. They may often behave in a manner that gives the impression that it is only the biomedical strategy that counts. In this way, they contribute to an antagonistic relationship between modern medicine and what is referred to as alternative treatment, complimentary health care or prayer for the sick. When the focus on natural science becomes too dominating and sick people are reduced to a diagnosis, we are actually dealing with inadequate modern medicine. Not only is it based on a one-sided belief in biomedical principles, but it could also contribute to an estrangement of the patient from the important role of being an agent of change in his own life. Good modern medicine must have as a goal to confirm the dignity of the patient and to empower the patient efforts to regain health.

That alternative medicine has gained attention in our time, may partly be a reaction against the biomedical orientation of modern medicine. Interestingly enough, alternative medicine tries at times to give the impression of being based on natural science by placing itself within the logic frame of «medicalization». What alternative medicine offers may seem a bit more speculative, but when patients encounter technical equipment and therapists that resemble that which they find in the office of the general practitioner, this will serve to create the expectations that alternative medicine can help. The advertising material provided by these care takers certainly communicates that many have been helped by their services.

It is important to state that alternative treatment covers many different areas. It includes treatments based on sound professional knowledge as, for example, with acupuncture. On the other hand, the market is also full of speculative wonder medicines and questionable businesses. Therefore, one should take care not to treat all alike in this «market»; such a perception is also not helpful in dealing with the people who seek alternative health care.

A crucial distinction relates to the Christian perspective that modern medicine must be perceived as God´s good gift. There is every reason to warn against alterna-

tive treatment as a substitute for ordinary medical care with the result that patients fail to seek contact their doctor or take prescribed medicines. Therefore, the concept of complimentary treatment is a useful one. In many cases this could be of great help, not the least on a mental and social level. At times, the treatment is done in cooperation with the ordinary health care.

Another important question has to do with the economic implications. Many are willing to pay large amounts of money for a treatment they expect will help. This is a situation that to some are tempted to exploit. From time to time the media discloses alternative treatments that have no proven effect. For this reason, public authorities are active in monitoring, for example, the marketing of health foods. One aspect of this picture is that some of the alternative health foods that are offered have their background in traditional folk medicine. This is an area that has received a renewed interest many places around the world. To poor people, natural medicine, in the form of herbs and teas, could be an alternative to expensive remedies bought at the pharmacy. In our part of the world, the same trend could manifest itself in overconsumption of expensive health foods.

There is also reason to keep a critical eye on the way humans are, at times, described in the alternative health environment. One speaks of magnetism and energy, aura and cosmic forces. Such concepts could be perceived as speculative; they are often rooted in esoteric religiousness that is not only alien to modern science, both also to the Christian perspective on life.

All these reservations could make it difficult for us to see the positive aspects of what is best described as complementary health work. It is important for people to find a setting where they can see their suffering from a holistic perspective and receive proper support and care. The therapeutic room comes in various forms where it is possible to integrate many different traditions and a variety of human competencies. A good foot massage may give warmth to more than just cold feet. Meditation can provide calmness and receptiveness to senses that have become dulled. In different ways, this can contribute to both body and mind developing the capacity to stop a vicious cycle or to face a demanding health challenge.

In the health professional community there is a discussion about whether religious belief and spiritual care have any health effect. In 2000, *The National Research Center in Complementary and Alternative Medicine* (NAFKAM) was established as part of the Department of Community Medicine at the University of Tromsø. This center has the task of stimulating, executing and coordinating Norwegian research within the area of complementary and alternative treatment.

In the Church of Norway, there is an ancient folk tradition for praying for people, and there is a perception that certain people have a special ability to even cure sickness. This healing tradition is especially strong within the Læstadius movement in the Sámi areas of northern Norway. For many, this was the only way to receive help in places far away from doctors and hospitals. There are many stories of bleeding that were stopped, pain that ceased, and death anxiety that disappeared. These stories have a strong religious background and, at the same time, they have an obvious social character. Because the authorities, both religious and political have been critical of this practice, it has often been performed quietly in the Sámi and Læstadian communities. In our day, there seems to be a new openness for this tradition with recognition of the belief and care it represents.

The understanding of complementary health treatment can reflect a holistic view of humans where the physical, mental, social and spiritual dimensions work together. When one of these dimensions, for example the physical, is hit by a disease, it has an effect on the others. At the same time it means that stimulating and caring for the patient mentally, socially and spiritually may also have a positive physical effect.

Both openness and a critical attitude are needed in facing the alternative health market. On one hand, it represents engagement, care and positive folk traditions. On the other, it may appear as speculative and commercial. In some cases, it has without doubt a positive a health effect; in other cases, it creates false expectations in a way that hinder people to acknowledge their life situation. Thus, there is a great need for counseling and help, and it is important that this is handled in a way that takes people's despair and beliefs seriously.

3.6 Religious Belief as Health Asset

Is there any relationship between people's religious beliefs and their health? The investigation that Per Fugelli and Benedicte Ingstad published in 2009 seems to indicate this.[41] When health is failing, many find their strength and meaning in the world of faith. Over the last years an increasing number of researchers, especially in US, have focused on these questions and have tried to document scientifically if belief and religious practice has any health effect.[42] There are also a few research projects underway in Norway involving theologians, psychologists of religion and physicians (see 3,4). [43]

When researchers claim that religious beliefs have a health promoting effect, they usually point to the following:

1. Religious people often have a healthier lifestyle; they have lower consumption of tobacco and alcohol than the average population.[44]
2. Investigations have shown that prayer, meditation and religious rituals have a positive and measurable effect, both by reducing blood pressure and the release of stress hormones.[45]
3. Religious belief helps people to interpret and find meaning in demanding life situations. It can give inner strength and calm, and can help people, for example, to cope with serious disease.[46]
4. People who believe are often surrounded by a social network where it is common to show caring for one another. The religious community has the potential to provide refuge, companionship, care and practical help, and prayer and blessing.

The question has been raised as to whether it is actually possible to thoroughly document this relationship. Some will claim that this is about more factors than belief and health, for example also about cultural context. This may be one of the reasons that these research results seem to be much more positive in the US than in Europe. It is evident that religious beliefs can have a negative effect and can, for example, reinforce mental disorders. This is particularly the case for what is termed «rigid religiosity» where perceptions of a strict and punitive deity are tied to one's own uncleanliness and guilt.[47] The experience of God's absence and the failure to receive an answer to prayer can make sick people more despaired. The religious community isn't always as inclusive as desired. Some feel they are met by indifference and judgmental attitudes when they are seeking understanding and care. Therefore, the question about belief and health is not foremost an academic question, but is rather about people's everyday life and how their health challenges are interpreted existentially and in terms of faith. Do those who strive with such questions receive help from inside their social network? Do they experience the congregation and the community as an asset? Which images of God are nurtured through preaching and education?

Another equally important question is if these issues are met with understanding when communicating with physicians and other health workers. Many health workers are hesitant about getting involved in conversations with a patient about belief questions, either because they don't see themselves as competent in this matter or because they are of the opinion that religion has a foremost negative health effect. Therefore, it is important to strengthen competence in this area, preferably as part of the professional education. However, the recognition of the health promoting role of religious belief should not allow for an instrumentalization of religion; that is to say, it should not allow for submission into a health agenda. Faith and religious practice is more than what promotes, or possibly damages, people's health, and it must be respected as such.

Even when it is recognized that religion and spirituality can have a health promoting effect, many will still be reluctant to use the word «healing». The reason may be that the word is perceived as being loaded with religious content or that it gives too many associations to «healers» acting in the more contestable arena of the alternative health market. Healing does not have to be perceived as a miraculous event outside the range of rationality. The word can also be understood as a process and effort to cure the one who is sick, the same process as in the ordinary health care system. In the process, different factors may have a role, and the interaction between these factors will promote a healing process. Sometimes the patient may recover from the disease, while other times the process teaches the sick to cope better with the disease in a manner that strengthens their daily mental capacity, and sometimes the process gives strength to reconcile with a coming death.

[41] Per Fugelli and Benedicte Ingstad (2009): *Helse på norsk. God helse slik folk ser det.* Oslo: Gyldendal akademisk, p. 375-415. (TN: Health in Norwegian. *Good health the way people see it)*

[42] An overview over this research field is in Harold G.Koenig, Michael E. McCullough & David B.Larson (2012): *Handbook of Religion and Health.* New York: Oxford University Press

[43] An overview is available in Lars Johan Danbolt, Hans Stifoss-Hanssen, Knut Hestad og Lars Lier (2014): *Religionspsykologi.* Oslo: Gyldendal akademisk (TN: Psychology of Religion)

[44] Norwegian Seventh-day Adventists have lower risk of cardiovascular diseases, have less of diabetes and cancer, and they live longer than others. Vinjar Fønnebø (1992): Mortality in Norwegian Seventh-Day Adventist 1962-1986. *Journal of Clinical Epidemiology,* 45 (2), p. 157-167.

3.7 Spiritual Care

Spiritual care should have a place in all kind of health work. By this, we mean care that includes all patients regardless of belief, spirituality or health condition. As referred to earlier (p.26), the health authorities have confirmed that residents at nursing homes and other institutions providing long term care, have the right to practice their religious faith and that it is the institution that has the responsibility to assure the provision of such activities. From early times, the Church has provided spiritual care for the sick. As referred to earlier (p.xx), the letter of James tells about the practice of praying for and anointing the sick and leads us to understand that it is the elders of the congregation who are responsible for making this service available (James 5,14-16). Today, many congregations are using anointment. It can be a rite, which provides the patient with a good framework for fellowship and prayer.

There is also a long tradition of celebrating communion together with the sick and dying. The sacrament says more than what can be expressed in words. It gives an experience of belongingness and meaning. Above all, it proclaims the graceful presence of God who creates faith, hope and love. Therefore, any celebration of communion, also the one at the ordinary Sunday Worship, can be perceived from a health promoting perspective. The sacrament preaches forgiveness from sins and freedom from all burdens; the bread and wine provide contact with the body and blood of Jesus and unity with his death and resurrection. In addition, the celebration of the communion confirms that we belong to a community, which is called to mutually care about and take care of each other. Special prayer services can provide a good framework for this kind of experience and may also provide the opportunity to offer confession to all who wish.

Spiritual care is especially important in times of crisis. When disasters and accidents happen there is a wide expectation that the Church will come forward to help those affected. The same happened following the terror attack of July 22, 2011. Many experienced the sacred room of the Church as particularly suited for expressing despair and grief. The ritual of lighting candles is experienced as meaningful even for people who do not consider themselves as active in Church. Rituals and symbolic acts contribute to creating meaning. These acts confirm belongingness and gives meaning in life in spite of the painful events that have occurred.[48] The sanctuary of the Church provides a framework for informal conversations with pastors and deacons. Over the last years the Church has acquired considerable competence and contingency plans for handling crisis situations. Contingency plans have been developed for all levels of the Church of Norway. For Norwegians living abroad, Sjømannskirken (TN: The Norwegian Church Abroad) has established emergency teams that can be quickly onsite when people are hit by accidents or similar crisis situations.

Most of us do not have to experience such dramatic situations at close range, but we are all touched by the vulnerability of life and the awareness that sickness and death belongs to our life condition as human beings. Therefore, it is realistic to expect that we will end up in the situation of having to receive care and perhaps, in particular, spiritual care. The hospice-tradition has deep roots in the Church and expresses the importance of accompanying human beings through the last stage of life and if possible, to help them reconcile with death. The Aronittic Blessing, the prayer of Our Father and well known psalms will often be valuable resources in such settings, and especially in the situation where the patient is no longer able to communicate in an ordinary manner. Even then, the words of blessing are recognized, and they carry a special force that brings peace and comfort, both to the sick and to those who are present.

All of these rituals give the opportunity for talks and pastoral counseling. At the same time, it is clear that spiritual guidance and pastoral counseling are not dependent on such conditions and settings. Pastoral counseling has always been a central task in Church and has, naturally enough, become an important subject in the training of pastors and deacons. Institutt for Sjelesorg at Modum Bad (TN: The Institute for Pastoral Counseling) a leading resource center in Norway, offers in-house treatment and counseling services and arranges training courses for professionals.

[45] Research from the county of North-Trøndelag shows that the more often people went to Church, the lower their blood pressure. Torgeir Sørensen, Lars J.Danbolt, Lars Lien, Harold G.Koenig & Jostein Holme (2011): The relationship between Religious Attendence and Blood Pressure. The Hunt Study, Norway. *The International Journal of Psychiatry in Medicine* 42 (1) p.13-28.

[46] A study of Norwegian cancer patients confirms this, most of the participants say that religion has helped them in coping with the new situation brought by the disease. Tor Torbjørnsen (2011): *«Gud hjelpe meg!» Religiøs mestring hos pasienter med Hodgkins sykdom. En empirisk, religionspsykologisk studie.* Oslo: Menighetsfakultetet. (TN: «God help me!». Religious coping among patients with Hodgkins disease. An empirical, psychology of religion study).

[47] Hans Stifoss-Hanssen (1996): *Seeking meaning or happiness? Studies of selected aspects of the relationship between religiosity and mental health.* Trondheim:Tapir.

[48] Hans Stifoss-Hanssen og Lars Johan Danbolt (2014): Om å stå oppreist etter katastrofen – ritualer og resiliens etter 22. juli. I: *Omsorg. Nordisk tidsskrift for palliativ medisin.* Nr. 1 – 2014, s.52-57. (TN: Standing upright after the disaster- rituals and resilience after the 22nd of July. In *Care. Nordic Journal of Palliative Medicine).*

3.8 Global health

That epidemics cross national borders is not new to our times, but in our globalized world epidemics threaten to have an scope that goes beyond that of earlier plagues. The Spanish flu that ravaged large parts of the world in 1918-20, resulted in approximately 40 million dead. In Norway alone, 15,000 people died from the Spanish flu. Life patterns in our globalized age makes it possible for such epidemics to develop more quickly than ever before, leading to what is called a pandemic, that is to say, an illness that is extensive and has a wide geographical distribution. For example, the spread of the HIV-virus, discovered in early 1980s, has infected 75 million people with a fatal outcome for 36 million.

Since the beginning of the millennium, there have been several pandemic alerts. In 2002, the SARS- epidemic broke out, three years later the Avian Influenza made big headlines around the world, and in 2009 the WHO declared that the Swine Flu had reached a pandemic level. Everywhere, health authorities were alerted. In Norway, mass vaccinations were carried out. In reality, none of these epidemics lead to a loss of many lives. In retrospect, questions have been raised as to whether the reaction was excessive and driven by a «hysteria» created by the media or pharmaceutical industry, who saw the opportunity for large profits when millions of people were to be vaccinated.

Regardless of how we judge such reactions to the threat of pandemics, there is no doubt that our vulnerability for new and unknown diseases has been revealed, emphasizing the importance of a global perspective on health. It is not enough to focus on national health care services. Both the UN and other international organizations point to a shared global responsibility for people's health, regardless of geographical and national location. As a result, health is a central theme in the millennium goals of the UN. This has also had consequences for Norwegian aid policy where health is a priority.

Health is also an important area in the work of Norwegian Church Aid and Norwegian missionary organizations, and in this respect their work is an expression of the Church's health mission. In many places, the early missionaries, often having a professional background as physicians and nurses, established hospitals and other health care services. Today this activity is for the most part transferred to national Churches. In some countries in Africa, approximately half of the health care services are provided by Churches and other faith-based organizations. Great effort has been made in order to support the Church's health mission, especially in poor countries.[49]

There is every reason to emphasize that global efforts are needed in a world where there are enormous differences in access to health care services and where large groups of the population cannot count on being treated by a physician or receive hospitalization when seriously ill. The right to health is confirmed in several international conventions, following the UN's declaration of Human Rights in 1948, where it was stated that:

> *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (§25, 1).*

For millions of people, this is not the reality. The reason is not any lack of development, for example, that it takes a long time to build out health care services in poor countries. Rather, to a large degree, it is due to failed efforts at development. One important factor is that the public health care budget is insufficient to cover all of the population, and is instead aimed at those who can pay. Already in 1978, this resulted in the WHO focusing strongly on Primary Health Care with the motto «Health for all». The vision was to give traditional «helpers» the opportunity to develop medical knowledge and competence in collaboration with health authorities. Unfortunately, the good intentions have had limited impact. This is perhaps due to a fundamental contradiction between traditional medicine and modern medicine, as well as the interests of pharmaceutical industry pulling in the direction of promoting western health care services.

This is above all expressed in the struggle for access to medication, seen most clearly when South-African authorities wanted to import less expensive AIDS-medication for their approximately 5 million people

[49] World Council of Churches had for many years their own commission, *Christian Medical Commission,* working with healthrelated issues. DIFAEM (Deutsches Institut für Ärztliche Mission) in Tübingen have together with World Council of Churches and the Lutheran World Federation organized important conferences on the Church's global health mission, the last one in June 2014. Christian Medical Mission, see http://difaem.de/

suffering from HIV- and AIDS. Most of these could not afford to pay for the medication that the pharmaceutical industry, thanks to their monopoly, had made available. In order to protect their monopoly, the pharmaceutical industry sued the government, but in the end decided to pull the case when confronted by international opinion. In this way, many people were able to gain access to medication that secured them a dignified life.

Today, contagious diseases do not account for more than 50% of the burden of disease in the world; this is also the case in poor countries. In addition, non-contagious diseases are rapidly increasing. In poor countries this represents a double burden of disease. Non-contagious diseases come in addition to the contagious diseases that continue to be a challenge. The four most important risk factors for non-contagious diseases are alcohol, tobacco, sugar, unhealthy fat, and inactivity. Prevention of non-contagious diseases, injuries and disabilities will, in the future, be very important in reducing mortality, disease and low quality of life throughout the world. In this respect, it is important to put into place laws and legal regulations that will protect the public health. It is also important to expand the health service in such a way that treatment is also available for non-contagious diseases. A key task is to have adequate legislation that regulates the large medical industry that makes a profit from promoting and selling products connected to the major risk factors and illnesses.

Mental health is a neglected area in international health work. Those living in poor countries rarely have access to adequate health care services. Poverty is by itself a mental stressor. In many places, people experience additional stress due to war and social unrest. WHO recognizes mental health as an enormous health challenge and acknowledges that there is a gap between the need and available treatment services.[50]

Another important issue is the migration of health personnel to the rich countries of the world. African countries, in particular, experience that physicians and nurses, on whom they have spent sparse resources to educate, choose to emigrate. WHO has pointed out the global need for education of health workers. In 2006, the WHO estimated a need for 4,25 million health workers, with Africa needing about half of these. In the same year, a study from Tanzania showed that this country, with a

population of 40 million people, had only 1,264 physicians working, whereas there were 1,356 Tanzanian physicians working abroad.[51] With this in mind, it is important to strengthen local education of health personnel in a manner that secures them adequate working conditions in the home country. Since 2005, Norwegian Church Aid, in collaboration with educational institutions in Norway, including diaconal colleges, has had a project in Malawi for the purpose of strengthening the education of nurses and midwives. This has been a collaborative project with the country's government and 13 national educational institutions, many of which are connected to the Church.

Access to clean water is fundamental for people's health. According to statistics from WHO, more than a billion people are living without access to clean water. As a result, more than 2,2 million people die every year from waterborne diseases such as cholera. In many places the situation is worsened by the privatization of waterworks, or the acquisition of ownership of water sources by private companies.

In Norway, we are used to thinking about health in the context of personal and legal rights. This is how it should be in the global context, whether it is with respect to the right to health care services, health personnel, medication or, fundamentally, clean water. The struggle for global health is about more than benevolent aid, it is rather about the effort to change economic relationships, the political power structure, and the general living conditions of the people. This is an arena that calls for solidarity, commitment and effort.

[50] WHO: Mental Health Atlas, http://whqlibdoc.who.int/publications/2011/9799241564359_eng.pdf?ua=1
[51] http://cip.cornell.edu/DpubS?service=UI&version=1.0&verb=Display&handle=dns.gfs/1351876999

4. The health mission of the church today

4.1 Health Related Assets of the Church

In this third part of the document the theme is how and where the Church can express the health mission today. On the one hand, the presentation is defined by the analysis of the welfare society and the challenges to health as described in the preceding chapter. It is in this context the Church is called to serve. On the other hand, the following text is inspired by the Biblical understanding of health and healing referred to in the first chapter. This serves to form and shape the nature of the Church's health mission.

It is reasonable to start this part of the document by confirming that the Church's health mission represents a rich heritage and a wealth of resources within the Church. The resources can be related to three different levels. The Church can contribute to strengthening people's identity, self-understanding and belongingness and, thus, also to the ability to cope with the various challenges of life. Further, there are large resources in the many different community-building activities that take place in local congregations. The Church has resources to meet various needs of care both for individuals and local groups. The specialized diaconal institutions with their high level of professionalism in the area of health services represent resources in the area of medical treatment and rehabilitation. In addition, the Church has resources as a formative institution and participant in the public discourse. The question, therefore, is not about the Church having an engagement in this area, but the direction of the Church's attention and how the engagement should manifest itself in concrete activities.

Care for the sick and those in vulnerable life situations have always been part of the Church's mission to the world, although this ministry has taken different forms from time to time. In the professional literature, there are references to faith-based organizations and the «religious health assets» they represent.[52] Resources are understood to mean both concrete activities and institutions, as well as other less tangible resources. When it comes to the first type, we have previously shown that there are more than 150 diaconal institutions in Norway. They represent an important resource for the Church's health related ministry. Many more exist, for example in the form of organized activities directed by local congregations and providers targeting special groups. An even more important resource is the number of people that, through their professional competence and commitment, ensure that these services are well-functioning. Many of these people are volunteers, and each year local churches and institutions mobilize thousands of volunteers in various health related activities. Volunteering is in itself a health promoting activity. The diaconal ministry has an important role to play in this arena. There are approximately 350 deacons and diaconal workers employed in Norwegian congregations. Put together, volunteers and employees are a tremendous resource that must be carefully maintained and supported.

In addition to these resources, there are also faith-based resources that are not equally tangible, but that nevertheless have a health promoting role; this would apply to, for example, rituals of different kinds. People who are struggling with their health, may experience becoming strengthened through participating in a prayer service or by attending Holy communion. Prayer and meditation can reduce stress and can help some find their way out of a depression. In addition, faith may promote other types of resources; for example, it may motivate people to pro-social behavior, it may form empathic attitudes in encounters with others, and it may oblige one to act according to moral standards and to promote that which is just, true and good. Faith shapes our view of being human and our confidence in the meaning of caring for others, especially for people in vulnerable life situations. It is an important task to activate these resources. This is not happening by itself. In the same way that Jesus talks about the talents that

[52] Kjell Nordstokke (2012): «Faith Based Organizations»- egenart og rolle. (TN: «Faith Based Organizations»- distinct characteristics and role). I Einar Aadland (red.), Ledelse i diakonale virksomheter. Trondheim: Akademika, s.93-108.

some hide in the ground (Matt. 25, 25), the local congregation can leave its resources unused, perhaps because those having them, do not get help in using them in the service of the community. To be entrusted with such resources should in no way make the Church arrogant and create thoughts that Christians are better and more willing to serve than others. The point is to see the possibilities that exist and to take responsibility for those tasks that actually are within reach.

In connection with baptism, confirmation, wedding and burial, church employees, particularly pastors have contact with large sections of the population. In the conversations occurring during these rituals there may be implicit a great deal of «public health work». This may be easiest to see in connection with burials. Those working at the cemetery contribute to the public health through relating positively to the mourners at the gravesite.

As mentioned previously, the service of the Church during disasters and accidents is also a health resource. This is expressed in the contribution to psychosocial support to victims and their relatives, through specially designed rituals, religious services and bereavement groups. Here, the Church collaborates with police and health care services.

The community-building work of local congregations is an important resource for health promotion. Traditionally, this may not have been a focal point in the local church effort to organize the church community or in other fellowships taking place in the Church. Unfortunately, there are examples where such communities have been directly harmful for individuals. Lifestyle demands, «correct» opinions and intimidating preaching have contributed to subduing and repressing the individual instead of strengthening and liberating the individual. In most cases, however, the religious, social communities will contribute to giving meaning to life and will be a resource in event of demanding life crises. Such sustainable communities must be nurtured and strengthened over time. «Creating inclusive communities» is therefore chosen as one of the four areas for diaconal ministry in the *Plan for Diakonia in the Church of Norway.* An important task for the Church is to build a society characterized by shalom as presented in an earlier chapter (2.1).

Art and culture, in addition to the aesthetic experience, in many way also provides a health promoting effect. To experience music, either through participating in a choir or through playing an instrument, may contribute to feelings of mastery, increased relational competence and coordination. Music has a special place in the encounter with people suffering from dementia, and research shows that there is less need for medication following a concert in health institutions. At church events, music contributes to both celebration and comfort. Luther said that «only music can create what theology creates in another way, namely to give peace and joy to the human soul». Church music is performed at the Sunday worship and at Church events, in choir activity and in concerts. An open church with meditative music may mean a lot to people living in a hectic life situation filled with stimuli. The architecture of the Church building decorated with art and handicrafts is an important local resource from a health promoting perspective.

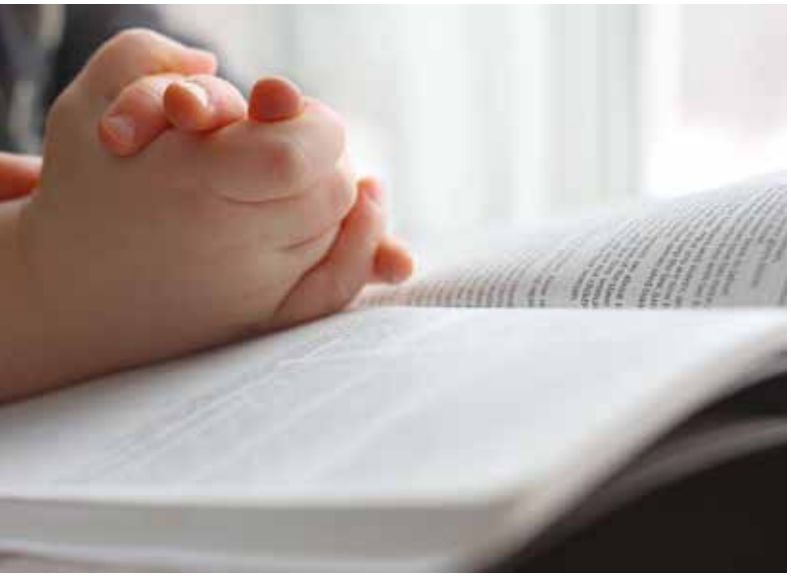
The health resources of the Church are diversified; they are relational, institutional, intellectual and spiritual. The Church's special role as a health service provider consists of the interaction between all of these various resources and assets; from the diversity of concrete activities through the centuries with all the competence gleaned, to the engagement growing out of the community of the local congregation that equips people to do good deeds. From the middle of the 19th century, a number of impressive initiatives were implemented as a result of this cooperative interaction; these initiatives were often characterized by a pioneer spirit that left their imprint on the health care services and society as a whole. Each time period requires new expressions. The challenge is to find out how to utilize this heritage today and to know in which areas the Church´s health mission can best be expressed.

4.2 Preaching and Education

The Church's health mission is expressed both in words and deeds; in other words, both through preaching and teaching, for example in Christian education and through diaconal activities.

Pastors and other preachers face this challenge when they are preaching the biblical texts related to healing.[53]

[53] See previous discussion about the validity of the stories today, p.11-12.



The distance between antiquity and the mindset of our own time makes it difficult to interpret these stories. It does not make sense to ask the listener to return to a bygone era in order to understand what has happened, we must rather find modern day expressions for faith. The task of the preacher is to make the Gospel credible for people of today. In this way, the word of the Gospel contributes to the mastery of life.

Those who lived in the time when the Gospels were struggled to interpret these stories of miracles. Even in the time of Jesus, his disciples experienced that they did not have Jesus` power to cast out demons (Matt. 17.19). The New Testament communicates that the disciples are called to do the same deeds as Jesus (Matt. 10, 7-8), but at the same time makes it clear that the authority of Jesus is unique. Only He is the incarnated God in the midst of everyday life. Only He can bring the authoritative words of God so directly to the sick and marginalized are immediately restored to health and new relationships.

Even though the Gospels and Acts tell that Peter and others perform miracles, it is emphasized that this happened in the name of Jesus Christ (Acts 3,6) as a sign of his continued presence and the power of his victory over death and evil. It was not long before the congregations interpreted this as a call to caring just as Jesus had shown care, comfort and compassion (Rom. 12, 7). The diaconal practice that developed over time is to be understood as a concrete expression of this mission.

This gives us a sense of how we today are to interpret the miracle stories of how Jesus heals. First, the stories may help us to see the uniqueness of Jesus' work, that He really is God, and that He has the power to make everything new. Wherever there is disease, poverty and injustice threatening people with judgment and death, He brings life. Second, His care is related to the whole person, not just the soul, but also the body and the social relationships to which the person belongs. Jesus cares about the whole person, and His healing brings about wholeness.

These must be the two basic perspectives for our interpretation of the healing stories. The focus must be on Jesus and the manner in which He met the whole person. The focus is wrong if it is directed towards that which can be perceived as miraculous or against nature. Neither do the evangelists emphasize this; for example, they do not adhere to any secret formulas or techniques.

The focus will also be wrong if we make this a question of faith, whether this is according to the worldview in the time of Jesus, or whether it is presented as an injunction to believe strongly enough. There are formulations in the Bible that may mislead us to think in this way, such as the saying of Jesus that faith can «move mountain» (Matt. 17,20). It would be wrong if this becomes a yardstick to measure a person's faith, with the conclusion that the person, whose prayer for healing is not answered, is not strong enough in their faith. Already in the letters of Paul we find statements that confirm this. Paul makes it clear that love matters more than faith that can move mountains (1 Cor. 13,2), and that the relationship between strength and weakness is not always as we think (2 Cor. 12, 7-10). The faith of which Jesus speaks is the one that is directed toward him with confidence. It is a faith that shames no one. In the midst of the everyday life of vulnerability and weakness, it can promote hope and life.

Thus, the stories of healing loose some of their power if they are conveyed in a way that limits the message to the spiritual sphere or soul. Jesus is present in people's

everyday lives, especially in places marked by the more difficult aspects of life. In the dark and difficult places, He is present with His caring for the whole person in any and all relationships. Here, He calls His disciples to follow. «Whoever serves me must follow me; and where I am, my servant also will be» (John 12, 26).

Preaching is also important when it comes to confirming the dignity of humans. Human beings were created in the image of God, and this applies to all. This must be proclaimed so that people can have a counterforce to balance today´s emphasis on the perfect body and expectations for success. The concept of *shalom* as presented in chapter 2.1 could be highlighted when addressing such issues in the Church.

It is also important that preaching speaks truthfully about life, both the «good life» and happiness as well as about defeat, grief and difficulties. In many ways, Christian faith and belongingness can contribute to coping with life. Many psalms, both recent and those that have been sung for hundreds of years under changing conditions of life, help to interpret life. This is an important theme in preaching and education. This is in accordance with the aim specifically mentioned in the *Plan for Christian Education* wherein education shall contribute to the Christian interpretation and mastery of life.[54] In connection with the mastery of life, children and young people will be engaged in dealing with central dimensions in human life, including themes such as self image, the body, identity, friendship and relationships, physical and mental health, grief and loss, and death and hope.

4.3 Health related activities in the local congregation

The local congregation has as a task to witness about the Gospel in words and deeds. This is the perspective of the *Plan for Diakonia.* When it is stated that diakonia is the Gospel in action, it is to make clear that diakonia is an integral part of what the Church is called to be and called to serve.

Thus, it is important that each congregation form a realistic picture of the health-related resources that it has at its disposal. Often, this will be more than anticipated, not the least with regard to human, relational, ethical and spiritual resources. To have these resources mapped will often create a powerful impulse for new thinking and discovering new opportunities for action.

Wholeness and mastery of life are important element of health, whereas loneliness and lack of belonging and security have negative effects. Therefore, it is very important that the local congregation emphasizes developing an inclusive community. Social networks characterized by mutuality and commitment for the common good and where everybody has a role to fill, is clearly health promoting. *Plan for Diakonia* has two goals in this area. One is that the community of the congregation is open and inclusive and the other is that the congregation is an active participant in strengthening networks and fellowship in the wider local community. The *Plan for Diakonia* also contributes with a number of questions that can be of help in the process of developing a local plan of diakonia.

Much of what happens in the congregation occurs by virtue of the extensive contacts created by the «folk church», where meeting places give opportunities for care and pastoral counseling. When individuals or local communities experience pervasive life events, for example, during funerals, important rituals, or even when attending a grave, the threshold is low for comforting words from the pastor, deacon, organist or cemetery worker. There is extensive interface between the Church and the local community, and the local congregation has a broad potential for health-promoting activities.

Providing care for people who suffer, is more than just one of the potential activities on the to-do list of the congregation. It is one of the characteristics of the Church of Jesus Christ. As it is written in letter of James: «Do not merely listen to the word, and so deceive yourselves. Do what it says» (1, 22). Later in the this letter from James, we can read that the elders of the congregation have the task of caring for the sick (5, 14-15); in other words, caring for the sick has an obvious place in the life of the congregation, and this is a task the leadership shares responsibility for organizing. In our situation we could say: This is a task for the council of the congregation in collaboration with the employees of the Church, where both the pastor and deacon are important participants.

[54] «The Christian interpretation of life involves understanding ourselves and all that exists in the light of our relationship to God, ourselves, other people and the rest of creation. This can equip us to live in working days and holidays, in joy and sorrow, in crises and disruption, alone and together. Mastering the art of living means being able to live through good and bad days; to have confidence in our own resources and hope for the future. Being created and loved by God makes such a hope possible». In *Plan for Christian Education* (2010), The Church of Norway National Council, p. 14.

At the same time, this includes more than just those who are employed by the congregation. The congregation is in true sense a community where everybody is called to care for those who are in need of help and assistance from their neighbor. A community is in itself health promoting, especially when it is inclusive. It must not be assumed that some are always the strong ones and therefore should always be the caretakers; «Healthy communities offer everyone the opportunity to give and receive. Such communities have room for diversity and ensure that no one is left out».[55]

Local congregations in Norway today will most likely not be able to establish services that provide professional medical treatment. The focus of the local congregation would rather be of a health promoting character, for example, by providing assistance that helps people better cope with a difficult health situation. From a public health perspective it is of utmost importance that members of the civil society take responsibility for such tasks. As we have seen, the public health care services are required to facilitate more cooperation in this area, in particular with regard to services of care. The nursing homes, including the ones operated by municipalities, are often a natural arena for such collaboration.

Hospitality and visiting services constitute two major pillars in diaconal practice. They both can have an important role in the health care related activities of the congregation. Both have as a goal to create a meeting place where the person in need of care experiences being taken seriously. Such meeting places may provide room for personal sharing and guidance, as well as an opportunity to experience a sense of solidarity. Some may need help in presenting their rights in facing public bureaucracy, others are in an acute critical situation and need help to assess their situation. From a diaconal perspective these are meeting places that create opportunities and impetus for transformation, reconciliation and empowerment. This may be experienced as impulses for healing: that processes are set in motion, allowing people to dare to gain new perspectives on life and may even allow them to assume the leading role in the process of mastering their personal challenges in life.

Such arenas can be created spontaneously, but it is preferable if they are created through a planned effort. In many congregations the deacon has a special responsibility for organizing visiting services and creating a hospitable environment. At the same time these are areas where volunteers could have an important role. Volunteerism is in and of itself health promoting, it creates both joy and energy in everyday life. Thus, using volunteers is about much more than saving money; it is about mobilizing and engaging people for mutual benefit and for the community. Thus, it is essential that the recruitment and follow up of the volunteers be given sufficient attention. Again, this is an area where the deacons are particularly skillful. A study showed that in those congregations where there was an employed deacon, those congregations had a broader pool of motivated volunteers and, through planning, made better use of the volunteers' resources.[56]

The same study showed that the deacons also contributed to a larger degree in collaborating with public agencies, for example, with the municipal health care services. This extends the importance of the health related activities of the congregation beyond its own boundaries.

Many important activities have been implemented. The Coordination Reform has already stimulated many congregations to become engaged in new activities. Through this, many people experience support and help in coping with «unhealth» of different types. An example might be bereavement groups where a person, having lost a loved one, can receive help in coping with grief. Through talking with others in a similar situation, new perspectives might emerge and give renewed courage and energy to move forward in life. Or, there could be other arenas providing help for people who are struggling and carrying heavy burdens. This might include the chronically ill, people suffering from persistent pain, those struggling with negative self-esteem, or those who are lonely. Some congregations in the western part of Norway cooperate with municipalities and hospital health authorities in providing services in palliative care; a deacon in the region of Telemark organizes pilgrimages in cooperation with the local mental health services for those who are referred to as «weary people»; in a community without crisis services for women exposed to violence, a deacon has contracted with a few private homes to provide for a «ready-made» bed in case of acute need.

Such activities are not always presented as health promoting, but there are good reasons to do so. It may

[55] *Plan for Diakonia,* p.18
[56] Olav Helge Angell and Anne Schanke Kristoffersen (2005): *Helse og kirke. Kartlegging av diakonalt helsearbeid innen Den norske kirke.* Oslo: Diakonhjemmet høgskole. (TN: Health and Church. A survey of diaconal health work in the Church of Norway).

help to clarify the connection to the Biblical presentation of health and healing and to the continuous call for the disciples of Jesus to provide care for the sick. It can also help to highlight in the public arena that the Church today acknowledges a health mission and is willing to rethink how to express this in concrete ways. This is negates the current claim that there is no need for a health mission of the Church in a welfare society with well-organized public health care services and where the traditional parish nursing is said to belong to the past.

The Church has a particular responsibility to include those in need of support if they are to be able to participate in an equal manner in the community of the local congregation. The Church Council expressed in 2012, «All people should have the same opportunity to participate and belong in the community of the local congregation as equal members, regardless of functional abilities and life situation». An important part of the health related activities of the local congregation is exactly this - to develop community for all, regardless of functional abilities and life situation and to have the possibility of participating and belonging to an equitable community. This is public health work, and is one of the great possibilities and great challenges of the local congregation. This is an arena that is well suited for developing positive and constructive collaboration between the Church and health care services.

These examples all illustrate the particular health related resources of the local congregations, and at the same time point to the trust many people will have when it comes to diaconal activities in this area. The resources are appropriate on individual, group and community levels. In the literature diakonia is at times described as a «go-between» activity. Not all congregations have an employed deacon, but they all have a diaconal mandate and are required to develop a plan for the diaconal engagement. With this in mind, diaconal activities should focus on the task of building and developing relationships. *The Plan for Diakonia* prioritizes inclusive community as an arena for activities. This may be perceived as relating to both the community of the congregation and the open social community of which we are all a part. The task of «going between» is relevant to many of the challenges today, not the least with respect to young people exposed to bullying and other types of violence.

There may also be reason to «go-between» in other situations, for example when somebody has to refute tabloid perceptions of health. It is part of the Church's health mission to speak about health in a way that includes both life and death as part of the health experience. This is also something that Christians should witness about through words and deeds.

4.4 Diaconal institutions

The emergence of the diaconal institutions, from the mid 1800´s, and the role of these institutions in the development of Norwegian health care has been discussed earlier in this document.

There is a tradition in the Church of Norway to speak of the «big four» diaconal institutions: Diakonissehuset Lovisenberg, Oslo (TN: Lovisenberg Deaconess Foundation), Diakonhjemmet, Oslo (TN: Diakonhjemmet Foundation), Diakonova, Oslo (TN: Diakonova Diaconal Foundation) and Bergen Diakonissehus (TN: Bergen Deaconess Foundation). These institutions are in charge of hospitals and university colleges offering degrees in nursing, social work and diakonia. Diakonissehuset Lovisenberg was one of the main sponsors responsible for establishing the Church's resource center against violence and sexual abuse. This foundation is of great importance for the Church's work in this area, providing important health services both in

terms of prevention and in terms of helping persons that have been exposed to abuse.

There are many other diaconal institutions in Norway. In addition to the «big four» (as of August, 2014), nine other institutions are a part of the stakeholder fellowship that is called Diakonia Leadership Forum. These nine institutions are (translation in parenthesis): Blå Kors (Blue Cross), Kirkens Bymisjon (Church City Mission), Kirkens Familievern (Church Family Counseling Services), Kirkens Nødhjelp (Norwegian Church Aid), Kirkens SOS (Church SOS), Kirkens Sosialtjeneste (Church's Social Service), Lukas stiftelsen (Lukas Foundation), Modum Bad and Stiftelsen Signo (Signo Foundation). As pointed out in previous paragraphs, interpersonal relationships are an important aspect of health. From this perspective, the Church´s family counseling services play an important role in health care.

Most of these institutions are organized as foundations. A foundation is independent and self-owned. Therefore, it may be difficult to maintain that these service providers are Church-based and, as such, are an expression of the Church' diaconal mission. As a result, some organizations have chosen another organizational model, as in the case of Blå Kors, Kirkens SOS and Kirkens Nødhjelp. They have chosen to anchor their organizations based on membership or through a direct connection to Church bodies.

The diaconal hospitals represent the most specialized part of institutional diakonia. Three of these hospitals are general community hospitals with long-term contracts with the regional health authorities. They deliver their services as part of the general health plan within the public system. For the most part, they are financed in the same way as public hospitals. Such is the case for Lovisenberg diakonale sykehus and Diakonhjemmet sykehus in Oslo, and for Haraldsplass diakonale sykehus in Bergen. Modum Bad located at Vikersund, and Borgestad Clinic in Skien belong to this group, even though these institutions have specialized clinical services. The first, Modum Bad, provides specialized services within mental health and psychiatry, while Borgestad Clinic provides services to those with drug and addiction problems.

Because these institutions, to a large degree, are organized in collaboration with the public health authorities, many perceive them primarily as health institutions rather than as an expression of the Church's ministry. For the most part, this also applies to other diaconal service providers. They, too, are perceived as professional providers on the same level as providers under public auspices. Therefore, over the last decades much has been done to clarify the profile and basic values of the diaconal institutions. In 1992, the Diakonia Leadership Forum prepared a strategic document with the title *Oppbrudd og fornyelse* (TN: Transformation and Renewal), and in 2001 the document *Diakoni – et annerledes språk* (TN: Diakonia - a different language) was published. Some institutions, for example Bergen Diakonissehjem, Diakonhjemmet, Kirkens Familievern and Stiftelsen Signo, have in their statutory defined their relationship to the Church of Norway. In revising their statutory, other institutions have chosen to change and rephrase direct references to Church of Norway.

The diaconal institutions have extensive educational activities. They have considerable professional competence in the various areas of their expertise, extending into the international arena. It is important to maintain that professional development and research are necessary parts of the Church's work in the area of health. There has been a strong development over the last 25 years in the form of active cooperation across professional boundaries. The development has occurred primarily in the area of psychology of religion. This research network now consists of approximately 20 persons with ongoing or completed doctoral dissertations; the network arranges a yearly conference and participates in the international network in this field. Researchers in this network group come from Menighetsfakultetet (TN: Norwegian School of Theology), Diakonhjemmet Høgskole (TN: Diakonhjemmet University College), Teologisk fakultet (TN: Faculty of Theology, University of Oslo) and Modum Bads forskningsinstitutt (TN: Modum Bad Research Institute) but also from other institutions in Oslo and elsewere in Norway.[57] During the same period there have been other important development works such as the VITA-treatment at Modum Bad, the establishment of Viken Center for psychiatry and pastoral counseling in northern Norway and the establishment of the Center for Psychology of Religion at Innlandet Regional Hospital. The *Journal of Pastoral Counseling* and the Pastoral-Clinical Education Program are both now

[57] The group published in 2014 the text book *Psychology of Religion*. Oslo: Gyldendal Akademisk

integrated into the academic meritorious system. This can been seen as part of the professional development in the health field and as a key contribution to the Church's work on health issues.

During a time when diaconal efforts are experiencing a certain degree of decline, it is important to recognize and confirm this development and see the potential that exists within this professional community such that the Church can continue to be proactive and constructive in the health field. The research being carried out within this professional community focuses on faith as a health asset, on spiritual care and on a broader understanding of health. Thus, it is relevant to the discourse regarding the characteristics of diakonia and the distinctive contributions of the Church. Based on the importance that health issues have in our society, it is important to continue to develop the activities in this area in order for the Church to have a qualified and informed voice in the discourse on health.

Institutional diakonia is not always included in presentations of what the Church of Norway is and does. Perhaps this is due to the fact that the image of the Church continues to be formed by a portrayal of the Church as a State Church and of the pastor as a representative of the government. This may have created an understanding of the Church as a «centralized entity» where the church building and the employed staff function as the key reference points. Given that the Church of Norway has recently become a free folk church, it may be advantageous for the Church to find additional reference points, for example in the diaconal institutions. This would give a multidimensional image of the Church involving more participants and processes that would, in various ways, contribute to the presence and ministry of the Church.

Therefore, there are many reasons for the Church, both locally and through central bodies of the Church, to acknowledge the diaconal institutions as important expressions of the Church´s health mission.

Such recognition would be of help to the diaconal institutions. Many institutions are actively engaged in the issue of how to express the diaconal character. In the interface with politicians and health bureaucrats, it is important to make explicit how diaconal institutions are different from commercial providers in the health market. At times the diaconal profile is presented as simply being a non-profit, charitable enterprise, without clarifying what this means in terms of day-to-day operations. Therefore, using the concept of diakonia may give more clarity to the understanding of the character of the organization, for example by referring to the Christian view of humans and to other fundamental values such as justice, equality, and compassion. The character of the organization should be evident in everyday practice, for example by attending to the patient as a whole person, by offering spiritual care to the residents, and through nurturing employees as valuable co-workers.

Many diaconal institutions have made arrangements for the use of volunteers. Volunteers often have the time to engage in conversation and to provide care that supplements the care provided by professionals; these are needs that may not be fully met in the course of a hectic workday. This is an area where it is possible to strengthen collaboration between institutions and local congregations and through this confirm their mutual roles in the Church's health mission. Many local congregations have already organized visiting services at diaconal institutions, but it is possible to envision an extension of this collaboration. Experiences from the United States related to collaboration between hospital and local congregations, show that follow-up services of patients at home after major surgery has a noticeable positive health effect.

Cooperation at the local level is an important task that can be expressed in many different ways, for example through the development of the congregation´s plans and activities. One can inform the congregation about these activities through regular newsletters, posts on the bulletin board and, not the least, through inclusion in the prayers of the congregation. One can also extend invitations to getting-to-know-you arrangements. The regular visitation of the bishop is a special opportunity where one can make explicit the connection between the diaconal ministries of the congregation and those of the diaconal institution. For some diaconal institutions closer cooperation with the Church would be most relevant on a district level.

Leaders of diaconal institutions will be encouraged to know that the Church stands behind them and confirms their work. Their everyday life is characterized by

demanding challenges. The specialized health care services are increasingly more expensive and demands an increasingly high level of professional competence. The public image of these institutions as user and service oriented can easily be weakened if a perception is created that the level of medical treatment is below expectation. We find the same tendencies in health care for the elderly and in other sectors where diaconal institutions are active. There is an increased demand for efficiency and professional management, and there is an uncertainty about the long-term survival of the institution within the framework defined by government.

There is no doubt that institutional diakonia will face great challenges in the future, whether in the area of provision of hospital services, care for the elderly or other areas of diaconal ministry. The Church will need to take on the task of publicly acknowledging the role of the diaconal institutions in the public sphere. This will include confirming the institutions as participants in the public discourse regarding the future health care services in Norway, including the political and economic conditions for these services, as well as what qualities and values they are to promote. When the parish nurse ministry was dismantled more than 40 years ago, there were few Church leaders who reacted. To a certain extent this was also the case when the HVPU-reform (TN: Mental Disability Reform) was implemented a few years later. These reforms were both needed and necessary, but could the Church have asserted its health mission and diaconal concerns more clearly? If we today see a tendency toward fewer diaconal institutions or a weakening in the quality of their services, should the Church, through its relevant organizational bodies, allow its voice to be heard and take a shared responsibility? It is worth considering what «capital» the diaconal institutions represent for the Church of Norway. This is about a «capital» that is multi-dimensional. It can be described as professional, social, symbolic and religious, where its real strength is in the interplay between the various dimensions.

At times, representatives for the diaconal institutions have expressed a wish for the top leadership of the church to more clearly articulate and confirm their role as social actors on behalf of the Church. Their primary mission is to promote a strong society with ample services for the sick and needy, motivated by the vision of a God who wants the best for all those created in the image of God. In this respect they ensure that the Church is actively present in the various areas of society where people experience the vulnerability of life. Here the diaconal institutions contribute to the establishment of credible contact between church and population. Is it possible to expect that the Church not only acknowledge the diaconal institutions as part of the Church's health mission, but also include them in their plans and strategies, to the extent that the Church can proceed to develop goals where the institutions are encouraged to participate in their implementation?

4.5 Pastors and deacons in public institutions

The diaconal institutions usually employ pastors and deacons, most of whom perform the services to which they are ordained. In the past there was a tradition of recruiting theologians and deacons to leadership positions. Pastors were chosen to the position of director (t/n-forstander) both to underscore the institutional connection to the Church and because the leadership role had a spiritual dimension. Pastors and deacons are also employed in public health care and social services. Here, they are generally employed in their professional roles as hospital and prison chaplains. In some places, such as St. Olav´s Hospital in Trondheim, both pastors and deacons are employed as chaplains. Those filling these roles often find their positions defined in two different ways. On the one hand, the person is ordained to perform a Church ministry and thus is under the auspices of the bishop. On the other hand, the person is employed as any other employee in the health care institution, working under the same conditions and with the same responsibility to report to the leadership of the institution. This dual relationship structure gives a special profile to these roles. The first one ties the roles to the faith and practice of the Church as expressed through preaching, pastoral counseling and the administration of the sacraments. These are services of the Church that loose their character if they are completely subordinated into the professional practice of the hospital. The other maintains the importance of being aware of the professional and organizational framework of the institution, recognizing that opportunities for professional practice would be more limited if the pastor or deacon comes

from the outside, as an extension of the church into a professional setting with high professional demands.

Lately, this has been connected to the discussion of «a society open to a diversity of religions and life stance», where some claim that any religious- or spiritual community could be represented in the role of the hospital chaplains. This argument runs the danger of undermining the professional competence that chaplains have developed over many decades. This professional competence has three basic components: First, their professional competence used in collaboration with other professional groups. Second, their responsibility for a holistic perspective in the professional discourse, based on the patient´s experience of what is happening to him/her. Third, their skilled competence in pastoral counseling. One cannot assume that an arbitrary representative from any religious or spiritual community would be able to fill the same role.[58]

The situation will also arise where a patient wishes to meet a representative from his or her own religious community and, of course, this wish must be respected. In order to accommodate this need, the Oslo University Hospital has gathered from its many experiences and, as a result, has developed an action plan. In addition to using the hospital chaplains, the hospital also offers «conversation partners» from different religious and spiritual communities. These are persons who have been through a continuing education course and a supervised practicum where they hone their skills in talking with people in a crisis situation. In safeguarding the holistic treatment and care of patients in hospitals and nursing homes, it is important to secure the professional competence of pastors and deacons. A resource team should, therefore, be an addition and not a replacement of this church ministry.

The hospital chaplain´s competence is not only used in direct encounters with individual patients, but also in other areas as, for example, in clinical-ethics committees, ethical reflection groups and in similar professional development projects. In a time with increasing diversity regarding patients ethnic, cultural and religious background, it is important that there is someone in the professional team with an understanding of what this implies. This is about having professional sensitivity for the resources that can be released through a patient's faith and spirituality, but also incurs the risk of burdening the patient because he/she may feel offended without anybody really noticing what happened.

There is no doubt that pastors and deacons working in the public health and care institutions contribute to the realization of the Church's health mission. The public status awarded the Church of Norway through the *Norwegian Constitution* and the *Act of Church of Norway* provides the basis for a church ministry in public institutions, for example in hospitals. However, the services must have a design that acknowledges and includes openness towards different life stances, and that recognizes within this framework the special role of the Church of Norway as a carrier of national traditions. This reasoning is not based on the needs of the Church, but rather on the needs of the public, more importantly, the needs of the patient.

On the other hand, this is a need that calls the Church to serve, not in any hegemonic way that demands a place for the Church's agenda, but rather ministry as a conscious and competent presence. In fact, these are arenas where health institutions, patients and family want this kind of presence, particularly the combination of profession and faith. Ordination to the Church ministry and the vows therein are also relevant to this context. The ordination empowers the person to take on the uniqueness of the ministry, and it anchors the professional competence expected of the pastor and deacon.

4.6 Focal areas for the health mission of the church

Thus far, the document has covered the extent of the Church's engagement in the area of health and care services. This is expressed on different levels, from prevention in local communities to specialized medical treatment at a high professional level. The Church´s engagement mobilizes volunteers and experts, and it is expressed through local communities, ambulant activities and large, complex institutions.

Both comprehensiveness and diversity are in themselves resources, but can also become a problem if the resources are spread too thin or, perhaps more importantly, if they function independently and fail to draw

[58] Comments of the Church Council (KR 39/2013) to the white paper NOU 2013:1 *Det livssynsåpne samfunn* (TN: A Society Open to a Diversity of Religions and Life Stance).

strength from one another. Networking and collaboration are therefore important internal challenges in the Church and diakonia, not only as related to public agencies and providers in the civil society.

At the same time one can question whether the Church should prioritize certain areas of activity based on the distinctiveness and values inherent in the Church's engagement, and based on an analysis of the status of health in Norway today. The goal of diakonia has traditionally been to provide services to the most disadvantaged. It is still the case that diaconal services are generally directed toward the chronically ill, the elderly and those with drug related problems, areas that are often perceived as having lower priority in today's health and care services. Should the Church continue to prioritize these areas, or are there other challenges that should be considered? What are the conditions for providing diaconal activities in these areas? Is it possible to establish a good environment for collaboration, both with public and volunteer organizations?

The elderly, care and dignity
Care for the elderly has been an area prioritized both by local congregations and diaconal institutions. There is every reason to assume that will also be the case in the future. At the same time, elderly people also represent a resource in society. It is therefore important to collaborate with the interest groups and organizations under the auspices of the elderly.

It is clearly an important task for the Church to help people to face the last stage of life with dignity and surrounded by care. An important part of this is to help people in their efforts to master both life and death and to confirm their dignity. These are arenas where it is possible to promote the Christian perspective and fundamental values that each person is unique and valuable throughout all stages of life and independent of health status. In addition, we also note the clear invitation from the political level to collaborate in providing the health and care services. The present care model in Norway is not sustainable considering the increasing number of elderly who will need nursing care in the coming decades. According to calculations from the Norwegian Bureau of Statistics, by 2060 there will be a need for 4.4 times more health personnel than is the case today. Given these figures, it is predicted that 38% of the work force in Norway will be working within the health and care sector. This is not feasible economically or in terms of personnel. Therefore, new models of extended collaboration are needed, including models that allow for the elderly to manage independently for as long as possible. Both as a local congregation and through the diaconal institutions the Church could be a partner in the development of such new creative models. Active aging is a relevant theme in this respect.

Persons with drug-related problem
Another health area where the Church traditionally has had a strong engagement is in the area of treatment and rehabilitation of drug-related problems. One reason for this is that many have seen the adverse effects of drug-related problems. This is not just about the drug-user as an individual, but about the parents and sibling as well as the extended family. It is especially tragic when the drug-addiction harms children and when violence is part of the picture.

One aspect of the Church's engagement in this area has been with in-patient treatment services for persons with drug-related problems. There will likely be a need for this type of service also in the future. Equally important are services to those who are indirectly affected by the drug-abuse. Many live with shame and dissimulation, bearing hidden wounds of body and mind, and carrying with them the fear of what may happen the next time there is an episode of drug use. The Church´s engagement in this area has also focused on preventive work, especially through involvement of the local congrega-

tions. Traditionally, all events and arrangements sponsored by congregations have been alcohol-free. There are many good reasons for preserve this principle. Diaconal ministry directed toward youth has an important role in offering alcohol restrictive zones and in promoting drug-protective attitudes. The vision must be to offer hospitable venues and to develop relationships that promote health and healing.

People with chronic disease or disability
In the future, it is possible that the Church should focus more on health promoting activities that will help people to master their everyday life. This is particularly important for those with chronic diseases and with disabilities. There are many different categories of disability. The Church has a long tradition of engagement in this area, especially for those with multiple disabilities, both physical and mental. Diaconal institutions such as Signo have done pioneer work in this area (t/n: The foundation Signo offers nationwide services to deaf and deaf blind persons).

Most people living with disabilities live a good life, residing in their own homes with good social networks. They feel healthy and are well functioning, and they are to be accepted for the individuals they are. At times those with disabilities may experience that poor health and the related symptoms are not taken seriously because all the focus is on the disability. Their experiences related to mastering health challenges represents an especially important resource, both for Church and society. Therefore, everyone will loose when those with disabilities are excluded from participation in the community either through physical or social barriers. It is an important diaconal task is to ensure that people with disabilities have access to Church arrangements and venues.

What concrete activities can the Church develop in order to raise the quality of life for people with disabilities? This can be divided into three challenges. First, the local Church includes people with disabilities in the communion of the Church in a dignified and professional manner, both in terms of a facilitated community or the general community of the congregation. Second, the Church advocates the cause of the weak when it comes to social rights and access to resources. Third, the Church explores the potential for daytime activities in terms of work or through an activity center.

Unfortunately not everybody with a disability, who wants to work, is able to find appropriate work. Here, it is important to reiterate the emphasis on the struggle for justice as spelled out in the *Plan for Diakonia.* In addition, it is important to underscore that the Church of Norway General Synod has solicited all Church employers to exceed the recommendations of the *Personnel Regulations for State Employees* with respect to the employment of disabled persons (KM 13/06). Lack of employment may be one of several factors contributing to loneliness and the feeling of being superfluous in society. The inclusive nature of the community is relevant. The important point here is to act toward those on the periphery in such a way that they are invited into and become a part of the community. It is equally important to allow the community to prosper through the richness that comes with inclusiveness.

Loneliness
Today, many people experience loneliness as a vicious circle where health problems lead to a loss of vigor, that in turn can lead to additional health problems.

Mastery and networking are therefore important key concepts in the Church health ministry. In the development of future health and social care services, it is important to look beyond the professional health workers and confirm the importance of «natural helpers» and their roles in health care.[59] Family, relatives, friends and neighbors can make the difference when a person is struggling to manage life, whether it is with respect to physical or mental problems. However, not everyone has this type of natural network. It is, of course, possible to develop a network. It may be a tightly or loosely knit network, all depending on the situation, what is required, and what resources are available. It is clear that good networks can be built and strengthened where congregations prioritize this as a central diaconal ministry and where deacons are available to recruit, motivate and support volunteers.

Mental disorders
Mental health represents a special challenge from a public health perspective. There is every reason to applaud that this has been made a political priority. During a lifetime, approximately half the population will experience mental problems or disorders. Anxiety and depression are the most common of these disor-

[59] Live Fyrand (red.) (1993): *Perspektiver på sosialt nettverk.* Oslo: Universitetsforlaget (TN: Perspectives on Social Network).

ders. Diaconal institutions are heavily involved in mental health services on a high professional level; nevertheless, this is an undertaking that can receive a greater focus. Mental health is an area that is often dealt with through secrecy and denial. The Church, and particularly the local congregations, can contribute to greater openness about mental health. This is the most important health problem affecting children and youth; 7-8 percent between the ages of 3-18 (approx. 70.000) have a mental problem that requires treatment.[60] This is a problem area that was discussed at the Church of Norway General Synod meeting for Youth (UKM 07/11), and where the Church was challenged to focus more on youth and health:

> «Young people face a number of demands, both from themselves and others, in terms of being perfect, healthy, successful, find a career. (…) This is in sharp contrast the view that it is normal for young people, for a period during this stage of life, to experience anxiety, depression, eating disorders or behavioral problems (…) The Church must be a place where we can talk about life as it actually is and where we can be ourselves. It is a task for the Church to promote human dignity. Everyone coming to the Church must be received with respect.[61]

As stated previously, many of the diaconal service providers do provide health services on behalf of the state and municipalities. This does not exempt them from having a special focus on people who are in particularly vulnerable situations in our society. The goal must be to make their situation less vulnerable and to ensure that they have access to the same public services as anybody else.

Refugees and the multicultural society
A special feature of today´s society is the movement from a mono-cultural to a multi-cultural society. Among the most vulnerable in Norway today are immigrants. In this respect, this development has raised challenges in terms of clinical services and in terms of communication with health personnel.

In the clinical area, the multicultural society has led to more complex and complicated medical situations and, at least in part, the resurgence of diseases that were considered abolished, for example tuberculosis. As a result of this development, migration health is now a defined professional discipline at many colleges of nursing. For the same reasons, knowledge and education in tropical medicine are experienced as more relevant in health institutions.

Challenges in the area of communication involve the exchange of health information, ensuring early contact with the health services in order to treat and prevent somatic and mental disorders. Studies show that children of immigrants have 3-4 times more dental cavities than ethnic Norwegian children. This clearly indicates that the need for dental care is poorly communicated.

Many immigrants come from countries ravaged by war and conflicts. In order to prevent and treat post-traumatic disorders those working in relevant health care facilities need extensive knowledge of culture and language in addition to empathy in their encounters with the individual seeking help. It is of great importance that the individual feels seen and appreciated. This is a special responsibility for diaconal health service providers.

The work of the local congregation in creating inclusive communities will be of importance. Collaboration with other local organizations and public agencies will be necessary.

The right to free practice of faith and spiritual and existential questions
The right to exercise one's religious faith and life stance and the obligation of the service providers to facilitate this is stated in the document from the Ministry of Health and Care (see page 29). With this in mind, it is important that the local congregation takes the role of an active participant in order to make room for individuals in need who wants to be part of the community.

Spiritual care is a substantial part of the priority areas mentioned here. It includes a fundamental readiness to meet people on their own terms in reflections about existential, spiritual and religious questions. It includes respect for the person´s thoughts, ideas and feelings as well as the ability to listen. The practice of such care is possible where there is time, trust, and faith to participate in the journey with another person.

[60] http://www.psykol.no/Foreningen/For-pressen/Fakta-om -psykisk-helse
[61] http://www.kirken.no/?event=showNews&FamID=215858.

Sometimes the spiritual care provides space for providing pastoral counseling, guidance and prayer. From a Christian perspective, these actions carry with them the implicit promise for reconciliation, transformation and blessing. However, this must not be a hidden agenda when offering spiritual care; if spiritual care does not open up for specific Christian acts, it is important that it not be seen as a type of failure.

The ability to show care is fundamentally human. Sooner or later everyone will face adversity in life, and everyone can experience that life is easier to master because somebody cared. In the perspective of faith, this is something that God calls all of us to do, in the same way that God cares for everything and everybody. At the same time, as a human action, care is ambiguous because it is exercised in a setting that requires sensitivity to that which is vulnerable and intimate; it runs the risk going too far and being perceived as pity, and may even lead to abuse. This is particularly the case for spiritual care. Therefore, it is important to strengthen the insight and competence of those working with these issues.

Mastery of life and community

Behind all of this there is a fundamental conviction that the Church's health mission is of importance and can make a difference in peoples´ lives. This happens when somebody experiences being seen, cared for or helped. There are not only factors causing disease and death, but there are also factors causing health, well-being and mastery of life; this is the case both for human beings themselves and in the existing context of life. The Church would like to promote these factors. The relational aspects of human life are prominent in several of the priority areas. Thus, an important area of activity for local congregations is to develop inclusive communities both internally in the congregation and in the local community. Strengthening and empowering people to master their own lives are important health promotion tasks.

4.7 The church in the public debate about health

The Christian view of humans and society is important for understanding the Church's health mission. Both are formed by Biblical images and perceptions and confirm fundamental values such as human dignity and justice. The view of humans is based on the Biblical text that human beings are created in the image of God, and the understanding that the will of the Creator is for all people to have a good and meaningful life. It demands a commitment to a holistic view of humans and to the right to be in charge of one's own life, even when health is failing. In the same way, the view of society is connected to the Biblical texts about the good community where justice and righteousness reigns, where there is a place for the stranger and the poor, and where «widows and orphans» are not left to themselves.

These are motives that should characterize the concrete activities of the Church when providing health and care services. It is also important that these are expressed in the public sphere, in the public exchange of what is good health, and not the least, in how to design the health and care services. It may be that the voice of the Church too often is absent in this discourse, or that it is articulated too randomly. Perhaps this is due to an uncertainty about who should speak on behalf of the Church in these matters and unclear strategies about how to bring forward the concerns of the Church. This does not mean that the Church is silent; for example, the Church gives important contributions through the preparation of «hearing documents» in response to political priority issues presented by the Government. It is important to strengthen this work by, among other things, coordinating the competencies needed to prepare such hearing documents on an informed and professional level. Several of the colleges and universities offering degrees in diakonia and theology have extensive research-based professional competence that is not always conveyed adequately to those with leadership responsibilities in the Church. There may also be a need to develop strategies at different levels in the Church in order to adopt a clearer role in the public discourse, for example, through more assertive involvement in the media.

It is also important to observe that the academic activities within the church-health sector (refer to section 4.4) include a broad level participation in the public debate about health. This applies to the public defense of doctoral dissertations, professional and academic books and articles related to health, presentations at conferences, congresses, and seminars, open lectures to the public, participation in the public debate related to belief and health, and more. All this is presented in the general academic and public discourse about health in society. It is important for the public debate that there is good communication between the organizations of the Church and the professional research communities in order that the contributions made by all parties can be perceived as input to the public discourse about Church and health.

This may be a complicated task for the diaconal service providers. They are performing services on behalf of the public, and to the extent possible they will avoid situations where they may be perceived as critical of those with whom they collaborate. But is the implication of this that they always should be in agreement with the authorities? It is conceivable to have a division of responsibility in this area; for example, could the central Church bodies have special responsibility to monitor what is happening in the health and social policy area? This presupposes that there is internal coordination in the Church.

It is important to identify priority areas. One such area may be the contribution to a truthful discourse in the public sphere about life and death. We need to have a critical view of the various forms of reductionism that at time are expressed and that may narrow the understanding of health to a more limited concept of physical «fitness» or absence of a diagnosis. It is important to emphasize that «health is more than health» as it is clearly presented in the book *Helse på norsk*.[62] The authors showed that those interviewed associated health with factors such as well-being, good relationships that contributed to making life meaningful, and wholeness and mastery of life. Each of these were important, but were not portrayed as absolute ideals. On the contrary, most of those interviewed expressed a more pragmatic approach to life, saying that their experiences did not have to apply to others. They claimed that health dwells in a good enough life, not in the perfect body or soul.

[62] Per Fugelli og Benedicte Ingstad (2009): *Helse på norsk.* God helse slik folk ser det. Oslo: Gyldendal akademisk. (TN: Health in Norwegian. Good health, the way people see it).

These are attitudes the Church should confirm and strengthen through preaching and other contributions to the public sphere. This will function as a counter-balance to the tendency to present health as absolute happiness, or the temptation to rank order the meaning of life along a scale of healthfulness. Health is not anything that can be explained by a simple formula in the way it is sometimes presented in the tabloid media. It is necessary to speak out against perceptions that present disease and other sufferings as abnormal. Stereotypical perceptions of perfect health may lead to a weakening of the human dignity for those who fail to live up to the ideal. In a worst case scenario, this may create the perception that some forms of human life, for example those with extensive disabilities or those suffering the frailty of old age, are not worth living. At its most extreme this may in reality provide arguments for a practice that in reality represents a movement in the direction of a view of human beings at the mercy of a sorting society.

Most people want to take care of themselves, but this must not lead us to the wrong conclusions about being dependent on the help of others. Therefore, it should be clearly stated that it is natural to need care and assistance from others. This is the case for most of us, especially as we approach death. As a way of illustrating our vulnerability, the Bible says that we are «dust», but it also reminds us that God «knows how we are created, and he remembers that we are dust» (Psalm 103, 14). At times, the weakest members of society are unilaterally presented as an expenditure in the health care budget, as if they are solely a burden. It is essential that the Church raise a voice in protest against this stance. If we are going to refer to a burden, the real burden is that which is placed on them and their relatives as a result of this type of labeling.

An inclusive society must show respect for and ensure good conditions for all citizens. This is according to the Biblical view of society, and it strengthens the perception that justice is an important value in the health and care services. With this in mind, available services must be arranged in such a way that «the last becomes the first». The Church and other stakeholders must have a critical eye on the development within health and social policies and must question the underlying assumptions. If there is a development toward a more commercial health market, it will be important to question the implications this will have in terms of changing values. Will it provide easier access only for those who are resourceful and who need occasional medical care while making it more difficult for those at the other end of the spectrum?

In some areas, it is particularly important that the Church uses it´s voice in the public sphere. This is the case regarding the public debate in the area of alcohol and drug policies. Increasing alcohol consumption in the population affects everyone, but the knowledge that children and young people are paying the brunt of the cost for the adverse alcohol habits of adults, presents a challenge for the Church. The Church´s commitment to the more than 90,000 children who childhood is affected by the adverse drinking habits of at least one of their parents must be expressed more explicitly, including in terms of proposing changes on a political level. Norway´s alcohol and drug policy, characterized by uniformity and consensus, is under political pressure. There is great need for an active support from the Church for an alcohol and drug policy characterized by solidarity and for activities leading to more responsible use of alcohol among adults.

Another challenge in this age of globalization is the free mobility of people crossing national borders. This mobility takes many forms, among them the many who come to our country seeking a better future, often fleeing war and poverty. Among those who seek asylum, many experience that their application is rejected. Nevertheless, they choose to stay in Norway. From a legal point of view, they are not entitled to remain in the country, and this limits their access to health care services. There is uncertainty regarding the number of «paper-less» immigrants in Norway, but it is estimated to be between 10.000 and 30.000. Many of these immigrants have various types of health problems, including mental health problems. A number of diaconal institutions have established health care services to this group, something that is of great importance to those who benefit from these services. Eager and committed health workers use their leisure time to provide these services. So far, the authorities have responded by declaring these activities to be illegal and, in some cases, there have been threats of economic sanctions against these organizations.

It is unworthy that a group of people this size is systematically being refused access to health and care services. Many of them are children and many have lived in the country for years. Even when it is clear that the individual does not have the legal right to asylum and public services in Norway, it is nevertheless essential to emphasize that the person in question remains a living human being who deserves to be treated with dignity.

This illustrates, on many levels, the unjust distribution of wealth in the world. From the perspective of the Church this is an intolerable situation, and it requires concerted effort to strengthen the health care services in the poor parts of the world. The United Nations Millennium Development Goals (MDG) addresses important health challenges today. Considerable progress has been achieved in some areas, but there are still many challenges remaining. Today, there is an increasing awareness that the responsibility of promoting health is a task the worldwide society has to share. In many countries it is unreasonable to expect that the national health care authorities will be able to handle this alone. The efforts to meet the intentions of the MDG will be evaluated during the course of 2015, and it is expected that new goals will be formulated. The worldwide church is involved in this process, advocating an increase in the health-promoting efforts, with particular focus aimed toward those who are most in need. Our privileged situation as one of the world´s riches nations requires that we have a high level of commitment in supporting and carrying out these goals.

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Deliberations from the general synod

Comments from committee on diakonia and social issues of the general synod 2015

1. Reference point
The vision of the Church of Norway,"More heaven on earth", states that the Church of Norway is a confessing, open, serving and missional "Folk Church" (in Norwegian: folkekirke). The committee believes that health related activities are part of the Church's health mission and, through this, contributes to the efforts of achieving this vision. The committee further believes that the present document, Church and Health, makes a significant contribution to an overarching and comprehensive understanding of the Chruch's health promoting ministry. This is based on the document's formulation of the Biblical perspective and the discription of some of the major development trends in society related to challenges facing the health and care sector.

The Church's vision of health is anchored in the works of the Triune God in the world. God creates all people in His image and gives every person a divine dignity. God became human and meets us in Word and Sacrament as the crucified and resurrected Jesus Christ. The Crucified and Ressurrected also meets us through the vulnerable, repressed and wounded human beings (Matt. 25, 31-46). The Holy Spirit is given through the Word and the Sacraments, and the Church is created as a grace community where all humans are included. The Church is given the mission of continuing the healing ministry of Jesus; this liberates and mobilizes for participation.

The World Council of Churches has formulated a holistic vision of health: "Health is a dynamic state of wellbeing of the individual and the society; of physical, mental, spiritual, political and social wellbeing; of being in harmony with each other, with the material and ecologic environment and with God". This vision is to be realized in a world characterized by the vulnerability of humans where there is a lack of well-being experienced along these five dimensions and where there is a breach in relationships between people, between people and nature, and in the communities on a local, national and global level.

2. A Holistic Understanding of Health
The document refers to a comprehensive concept of health and a holistic understanding of health. The committee will emphasize the importance of this in our society, where we often are met with a tabloid understanding of health and a body-focused culture cultivating a one-dimensional and superficial image of good health. Body and health are becoming more commercialized. In the health care services there is, to a certain extent, a focus on metrics and what can be counted. By basing the understanding of health on a holistic concept, the Church can function as a counterculture in this respect. The Church is challenged to evaluate its own practice and its own attitudes based on the document's holistic understanding of humans and health.

The committee will affirm that one of the goals of diakonia is to promote respect and dignity. Diakonia will help people to live in reconciliation with themselves and others, and will empower people in their own lives. Spiritual care is part of a holistic understanding of health. The committee will emphasize the Regulation I-6/2009 from Ministry of Health and Care titled Retten til tros- og livssynsutøvelse (TN: The right to exercise one´s own religious beliefs and life stance). There is a need to strengthen the competence in the health care sector in this respect and to implement the prepared guideline titled Samhandling mellom helse- og omsorgstjenesten i kommunene og tros- og livssynssamfunn (TN: Collaboration between municipal health and care services and communities of religion and life stance), published jointly in 2013 by the Council for Religious and Life Stance Communities and the Directorate of Health. A prerequisite for the public health services taking their responsibility seriously in this area is that the local congregations contribute in close collaboration. The Cooperation Reform opens up new opportunities for collaboration between local congregations and municipalities in this area.

The Committee will also emphasize that through the ordinary activities of the Church, such as preaching, liturgy of the sacraments, prayer and pastoral counseling, important health-promoting activites take place. It is also important to emphasize that music and

different expressive arts, performed at different venues including local congregations and institutions, have diaconal and health promoting aspects.

The Committee will underscore the connection between physical and mental health, nutrition, and physical activity. It is important that local congregations and Christian organizations encourage creativity and physical activity.

3. Welfare State, Health and Social Differences
The Norwegian welfare state has been developed over generations, in part inspired by the Church's diakonia and by an emphasis on human dignity. Every good social and welfare arrangement provides safety to the population. A legal rights perspective is vital to the Norwegian welfare state´s understanding of health care and welfare services, thus ensuring that health and care services and the full range of social rights are made available to the entire population. The challenge to the welfare state in the future is how to maintain and develop these rights and services in a sustainable manner. In order to secure the viability of the welfare state it is necessary that citizens' rights and obligations are well-balanced.

The welfare services are carried out both through public and volunteer efforts. The Cooperation Reform supported by the Health and Care Act and Public Health Act, allows for the participation of non-governmental institutions and organizations as important resources in the future welfare state.

There is an increase in social and economic differences in society. This is also a problem for public health. A balanced distribution of society's resources promotes health and well-being. However, a skewed distribution leads to, among other things, differences in life expectancy among various groups in society. It is also of concern that too many people are excluded from the labor market.

According to the Committee, the welfare state has a special challenge related to the imbalance of available services and the lack of access and rights for those falling outside the system.

In particular, the Committee wants to focus on the lack of adequate health care services for undocumented immigrants. These individuals live in Norway without the legal right to asylum, and many of them have had their applications declined. Various health problems are common among this group, but their right to health care is very restricted. Undocumented immigrants are one of the most vulnerable groups in Norway and in Europe. The Committe finds it problematic and unworthy that this group is systematically excluded from important health and care services.

Several diakonal institutions and other organizations have etablished services for undocumented immigrants. Committed health care professionals use their leisure time to make these services available. The Committee wants to recognize the invaluable importance of this kind of services.

Several organizations, among them Red Cross, the Church City Mission and the Norwegian Medical Association, presented a petition to the governement in january 2015, asking that undocumented immigrants staying in Norway be awarded access to health care services. The stance of the petition was based on medical assessment, ethical guidelines for health professionals and principles of human rights. The Committee endorses this petition.

4. Wholeness, dignity and healing
The Church has the responsibility for affirming and promoting the human dignity of all humans from conception to the end of life (Item KM 9/2014 Den norske kirke og menneskerettighetene. TN: The Church of Norway and Human Rights). The dignity of humankind is steadily challenged. The media presents a one-dimensional ideal how one should look and how one should define prosperity. In the public bureaucracy, including within health care, people are at times referred to as expenditures. The Church must raise its voice in opposition to these ideals and provide alternatives. The diversity of humankind must be enhanced as a means of counterbalancing this narrow view of body, appearance and functionality. Valuing human diversity, as represented through different languages, culture and different expressions of identity, is an important contribution to good health.

The loss of or lack of support for the Sámi and Kvensk languages represents a health challenge, especially for the elderly having Sami and Kvensk background when

using the health care services. Recent research shows that ethnic discrimination of Sami is still a problem in Norway. About four out of ten Sami-speaking adults say they have experienced ethnic discrimination; this is roughly ten times more than for ethnic Norwegians. Self-evaluated health status is somewhat worse among Sami than ethnic Norwegians, and it is lowest among Sami living outside the Sami administrative areas. The Committee is of the opinion that the Church's efforts to recognize and make use of the Sami and Kvensk language and culture are important from a health promoting perspective.

The Committee wants to point out that this challenge may also apply to people of other minority cultures and language groups. It is important that recognition of language and culture be included in any health-related work.

Healing is perceived in the Bible as a process that restores coherence and wholeness. The image of God as healer shows a merciful God who strengthens vitality and gives hope to the sick. God´s work is manifested through all the care-taking activities that occur between people, through health care services and health personnel, through diaconal institutions and organizations. There is a tradition in the Church for praying for the sick and providing care and companionship. The liturgy of the Church includes prayer and anoitment. Many people have told of the experience of healing, although they were not cured of their disease. Some individuals have recovered from their disease without there being a good medical explanation. These types of experiences must not be understood in terms of the strength or quality of the individual´s faith.

The Committe will maintain that in the Sami tradition health is understood from a holitic perspective where the physical, mental, social and spiritual aspects of a person are interrelated. Jesus used clay from the earth when healing the man born blind. In the same way, the Sami healing traditions include elements that make explicit how the health of a person is connected to the earth and the elements. For indigenous people, protecting the created world and the environment, the basis for their sustenance, is fundamental for the physical and spiritual health of both individuals and community.

In the Sami culture there is an ancient Biblical and folk tradition of praying for people, and understanding that some individuals have a particular ability for healing the sick. This tradition is especially strong in the Læstadian groups in the Sami areas.

The Committee will emphasize that a holistic concept of health, with a focus on human dignity and mastery of life, provides an approach to many of the ethical challenges we see in today's society. The Committe expects the Church to participate in the public debate and to get involved in important existential questions. Some of these questions may be relevant for the agenda of the Synod meeting, whereas others are better pursued through research, public hearings, continous ethical reflections and concrete actions.

5. Affiliation and Community

The Church's presence in every municipality in Norway represents a unique possibility for inclusive and open communities for all. The Committee wants to emphasize that inclusion and community are important health-promoting elements. These elements are provided in the Church as a gift through the ritual of baptism. In baptism the individual becomes a part of the Christian community, regardless of health or ability. The Committee refers to this in the document KM 9/2012 about equality, inclusion and facilitation. In the resolution paragraph 1, it says: "All people should have the same possibility to participate and belong to the community of the local congregation as equal members, regardless of functional abilities and life situation".

The Christian community includes concrete local fellowships, connections to the national and universal Church, and traditions that bind generations, the past, present and future, together. Cultural expressions in visual art, music and architecture contribute to and underscore this experience of belonging. Also individuals that are alone can experience this type of communion and beloning together. This type of belongingness can also be experienced by the individual when alone.

Vounteering is health-promoting. The person who at the outset may be defined as a provider, can also be the recipient of joy and opportunity for development and growth, while the individual who is initially defined as the beneficiary, may be the one who has the most to give.

The Committee wants to emphasize that an inclusive community is particularly important for those who are facing the challenges that come with being outside the labor market.

The Committee points out in particular that loneliness is a significant problem in terms of mental and physical health. This is a special challenge for the local congregation who can contribute with unreserved presence and availability. Relationships can be built in the Church community through hospitality and outreach activities. The Committe wants to point out the important work carried out by, among others, Kirkens SOS (TN: Church SOS- Norwegian equivalent to the English Samaritans emergency phone services) in providing help to those in danger of committing suicide and for those who are in emotional turmoil or existential crisis.

The Committe will point out that not all Christian communities are health-promoting. When someone is being excluded, the community is not functioning according to it´s intentions. It is important to reflect on how the communities of the Church can be more open and inclusive. The Synod's Youth meeting contributes to this as referred to in the document UKM 07/07 Created in the image of God to be a fellow human being.

The Church must always be aware of the presence of power relations and the danger that trans-normative behavior and abuse, both of a physical and a spiritual nature, may occur.

6. Diaconal Actors

The health-promoting ministries of the Church involve different actors. The Committee refers to the three levels of diakonia: general diakonia, the organized and the specialized diakonia. The general diakonia is the ministry performed by all those who are baptized in their daily encounters with their neighbors. The organized diakonia takes place in the local congregation through volunteer work connected to, for example, visiting services, facilitated meeting places in the local community, and various other forms of activities performed by both ordained employees, other employees and volunteers. The specialized diakonia requires professional competence and a professional setting and takes place in diakonal institutions and organizations; it is also provided through the spiritual counseling of deacons and pastors. Each of these actors contributes to the health-promoting mission of the Church in their own particular ways.

The diakonal institutions and organizations have often been, and are still, pioneers in professional education and practice in the health sector.

Due to the continuous advancements within the health care system and the demand for a higher level of professional education, the diakonal institutions and organizations have, to a certain extent, become a part of the public health care system. This does not mean that these health-providing services of the Church have lost their relevance. There are still many challenges, and new issues have arisen that must be faced by the local congregations and the diaconal institutions and organizations. Important health reform, for example, the challenges presented by the Coordination Reform, facilitate and demand more cooperation between the public health system and other actors.

The Committee maintains that the present document, Church and Health, provides valuable inputs for answering these challenges. The diaconal institutions and organizations are challenged to further develop their distinctiveness, to continue in their role as a spearhead and pioneer in developing health related services and education, and to contribute to further advancement of holistic health care. It is important that the diaconal institutions have good working conditions; the role of the local congregations must be included in this context. A special challenge is to develop new kinds of collaboration between the specialized diaconal institutions and organizations and the health ministry of local congregations, in particular when it comes to social innovation and entrepreneurship.

The Committe wants to emphasize that the opportunity for decentralized diaconal education is important, pointing out that it may serve to increase recruitment to these job positions.

In order to be able to make an optimal contribution to the local community, a precondition for the Church is to have sufficient personnel resources. The General Synod has repeatedly passed resolutions asking for more positions for deacons and better access to diaconal competence. In 2007 the General Synod decided on an ambitious goal of increasing the number of new

positions for deacons (Item KM 6/2007), and in 2011 a resolution was passed stating that by 2015 there should be at least one deacon in every district level of the Church. This General Synod also decided that every congregation eventually should have either a deacon employed in the congregation or access to diaconal competence (Item KM 9/2011). In 2012 the General Synod emphasized again the importance of having positions available for deacons; in this instance with regard to the implementation of the vision of the Church as "a Church for everyone" (Item KM 9/2012). The Church is still far from implementing these goals, resulting in great harm to diakonia in the local congregation. The lack of professional diaconal competence is hampering the collaboration in the local community in their efforts to develop health-promoting local environments for people of all ages and in different life situations.

Pastors and deacons in hospitals and institutions encounter people in life's most vulnerable situations. They are part of the interprofessional teamwork at the hospitals and contribute with their competence in pastoral counseling, ethics and an understanding of religion and life stances. The Committee underscores that it is of invaluable importance to maintain this service.

7. Global Health

The global health challenges are still formidable. In addition to the acute humanitarian crises occurring in our time, the primary problem is poverty and the lack of resource distribution both between rich and poor nations and internally within some countries. An important challenge for the Norwegian Government is to develop and implement a foreign policy, including trade and aid policies, that would combat poverty. Another aspect of the global health challenges is the depletion of eco-systems and diversity in nature. The climate changes continue and will increasingly hurt the poorest countries and the poorest socio-economic groups in these countries. Humans are a part of nature, and the destruction of nature and the balance in nature will have consequences for the possibility for people to live a good life of well-being and health. Numerous times, the General Synod has discussed issues of climate and environment, creation and sustenance (Item KM 5/2008, sak KM 4/2012 and Item KM 12/2013). The Committee also refers to agenda item KM 10/2007 entitled Economic globalization as a challenge to the Churches.

Even though the present document discusses certain aspects of health from a global perspective, the main focus of the document is on the national level. The Committee supports this appraisal. At the same time, the Committee emphasizes that the health challenges in our own country must be understood in light of and in relationship to the global challenges.

8. Further Work

In conclusion, the Committee will underscore the importance of using the document Church and Health to contribute to the strengthening of the Church's awareness of its health mission based on a holistic conception. In particular, large parts of chapter two and three provide important inputs in this respect.

Chapter four provide an important insight into the work of diaconal institutions and the value of their services to society. The Committe encourages further development of this document.

Resolution Proposals

God created all human beings in God´s image, and every human being has an inate, God-given dignity, independent of factors such as gender, age, ethnicity, religious and sexual identity, or level of mental or physical ability. This basic dignity can never been taken from a human being. The Church has a special responsibility for upholding the value of all human beings from conception to the end of life.

It is important for the Church that human beings can live as whole persons, and the health-related ministry is an important part of the Church's mission. The General Synod endorses and anchors its work on the health definition of the World Council of Churches: "Health is a dynamic state of wellbeing of the individual and the society; of physical, mental, spiritual, economic, political and social wellbeing; of being in harmony with each other, with the material and ecologic environment and with God."

1. The General Synod endorses the main content of the document Church and Health and emphasizes that:

a) In the local congregations there are a wide variety of health-promoting practices that are of importance to the public health and that provide good opportunities for local collaboration.
b) The specialized diaconal institutions and organizations, including research and education, have a central role in implementing the Church's health mission.

2. The General Synod challenges the congregations to:

a) Survey and mobilize their health-promoting resources and use these to revitalize their work with the local plan for diakonia
b) Develop inclusive communities where people can participate with their entire life and meet each other as they are.
c) Actively follow up agenda item KM 9/2012 Equality, inclusion and facilitation. People with disabilities in the Church of Norway, so that people with various degrees of disability are a natural part of the congregation's community.
d) Further develop collaboration with diaconal institutions and organizations based on Plan for Diakonia in Church of Norway.
e) Collaborate with public agencies based on the recommendations from the Cooperation Reform. An important area is participation in local emergency and crisis work.
f) Ensure that recipients of health and care services are able to exercize their rights to practice their religion and life stance, and provide guidance for health personnel
(based on Regulation I-6/2009 from the Ministry of Health and Care).
g) Make visible the Church's ministries of prayer, pastoral counseling and confession.

3. The General Synod petitions the Diocesan Councils and Bishops to:

a) Encourage focus on the theme of health and mastery of life in preaching and education
b) Become a driving force in adopting local plans for diakonia and developing routines for reporting
c) Initiate discussions during regular visitations from the Bishop about collaboration between the Church and the municipality on the issues of health and mastery of life.
d) Contribute to further development in pastoral counseling

4. The General Synod challenges the diaconal institutions and organizations to:

a) Strengthen and further develop the efforts to help those in vulnerable situations such that their rights are upheld.
b) Strengthen their role in contributing to the public debate about health-related issues.
c) Strengthen global health efforts.
d) Continue professional development and research in the field of health and diakonia.
e) Further develop the understandig of their distinct diaconal characteristics specifically as related to the Church of Norway.
f) Strengthen collaboration with Christian organizations and local, regional and national Church bodies through, among other things, developing joint arenas for promoting development work.
g) Utilize the document Church and Health in education and in relevant gatherings for leaders.

5. The General Synod challenges the government to:

a) Ensure that the holistic understanding of health and human dignity impacts the implementation of policies in the health and care sector.
b) Contribute actively, through policy documents and training, in designing the health care services to safeguard the whole person.
c) When prioritizing the budget for health care services, to pay special attention to people in vulnerable life situations and their rights, and to ensure that the languages and cultures of minorities are safeguarded.
d) Pass drug policies characterized by solidarity that limit the damaging effect of alcohol and other drugs on social and health factors.
e) Provide a good framework for the Church's and other non-profit organizations' special contribution to health and care services.
f) Provide undocumented immigrants in Norway real access to health care, based on medical assessment,

professional ethical guidelines, and principles of human rights.

g) Ensure that health care services, whether under the auspices of state or municipalities, follow Regulation I-6/2009 from the Ministry of Health and Care regarding the right of patients and residents to exercize their religion or life stance.

6. The General Synod petitions the National Councils of the Church to follow up the document Church and Health, by attending to:

a) Ensure follow up of earlier resolutions of the General Synod to increase the number of job positions for deacons.
b) Strengthen the contact between institutional diakonia, diaconal educational institutions and the central boards of the Church.
c) Develop further the arena for contact and collaboration with public health authorities.
d) Ensure that the document Church and Health is further developed and made available.
e) Develop training courses and educational materials about the health-promoting ministries of the Church for use in the congregations
f) Strengthen the Sami dimension and safegard the indigenous perspective in the further follow-up
g) Continue the contact with the Council for Religious and Life Stance Communities in order to strengthen the significance of faith and life stance in health and care services.

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