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The Church's Challenge in Health

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Striving for Fullness of Life:
The Church's Challenge in Health



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STRIVING FOR FULLNESS OF LIFE: THE CHURCH'S CHALLENGE IN HEALTH

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Introduction

Jimmy Carter
39th President of the United States
Chairman, The Carter Center

A little more than five years ago, The Carter Center of Emory University held a conference entitled "Closing the Gap," which focused on what Americans can do to improve their health. The most disturbing revelation of that conference was that we as individuals deliberately forego the opportunity to live healthier and more productive lives. We ourselves decide the status of our health, through either a failure to learn the facts or a failure to apply the facts to our own lives.

Consider, for example, those of us who live in comfortable homes, dine in nice restaurants, and when we are ill, consult the physician of our choice. We are aware of the guidelines that can potentially help all of us live longer, healthier lives. If we exercise (which should be enjoyable); if we eat the proper diet (which should not be a sacrifice); if we don't smoke (which saves us money); if we have regular physical examinations, and if we even do simple things like fasten our seat belts, we could live longer. But the answers are so simple that we say, "Well, anybody can do that, so I'm not going to do it."

But living among us are people who are not able to choose a healthy life. The poor of our inner cities face many obstacles they feel they cannot control, such as the polluted conditions in which they live, the lack of access to proper medical care, and an inadequate diet. There is a tremendous difference among many

poor people between the amount of suffering that health indicators suggest and the actual amount of suffering that occurs. The difference is due to a factor that might be characterized as despair or hopelessness. The fact that particular people do not believe that anything they do will be successful or will help them live a better or longer life makes a difference. When people are offered drugs or cigarettes, or when they get sick, they do not have enough energy to resist or to recover. There is a quiescent acceptance of a dismal, tragic life.

These are sociological problems that cannot be solved even by the most enlightened government. It takes a multitude of efforts to make possible educational opportunities, improved housing, adequate medical care, and other programs that build self-respect and let a person know that his or her ambitions can be realized.

Churches, synagogues, and religious organizations have an important role to play in building self-respect and in teaching people to take an active role in leading a healthier life. There is no church in the United States that could not coordinate and carry out an immunization program against measles in their congregation. But to cross the chasm that exists between rich and deprived or suffering people sometimes three blocks away takes initiative and a great deal of humility.

The challenge of our conference, "The Church's Challenge in Health: Striving for Fullness of Life," this past October, was to derive from the different faiths common premises on which to build an acceptable, effective health program. Our hope is that each person who attended the conference carried away some ideas and examples of ways in which his or her congregation can reach out to

those in need.

We must put our shared beliefs into action. I think that the adage "charity begins at home" is particularly appropriate here. For unless each of us begins to take responsibility for our own health, we will be ill-equipped to go about the important business of helping those who cannot always choose for themselves the path to a full and productive life.



President Carter and Carter Center Executive Director William Foege.

Preface

*Dr. William H. Foege
Executive Director,
The Carter Center
of Emory University*

One way to measure a civilized society is by the quality and extent of its concern and care for the health of its people. How does our society measure up?

The health crisis we face today in this country places an enormous economic and moral burden on us all. The United States' infant mortality rate lags way behind that of most industrialized nations. The health status gap between white and minority Americans is ever widening. The tobacco industry in this country spends billions of dollars each year to promote and glamorize the addiction of a substance that takes 1,000 lives each day. And scientific findings tell us that the majority of people in the United States die premature deaths from preventable causes.

Our nation's understanding of health care should be based on an holistic perspective rather than a solely medical one. The health care wheel has physical, psychological, social, and spiritual cogs which must all be in place for the system to function smoothly and efficiently. We must strive for this comprehensive approach to health services in our homes, churches, and communities.

The 1984 "Closing the Gap" conference studied the scientific dimension of health care and concluded that the majority of death and disease in the United States is premature because we don't make

effective use of the prevention tools that we already possess. If the key to equity and success in our health future is prevention, then the informed have a responsibility to teach such prevention. If we do not apply our knowledge then we do not progress. We end up with another broken cog in the wheel. Two hundred religious leaders from the largest faith groups in the United States answered our call in October 1989 because they feel the economic repercussions of 37 million uninsured Americans; they are disturbed by the moral and ethical impact of the need for preventive services and affordable health care; they are moved by the personal and spiritual implications of the lack of action; and they are challenged by their mission.

Let's gather our resources in the religious community, teach health education, support screenings and clinics, and provide compassion to help raise ourselves out of the health

care crisis that burdens us all. The religious community must serve as an advocate for social justice in health. It is our responsibility to help patch the wheel.



President and Mrs. Carter, C. Everett Koop, Reed Tuckson, William Foege, and James Mason meet in President Carter's office prior to the conference.

Overview of the Foundations of the Conference

The church has a history of ministry to persons and communities in relation to spiritual, physical, and mental illnesses. However, with appropriate motivation, support, and resources, churches and other faith groups could be doing much more in the realms of health promotion, disease prevention, and various needed ministries in caring and healing.

In 1984, The Carter Center sponsored "Closing the Gap," a major consultation on health that focused on prevention. The study concluded that current technology and scientific information was not being efficiently applied to prevent premature death and disease. The Carter Center pointed to clergy as one of four essential groups to receive and use the findings of the report. The potential for impact within the religious community seemed great.

In summer 1988, the Wheat Ridge Foundation, a Lutheran charitable organization that provides seed money for healing ministries, agreed to co-sponsor with The Carter Center of Emory University an ecumenical conference designed to promote the church as a mechanism for disseminating health information. A Steering Committee met in September 1988 to plan a national ecumenical conference on health. Dr. William Foege, Executive Director of The Carter Center, and the Reverend Robert J. L. Zimmer, President of Wheat Ridge, headed the Steering Committee, which also included representatives from the American Baptist Churches, the Southern Baptist Convention, the United Methodist Church, the

National Baptist Convention, the Evangelical Lutheran Church in America, the Lutheran Church-Missouri Synod, the Episcopal Church, the Roman Catholic Church, and the Presbyterian Church (USA).

President and Mrs. Carter and Surgeon General C. Everett Koop agreed to serve as Honorary Co-Chairs for the conference. Dr. Foege and Reverend Zimmer served as Co-Chairs, and Dr. Constance Conrad of Emory University accepted the duties of Symposium Coordinator.

Funding for the National Church Leaders Symposium on Health was secured from the following agencies and foundations: The Centers for Disease Control, Henry J. Kaiser Family Foundation, Robert Wood Johnson Foundation, Lutheran Brotherhood Foundation, W. K. Kellogg Foundation, American Medical Association, Emory University Department of Community Health, Episcopal Church, United Methodist Church, Evangelical Lutheran Church in America, and Presbyterian Church (USA).

Methods

The initial plans called for the participation of church leaders (clergy and lay), church publications editors and policy board members, directors of health missions and local health projects, and grassroots ministry leaders.

A concern for inclusiveness spurred the Steering Committee's efforts to balance ethnic, racial, gender, and geographic diversity in participants. They also endeavored to obtain appropriate representation

among denominations as well as other faith groups. In addition, participation was secured from representatives of funding agencies, theological seminaries, religious publications, religious medical organizations, and related agencies.

Thirty-two Christian denominations, along with members of the Jewish, Islamic, and Native American faith groups, were represented at the symposium in October 1989.

Symposium Process

During the planning of the conference, the desired outcome was one of action-oriented resolution. The project strove for a renewed commitment at every level of the religious community to work toward solutions to health problems and the promotion of full, healthy lives. To this end, the program goals were set as follows: to provide information about primary health issues in America today, to address the role of the faith community in health and healing, and to mobilize the faith community to respond to health needs and to commit to the promotion of full and healthy lives.

Striving for Fullness of Life: The Church's Challenge in Health was held at The Carter Center on October 25-27, 1989. The symposium offered plenary sessions, discussion groups, resource material, a literature display area, a book display, a health risk assessment, workshops on church-based health-related models, and a field trip to local church health programs. But most important, it offered a unique opportunity for members of different faith groups and denominations to interact, share information, and inspire each other. In this paper, each conference goal is addressed in a separate section and supported by speeches, feedback, and reactions of conference participants.

Closing the Gap

In November 1984, The Carter Center sponsored a major consultation on health which involved national health leaders from the public and private sectors, academic, voluntary, and professional organizations. Entitled "Closing the Gap" and supported by grants from the Robert Wood Johnson Foundation and the Culpepper Foundation, the consultation focused on the "gap" represented by health problems that are unnecessary in light of our current scientific knowledge. The health leaders examined current intervention and prevention efforts and sought to develop new strategies to address precursors to premature death and disease.

The study examined the primary causes of illness and death in the United States and identified attributable risk factors. The six generic risk factors—tobacco, alcohol, injuries, mental health issues, preventive services, and unintended pregnancies—were found to contribute to more than half of the deaths and illnesses in this country [chart A]. The clear conclusion was that two out of every three deaths in the United States are premature or unnecessary given our technology. Tobacco was identified as the leading single cause of premature death in the United States.

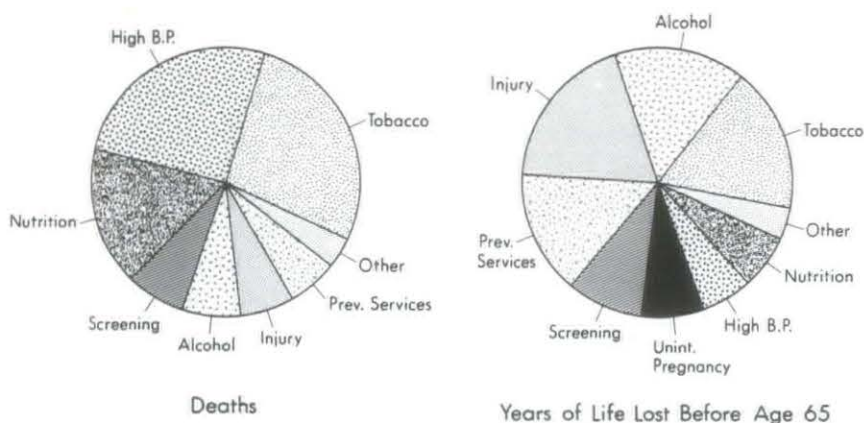
The study noted that a pronounced disparity between the health status of minority Americans and white Americans persists, displaying the socioeconomic factor in the widening health gap. A lack of preventive services accounts also for the United States' infant mortality rate ranking 22nd among industrial-

ized nations—deaths that are preventable with proper prenatal care.

The consultation brought to light the burdens imposed on society by premature disease, disability and death, measurable in humanitarian as well as economic terms. Premature, preventable disease consumes resources, exhausts health budgets, and presents an ethical challenge to the country.

The study concluded that we can improve our nation's health status simply by applying the knowledge and skills of prevention that we already possess. To bridge the gap, we must make more effective use of medical science in our communities and churches and promote healthier lifestyles. The nation is not as dependent on research and technology to achieve an enormous improvement in health as it is on individual will and ability to make informed choices and adopt healthier habits. Lifestyles are shown to be the major determinant of health and well-being [chart B]. Since we are

Chart A:



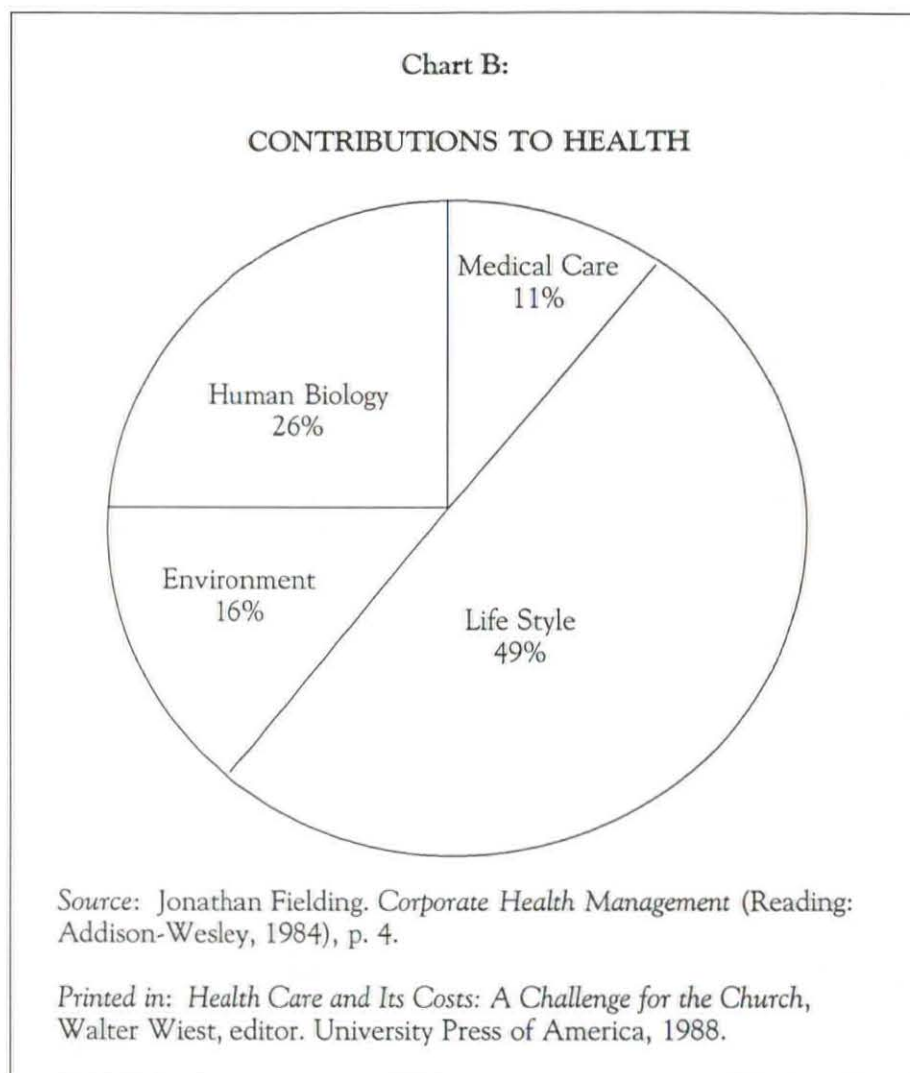
Printed in: *Closing the Gap: The Burden of Unnecessary Illness*, Robert W. Amler, H. Bruce Dull, eds. Oxford University Press, 1987.

responsible for our own lifestyles, "Closing the Gap" informed us that we are largely in charge of our own health destinies.

About 1,000 premature deaths occur in the United States each day due to tobacco alone. Religious organizations were identified by the consultation as one vehicle for disseminating the current disease prevention and scientific information that might help alter that statistic. The goal was to enlist the clergy in exploring the ethical relationships among society, community, industry and health of the individual. The religious community was cited as a resource to explore in future studies. Following the consultation, the proceedings were published in *Closing the Gap: The Burden of Unnecessary Illness*, a special supplement to the September/October 1987 issues of *American Journal of Preventive Medicine* (through a grant from the Henry J. Kaiser Family Foundation). In addition, Jimmy and Rosalynn Carter co-authored *Everything to Gain: Making the Most of the Rest of Your Life* (Random House, 1987), which emphasized the impact of personal decisions and behavior on one's health at every age.

Several conferences and workshops were inspired by "Closing the Gap," including a forum on tobacco, a global consultation on health risks in the developing world, and the National Church Leaders Symposium on Health.

Following "Closing the Gap," The Carter Center collaborated with the Centers for Disease Control to update the public domain health risk



appraisal system. This system alerts individuals to their personal health risks, especially those that can be altered to protect their health. The HRA is now being modified to target specific populations such as the elderly and minorities. You can read more about using the HRA in churches on page 19.

Section I

Primary Health Care Issues in the United States Today

Introduction

The first section of the conference focused on the major health issues in the United States, first from a scientific and then from a social perspective. These issues laid the foundations for further discussion of health concerns and provided current scientific information on the health status of Americans today.

Assistant Secretary for Health James Mason began the session with a review of "Closing the Gap," a 1984 Carter Center consultation [see page 7], and pinpointed the major causes of unnecessary illness and death in the United States. Surgeon General C. Everett Koop discussed the social issues involved in the health care dilemma: equity, access, and cost. Panels of experts responded to the speeches, and both speakers fielded questions from the conference participants.

With a better understanding of the health burdens America faces, participants listened to President Jimmy Carter's vision of the church's involvement in health. The former president highlighted The Carter Center's health initiatives and called on the faith community to join in the effort to bring better health to all Americans.



Nearly 200 religious and health leaders participated in the conference.

Health Care in the U.S. : The Science Issues



James Mason
Assistant Secretary for Health,
Department of Health and
Human Services

Among the major health issues in the United States today, the weaknesses of the nation's medical care system figure prominently. Our country's health care system is fragmented and costly. In addition, nearly 32 million Americans are uninsured or significantly underinsured. Most of these people are the working poor and their dependents. They earn too much to qualify for Medicaid and too little to buy private insurance or to pay directly for medical care. Too many find it preferable economically to join or rejoin the ranks of the Medicaid-eligible unemployed, and few incentives exist for sustained independence.

We need a health care system that guarantees high-quality care, access to all, affordability, and an orientation toward prevention. At the direction of the Secretary for the U.S. Department of Health and Human Services, the undersecretary of the department will be making recommendations to reform our financing of health and long-term care. Successful reform, we realize, will hinge on our attention to the

needs of those who are disadvantaged by current policies and programs. The current Medicaid program must be made more equitable and more attractive to potential providers, with continued efforts to improve quality and control costs. In addition, we will need to explore the creation of partnerships among federal, state, and local governments, the private sector, and churches to strengthen the health care delivery system and make it more responsive to the needs of the poor.

Although the gaps in health care delivery in the U.S. are prominent, this century's successes in public health should not be minimized. Furthermore, the dramatic progress made in lengthening the lives of most Americans and improving the quality of their lives offers lessons for our present course of action.

In this century alone, life expectancy has increased by over 25 years—a 50 percent gain. In other words, every week since January 1, 1990, the average American has gained two days of life. (The average

non-smoker has in fact gained three days per week, while the average smoking American is stuck with the life expectancy of the 1960s.) Most of this increase is due to disease prevention rather than treatment. Improved sanitation has provided safer milk and water supplies, and nutrition for most Americans is better. Immunizations and improvements in maternal and child health have made the most difference. Over the past quarter-century, mass vaccination programs have reduced the incidence of measles, mumps, rubella, tetanus, diphtheria, pertussis, and polio by more than 98 percent.

In 1985 The Carter Center of Emory University and the U.S.

If our churches and families do not nurture positive moral character—including integrity, responsible self-reliance, self-discipline, self-esteem, and charity toward others—our children will increasingly give in to high-risk behaviors.

Centers for Disease Control (CDC) listed 14 primary causes of illness and death in the United States, including infectious disease, substance abuse, cardiovascular disease, cancer, dental disease, alcoholism, unintentional injury, and homicide/

suicide. Together, these causes are responsible for 85 percent of all health care costs, and 80 percent of the deaths in the United States. They also account for 90 percent of the potential years of life lost because people die unnecessarily before they are 65 years old.

Two-thirds of the total years of life lost by Americans before the age of 65 are preventable. An estimated 45 percent of cardiovascular disease deaths, 20 percent of cancer deaths, and more than half of disabling diabetes complications could be prevented through improved and broadened application of existing preventive measures and risk reduction strategies. Nearly two-thirds of Americans are too fat, according to a recent health survey. Many of our modern plagues thus have a strong behavioral component, presenting public health and other American institutions with a serious challenge in communication and motivation.

Infant health is another area of concern. In 1988 in the United States, almost 39,000 babies died before they reached the age of one year. And annually, an estimated 400,000 babies who have been subjected to less than optimal intrauterine or prenatal environments develop a chronic disabling condition. America's infant mortality rate ranks 22nd among industrialized nations—twice as high as Japan's and those of the Scandinavian countries. Black infant mortality is double the white rate, and the rate for whites ranks twelfth world-wide.

If we just applied what we know about prenatal care, case management, outreach, and home visiting, an estimated 10,000 of the 40,000 babies who die each year could be saved, and the benefits in human and economic terms would be

Today there is a need for the non-medical lay person, those who make up our religious communities, to reach out and assist in ministering to the health needs of families and individuals who are not acutely ill, but whose lifestyles and health practices place them at high risk for becoming acutely or chronically disabled. —Sister Mary Madonna Ashton, Commissioner of Health, Minnesota Department of Health

The church cannot sit around and wait for the government to solve the problem. The issue is for the church to quit holding macrame classes and trying to convince us that it's a viable ministry. It's time for the church to be involved actively in caring for the poor and caring for the sick. —Dr. Scott Morris, Executive Director, Church Health Center of Memphis

enormous. In 1988 the National Commission to Prevent Infant Mortality estimated that the hospital costs for low-birth-weight babies were in the range of \$2 billion annually, while the costs of providing early prenatal care to every woman not receiving it were as low as \$500 million.

The clear conclusion of The Carter Center-CDC consultation was that we are not dependent upon additional medical knowledge and research breakthroughs to achieve an enormous improvement in health. We can become a much healthier people by making more effective use of the knowledge of prevention and interventions we already possess.

Part of the challenge is to adapt traditional public health tools like epidemiology and surveillance for new applications in health-related fields. Injuries and violence, for example, are leading causes of death and disability which have not, until recently, been attacked as health problems.

Another part of the job is to be able to respond effectively when a new threat to health appears. AIDS, a disease unknown eight years ago, is

now the highest cause of death in New York City for males between the ages of 24 and 44. We don't yet have ultimate answers to the treatment of AIDS—but we know enough to stop the transmission of the virus from one person to another and to mount educational programs that will help people avoid putting themselves at risk for getting the HIV infection and AIDS.

The Carter Center-CDC study also identified a number of risk factors associated with the 14 primary health problems, and many of these risks can be removed by individual choice. Most frequently cited were use of tobacco and alcohol, uncontrolled high blood pressure, unintended pregnancy, injury risk, lack of preventive medical services, and improper nutrition. Tobacco was identified as the single leading cause of preventable death. About 1,000 preventable deaths occur in the United States each day—or 360,000 deaths per year. Use of alcohol was the second most important risk factor.

There is good news about progress against the diseases that kill Americans today. First, smoking is down about 25 percent over the past 20 years. This is a major public health gain against such diseases as lung

cancer, emphysema, and heart disease. The decrease in lung cancer in males parallels the decrease in smoking, while smoking is still increasing for women. (Tobacco advertising targeted to women, the poor, and minorities is still winning converts to the ranks of smokers.) Second, from 1950-1970, the incidence rates of invasive cervical cancer fell by more than 50 percent, and the rates are continuing to decline. The National Cancer Institute credits this success to earlier detection (the Pap smear) and treatment. Third, in the past 25 years, mortality rates for coronary heart disease declined 40 percent and mortality rates for stroke declined 25 percent—due in large part to control of high blood pressure, cholesterol, and smoking.

This progress is promising, but it cannot trigger complacency. We still find in this country a pronounced and stubborn disparity between the health status of minority Americans and white Americans. Commissioned by the Secretary of Health and Human Services, a 1985 report by the Task Force on Black and Minority Health gave evidence that more than 60,000 excess deaths occur each year among America's minority citizens. (Excess is defined as deaths that would not have occurred had mortality rates for minorities been as low as those for whites.) These are preventable deaths. The report identified six areas in which an overwhelming difference exists between the health status of white Americans and that of minorities: cancer, cardiovascular disease, diabetes, homicide, injury, and infant mortality. AIDS has subsequently been added to the list because it also disproportionately affects black and Hispanic Americans.

This disparity bears the clearest

witness to our failure in achieving the health goals that are realizable, given the current state of scientific knowledge. Bringing equal opportunities in health to all U.S. citizens depends on increasing our efforts to educate people about good health. Prevention is the key to equity in our

Two-thirds of the total years of life lost by Americans before the age of 65 is preventable.

health future, for infants, children, and adults. One of my personal goals by the year 2000 is to help assure comprehensive health education classes from kindergarten through twelfth grade in every school in the country.

Because modern plagues are behaviorally driven, the choices we make on a day-to-day basis largely determine whether we will suffer from sexually transmitted diseases including AIDS, become incapacitated by addictive substances, become pregnant teenagers, die prematurely from cancer or heart disease, or suffer traumatic injury or death.

Action and responsibility for control of behaviorally based disease lies ultimately with the individual, but communities, churches, and families have significant roles to play. Let me illustrate with two examples of community-based behavioral change.

In 1978, concerned citizens in a

Maine community noticed a high number of auto fatalities and injuries associated with high school graduation activities and resolved to do something. In Project Graduation, the city, the school, churches, and parents joined to help their teenagers develop alternative alcohol-free graduation activities, along with ways to avoid drinking and driving. This community resolve resulted in the elimination of teen alcohol-related auto fatalities during the graduation period each year thereafter. Communities in over two dozen states have since adopted Project Graduation, and it has clearly reduced a major health risk among adolescents.

A second example is a program sponsored by the Emory University School of Medicine: "Helping Young Teens Postpone Sexual Involvement." One-third of the school districts in Georgia use the curriculum, which is presented by community volunteers. The program has now been presented to 40,000 teenagers between the ages of 13 and 15, and over the last three years, pregnancies, abortions, and birth rates have declined. A program evaluation shows that 5 percent of the participating teens became sexually active, while 15 percent of a matched comparison group became sexually active.

The point should be obvious to church and synagogue leaders: behavior is value-laden. If people are uncomfortable talking about moral values in the public square, if society has backed away from moral absolutes, if the schools are compelled to maintain a mythical "value neutrality," how will children and adolescents learn to behave in positive ways that do not put them at risk for life-threatening diseases? If our churches and families do not nurture positive moral character—

including integrity, responsible self reliance, self-discipline, self-esteem, and charity toward others—our children will increasingly give in to high-risk behaviors.

The participation of churches and synagogues is needed in this endeavor, and their involvement is historically grounded. Familiar scriptural passages attest to the long history of the holistic approach. Moses gave directions to ancient Israel on both treating and preventing disease. By avoiding pork, trichinosis was prevented. Treatment and prevention strategies for leprosy, boils, and ulcers were provided, and sanitation was clearly part of their religious life.

The scriptures also contain clear instructions regarding the expression of human sexuality. Abstinence from sexual activity until one enters a stable marriage relationship is prescribed for spiritual and social reasons. The sexual prohibitions promoted health and welfare by preventing sexually transmitted diseases, out-of-wedlock pregnancy, and the trivialization of sexual expression.

In the New Testament Paul taught that the body is the temple of God. "Know ye not that ye are the temple of God...if any man [or woman] defile the temple of God, him shall God destroy; for the

temple of God is holy, which temple are ye." The body's role as a temple or tabernacle for the spirit provides an added incentive to promote health and prevent disease. The scriptural commands to demonstrate concern for the sick, lame, halt, blind, and deaf reinforce the concept of the body as temple, as do the commands to love others as we love ourselves. But one need not turn to past religious experience for examples of promoting health, compassion, and caring; such behavior continues to characterize the work of most contemporary churches. Churches including Seventh-day Adventists and the Church of Jesus Christ of Latter-day Saints have proscribed tobacco, alcohol, and other addictive substances, encouraged diets rich in fruits, vegetables, and whole grains, and either prohibited use of meats or recommended sparing use. And studies of members of religious organizations indicate that churches with teachings on health care are capable of influencing life-style and behavior, thereby leading to disease reduction. For example, studies have shown that members of the Mormon church living in Alameda County, California, experienced an adjusted cancer mortality rate only 55 percent as great as that of the whole country. Churches and synagogues are

obviously equipped to make a significant difference in the health of the nation if they will articulate the health benefits from their various traditions.

Our nation's families must also participate. They must nurture moral character in children, which comes only through training. The church should then encourage and fortify home, and society as a whole should not make the job of the family any harder than it already is. As President Bush has observed, we need to find "ways to preserve and strengthen indispensable institutions like the family in the midst of social change. As I look on the fabric of society and at the instability of family relationships, I see a real threat to our future."

The challenge for all of us who are active in churches and synagogues is to articulate clearly the relationship between right behavior and good health. Many keys to good health in the Judeo-Christian Scriptures are as valid today as they were two or three thousand years ago. We need to help people, especially young people, understand that many diseases and illnesses are direct or indirect results of behavior that we've been told to avoid. But beyond talking about it, we have to be good role models ourselves.

If we are trying to deal with the gap between what is known about health promotion and disease prevention and what is applied by the nation's citizens, we need to be talking about people's concepts of self-worth. If a person doesn't believe in the possibilities of the future, then what difference does health information make? A young man in the inner city may be warned about the dangers of casual sexual relationships, but he is likely to reply: "I'm not going to grow up and be in charge of the space around me. I'm not going to decide who gets hired and fired. I'm not going to move resources from this part of the planet to that part. I'm not going to get a job; I'm not going to do anything. The only way I can control my environment is to control people. How am I going to control people? Through violence and through sex. Who ever tells me I'm valuable and worthwhile in this country? Only the woman I make love to. And you tell me to stop?" The health message is absolutely irrelevant in such a context. That's not work for the health commissioner. That's work for the church. —Dr. Reed Tuckson, Commissioner of Health, District of Columbia

Health Care in the U.S. : The Social Issues



C. Everett Koop
Surgeon General, USPHS,
1981-1989

A huge gap exists between the dream of ideal health care in the United States and the reality of its availability. Our aspirations far out-distance the resources available to pay for them. In the circles in which I travel, conversations on this subject are constant. I hear them among doctors and patients, nurses and therapists, social workers and pharmacists, representatives of big business and small business, members of Congress, the elderly and the young. It isn't so much that things are changing as that things have changed, but many people are trying to plan the future as though it were indeed yesteryear. Several current realities need to be faced squarely if our planning is to be intelligent.

First, the doctor-patient relationship has deteriorated significantly over the past two decades. This deterioration began, I believe, when professionals in the delivery of medical care—doctors, nurses, therapists, and so on—started to accept the nomenclature of providers. Their patients in turn slipped several cogs when they permitted themselves to be called consumers.

People aren't happy about being ill or needing to go to a physician. Having to pay a high price for a physician's care increases people's dissatisfaction. But we need to subordinate the economic aspect of the relationship to the climate of trust between doctors and patients.

Second, the gap between our aspirations and our resources has opened at the worst possible time, a time when demographic trends are running against us. Today, for example, for each person over the age of 65, there are five younger tax-paying wage-earners to pay for that one person's Medicare coverage. In another 20 years, however, for each person over the age of 65, only three younger tax-paying wage-earners will be contributing to Medicare. In a climate of scarcity, Americans will have to work out an equitable sharing of needed medical resources between one population that is growing—that is, those over the age of 65—and the population that is shrinking by comparison—that is, those under the age of 18.

Third, the American family has changed, and these changes are now

rather solidly set in society. A stereotype of the American family held not so long ago—the father at work, the mother at home spending her life taking care of 2.2 children, her husband, and her house—is now met by only 10 percent of families. Families today are smaller. We have more single-parent families, and we find a greater variety of living arrangements. Mothers are out of the home; six out of every 10 mothers with preschool-age children are in the labor force, two-thirds for economic reasons. Individual members of families are older than they were a generation ago. Alcohol and drugs are abused by more family members. More teenagers are becoming mothers. Because families are smaller, and because more elderly people are dependent upon families, the responsibility for such care falls on fewer children for longer periods of time.

Another change in the management of the public's health, made before I came into the federal government, was the closing of many

Our current system of health care is not fair, not just, and therefore not the morally strong system that our society needs—and deserves.

mental institutions with the expectation that communities would absorb the inmates in halfway houses and sheltered workshops. But those inmates have not been sheltered and

protected, and today they form a large segment of the homeless in America. (Americans, it may be observed, are generous to a fault, but they do not like AIDS hospices, drug abuse treatment centers, homes for the retarded, or shelters for the mentally ill in their neighborhoods.)

Another change has been the closing of the great city hospitals in this country. But these are desperately needed now to care for the indigent, the homeless, and now the burgeoning number of AIDS patients, who frequently are also either indigent or homeless.

The health care system in America today does not respond at all to some 12 to 15 percent of our population. This fact constitutes a terrible moral burden. And because that same system satisfies its own uncontrolled needs at the expense of every other sector of American society, it creates a terrible economic burden for society as well. We need to change that system thoroughly, and we need to do it soon.

Some critics attribute the economic crunch chiefly to the budget deficit. Once we get rid of the deficit, they say, we will also close the gap between aspirations and resources—between dreams and reality. Before we had a budget problem, however, we had a health care economy whose annual inflation rate was two to three times the inflation rate for the rest of the American economy.

Some will counter that things really aren't that bad: they suggest remedies like putting a reimbursement cap on this, changing the eligibility regulations for that, cutting back a little here, or pruning a little there. During eight years as your Surgeon General, I thought about the true human costs associated with such a patchwork approach, and today I'm more con-

We are a community of the whole, woven together by our society, and there is no place better than our churches to help us understand that interweaving of society. And there is no safer place in which to have those painful, face-to-face debates about how we are to grope with our own changes and our collective changes toward sustaining one another in more healthful behaviors. —Kristine Gebbie, R.N., Secretary, Washington Department of Health

Churches and church leaders are urgently needed in two roles: as advocates for those with limited access to health care and as participants in discussions about resource allocation. —Patricia Butler, J.D., Consultant, Center for Health Ethics and Policy, University of Colorado

vinced than ever that our whole health care system needs some major corrections. Critics will say, "Wait a minute, Dr. Koop. The system ain't broke, so don't fix it."

But I have to reply, "You're wrong. The system is broken—and it must be fixed." Band-Aids won't do. Hospital costs are still climbing, and no one can prove to the American people that the quality of hospital-based care is uniformly going up as well. On the contrary, our people complain that they are paying more and more for medical care while getting less and less. Worse still, as the cost of hospital-based care increases, the hospitals themselves are trying to narrow their patient pool—for example, eliminating inpatient medical care for poor and disadvantaged Americans. Something is terribly wrong with a system of health care that spends more and more money to serve fewer and fewer people. And the same scenario could be painted with respect to physician services and fees.

The economics of health care are peculiar. Its economy, though laissez-faire, is not freely competitive, and hence it has virtually no moderating controls working on

behalf of the consumer (the patient). In most other areas of our economy, the marketplace does exercise some control over arbitrary rises in charges to the consumer. But in health care, prices have gone up regardless of the quality of care being delivered.

Try as it might, the medical profession has not achieved much success in self-regulation. Physicians can help put the brakes on some general expenditures, but very few physicians can honestly and effectively control the delivery of service—much less control the costs of that service—while caring for an individual patient at the bedside.

What is the effect of a health care system distinguished by a virtual absence of both self-regulation on the part of the providers—that is, hospitals and physicians—and the controls of competition regarding price, quality, or service?

One has been the emergence of three tiers of health care, despite the objections of many to even a two-tier system. The available options in the face of this reality are two, and both require major changes. Either we maintain the diversity of the American health care system, keep it in the private sector, and demand the rewarding of efficiency and quality

with more patients rather than more money; or we go to a government cost-controlled system.

Experience the world over has shown that when government economic controls are applied to health, they prove in time to be detrimental. Eventually, there is erosion of quality, productivity, innovation, and creativity. The replacement of physicians by non-medical bureaucrats as controllers of the system usually results in the lack of responsiveness to patients. And finally, rationing and waiting lines become necessary.

Governmental cost controls cannot be the answer, but can we succeed in the alternative course? I'd like to think we can—because we have to—and especially because we've met similar challenges before.

Some 50 years ago, for example, we knew that it was morally wrong for our society to allow its old people to drift into poverty and starvation, so we enacted a Social Security law to assure every American a measure of human dignity and respect in his or her twilight years. It was an act of fundamental decency. We knew we had to do it, and we did.

Back in the 1950s and early 1960s, Americans became painfully aware of the terrible unfairness of separate but equal education, and the courts and legislatures began the process of ridding our country of the crushing official, legal burden of segregated schools.

Did we get rid of those burdens once and for all? Well, not exactly. We haven't yet solved every problem associated with "growing old in America." And we haven't yet produced the perfect egalitarian school system. But we have lifted from the shoulders of our people a large part of the burden of shame and guilt that came with doing nothing. We did what was morally right for this

country, and we must do that again.

Let's finally say what we've failed to say for too many years: our current system of health care is not fair, not just, and therefore not the morally strong system that our society needs—and deserves.

I will conclude with a few words about the church and the churches. There was a time in the Christian church, at least, when those propagating the gospel were afraid that concern for the welfare of one's fellow human beings might be considered a distraction from the principal concern for the salvation of the lost. In recent years, I believe,

Critics will say, "Wait a minute, Dr. Koop. The system ain't broke...." But it is broken and it must be fixed. Band-Aids won't do.

thinking people have been able to espouse social action as part of the effect that the gospel is supposed to have on the lives of men and women.

Some of you remember the criticisms of social programs in the early years of the first Reagan term. Although the president himself talked about a safety net, it wasn't quite clear to everyone what he meant, what the dimensions of that net were, how strong it might be, and especially how universal. In those days I had a title and very little to do while I was waiting for confirmation. I got a call one day asking if the

churches were part of the safety net. Without even thinking, I said yes. I was raised to consider my church and my family as a safety net (although of course we didn't call it that) for those less fortunate, either in health or in worldly goods.

Yet today many church people separate their faith from action. It should go without saying that church members should be politically active, understand issues, vote properly, and make their representatives understand what they believe and what they want to see accomplished. We may believe in wholeness, in fairness, and in justice, but if we were exercising all those virtues, there would be no need for a conference on the topic of the church's challenge in health. I will, however, dwell on several obvious gaps in the outreach of the church—and I will speak about the Christian church because that's the only one in which I have had any experience.

Three ethical issues have been very much a part of the social relief system and the political activity of churches: abortion; the care and feeding of handicapped children as exemplified by Baby Doe; and the plight of the elderly, which leads all too often to a discussion of euthanasia. Each of these presents a specific challenge to churches.

I am opposed to abortion but have always admonished any church audience I've spoken to that it is not enough to oppose abortion unless the church is willing to extend understanding, shelter, nurture, and economic aid to a woman who is carrying an unwanted pregnancy and seeking a way out.

It is not enough to oppose withholding fluids and nutrition from handicapped newborns unless the church is equally willing to stand by the parents of the handicapped child. Many parents simply lack the

resources—whether material, social, psychological, or moral—to care for a disabled child, even in their own family.

It is not enough to bemoan the plight of the elderly if the church is not attentive to the needs of people who face the problems of living with

I have been preaching and teaching that we must fight the disease of AIDS—not the people who have it.

an elderly family member. Church members can provide a respite for the family or the individual almost overwhelmed with the burden of caring for an incapacitated elderly individual.

And finally, the issue of AIDS must be faced by American society and particularly American congregations. Until this point, we've been able to deal with AIDS within the familiar public health model of compassion and restoration: the American people feel bad when any of their number get sick, and they truly want to help. They also feel they are sufficiently rewarded by the return of the ill or disabled person to his or her family, community, school, or workplace. That's restoration.

AIDS draws upon the great reservoir of compassion in this country. Except for the final weeks of a terminal AIDS-related illness, a person with AIDS may continue with a normal routine of family life, work, education, and leisure activities without endangering other people. But restoration is far from assured. The mortality rate for

AIDS is essentially 100 percent. And after several years of intensive public education on the subject, the American people may not be inclined to be forgiving and compassionate with someone who today engages in casual, unprotected anal intercourse or shoots illegal drugs with a used needle and catches AIDS.

I have been preaching and teaching that we must fight the disease of AIDS—not the people who have it. And I still believe that has to be our attitude. But I'm also a realist, and I don't see Americans keeping that distinction clear in their minds much longer.

The cost to the nation's treasury is already beginning to mount well beyond anything we could have imagined two or three years ago. The average annual cost for the care of a single person with AIDS ranges from \$40,000 to over \$100,000, depending on what you include in the computation and whether you are on the West Coast or the East Coast. Multiplying the mean cost by the current annual caseload of 33,000 patients yields a theoretical cost of patient care this year that could exceed \$2 billion.

And this is terminal care for some individuals who, despite public advice to the contrary, choose to do something risky. They have gambled—and lost. So the cost of compassion without restoration is already very high, and it can only get higher until we find a vaccine. Because we are still several years—maybe a decade—away from the development and release of an AIDS vaccine, it is absolutely essential that we view this problem with clear eyes. Then, with the same clear eyes, we must put aside our natural instincts to be vindictive or holier-than-thou or to say, "I told you so"; we must

instead pursue the traditional, non-judgmental American course of public health care.

The burden of delivering this message unfortunately will fall most heavily upon the leadership of the black community, where the sharpest and most alarming increases in AIDS cases are being reported—direct results of the drug epidemic in that community. I can only hope and pray that American blacks have learned from the early experience of the homosexual community and will not politicize the issue. In public health matters, political posturing costs lives; it does not save them.

The good sense and good heart of the American people—of all the American people—must be appealed to and mobilized for the remaining years that this aggressive and vicious disease survives among us.



Church Health Center Director Scott Morris and Assistant Secretary of Health James Mason listen as Dr. Koop discusses the social issues of health care in the U.S.

Health Care in the U.S. : Accepting Our Responsibility



Jimmy Carter

To talk about the church's challenge in health is to talk about a new responsibility, and for most of us accepting new responsibilities is very difficult. Even when we're faced with a crisis that we commonly recognize, we often seek to put it off on someone else, on some other organization that is either nonexistent or also unwilling to assume new and vital duties. We face gaps in our lives—gaps between our personal dreams and our genuine, proven accomplishments, and gaps between a rapidly evolving science and technology, on the one hand, and the moral and ethical understanding that is necessary to accommodate rapid change. We face, as well, an apparent incompatibility at times between science and deep religious faith. (I should add here that I don't personally experience anguish or pain on this score because the more I know about the complexities of the universe—its broadest dimensions in space and its subatomic detail—the more convinced I am that my religious faith is sound.) We also face a gap between our ideas in life, our religious ideals, the ones

that we profess as paramount, and what we actually do in practice. This gap can extend through a day of existence, a week, a month, a year, or an entire lifetime. It's so easy to rationalize a delay. We say, "Well, when I am financially secure, or

One-third of the biblical text of the four Gospels is devoted to healing by Jesus.

when I reach retirement age, or when I accomplish this next material goal, or when I'm properly recognized by my peers—then I am going to put into practice what my faith requires." These gaps have existed, have been prominent in my own life, and I don't know of an easy solution.

One program that serves as an example of bridging the gap between

ideals and practice is Habitat for Humanity, in which Rosalynn and I are involved. I belong to a very nice church in Plains, a small church. Rosalynn and I teach Sunday School every Sunday that we're there. There is very little reaching out from this cozy, compatible, relatively homogeneous group of Southern Baptist Christians to those who genuinely need the ministrations of compassion, understanding, and love.

Habitat for Humanity gives me an opportunity to cross that chasm. Through Habitat, which is supported by individual congregations, we work side by side with some of the most destitute people in the world to build homes for them. All of us are volunteers, and many of the materials are donated. Rosalynn and I act as carpenters for just one week a year, and we get a lot of publicity for the program. Rosalynn has learned to pour concrete, erect stud walls, put up sheetrock, lay flooring, and put on a baseboard. But the essence of the program is that we are joined in an equal partnership, not from a position of superiority, with families who perhaps never before accomplished anything that would bring them sustained pride or even self-respect. We don't take any government money, and we don't give away anything. The families have to pay for their house, full price, no profit, no interest. The Bible says when you lend money to a poor person you don't charge interest, so we don't. Just moving into the house built through this shared labor can transform the life of that family. Now some principles of the Habitat for Humanity program may very well be applicable to the problem of the church's challenge in health.

How can we break down these enormous, sometimes impenetrable barriers that separate religious

leaders from the people who are destitute, forlorn, neglected, inarticulate, without influence, and actually suffering within the heart of communities in the richest nation on earth? We can easily answer that it's not our responsibility, that one person can do very little, or that the government should take care of it. But I hope we'll instead come to grips not only with the problem but also with the opportunities we have. We can look around where we work or live and say, "I myself am going to do something about the health problems in this country if no one else does anything. I'm going to use my innate intelligence, my ability, my innovation, my inspiration, my

prayers, my experience, my influence, to bring about an improvement in the health of those for whom I care and for those with whom I'm not acquainted." There is a way to break down those barriers and reach out, not as superior beings giving blessings or benevolence but as equals.

I recently learned that one-third of the personal teachings of Jesus in the four Gospels are devoted to healing. He treated the mental and physical afflictions of those who walked the same roads, lived in the same communities, and suffered the same political oppression but most often were outcast, despised, ignored, condemned, scorned, and

punished by Jesus' own associates.

The contemporary problem of AIDS, and the way religious believers have dealt with it, comes immediately to mind. I have a problem with AIDS because of its connections with homosexuality, with sex outside marriage, with the use of filthy needles to inject illicit drugs into the body. These links cause me great discomfort. But the reality of leprosy two thousand years ago was not so different. Lepers were perhaps even more outcast, more despised, more condemned, and more avoided than AIDS victims of today even in their worst circumstances. The society held a general conviction—almost unanimous, I believe—that

Health Risk Appraisal

The Health Risk Appraisal (HRA) was developed by The Carter Center in collaboration with the Centers for Disease Control in order to help individuals understand the health risks that are linked to their lifestyles. It is a preventive tool and provides concrete suggestions for reducing risk.

Health promotion programs at the community level can aid in reducing the risk factors that are known to lead to injury or life-threatening diseases. The Health Risk Appraisal can be employed in the design and implementation of such programs. Two helpful tools result from the use of the Health Risk Appraisal. One is the personal report identifying the individual's most significant factors for generating illness or premature death. The second product depends on the wide-scale use of the Appraisal in a congregation or community. After administering the HRA to a group of people, an aggregate report can be compiled which details the most significant concerns for that group. From this report, priorities can be set for program development.

Most people can be reached through some sort of infrastructure. Young people can be accessed through the school system; the midlife population can be located through business and industry. But for our elderly, the only common structure which exists is the religious community.

The Appraisal can be a vital instrument for the elderly in identifying those factors that may lead to risks such as a broken hip, a highly prevalent condition. When this is done, not only can the hip fracture be prevented, but so can the move to a nursing home and thus the loss of independence that often follows such an injury. The Carter Center is developing a risk appraisal for the elderly which will soon be available for general use.

As we enter the 21st century, a quantum shift is taking place. It is the assumption of responsibility for one's own health, a shift to proactive rather than reactive thinking. Religious organizations can join this move by investing in programs that preclude the onset of injury and disease rather than treating the morbidity after it occurs.

these people suffered from the most horrible disease on earth because of some sin known by God. And Jesus embraced them, had no hesitancy about touching them or being with them; he ministered to them. He didn't approve either of sin or leprosy, but he showed his love for lepers. No matter how conservative a position one takes on the issue of homosexuality, then, it should not be an obstacle to dealing in a kind, gentle, loving, and compassionate spirit with those who have AIDS. The task is still difficult, of course; I'm not underestimating the difficulty.

In setting up the programs of The Carter Center, we have to wrestle with some of these same problems. One basic guideline is that we not duplicate what others can do as well. Second, we seek to be nonpolitical and nonpartisan. We try to bring to our conferences both those who are

It is sobering for me to know that more Colombians died last year from smoking American cigarettes than did Americans from using Colombian cocaine.

experts on a particular subject and those who can actually implement the ideas or recommendations that are forthcoming. To bring people here who can actually observe what the problem is, learn about it, and go out and do something—that's one of the elements of our center's work.

One of the earliest health conferences we had at The Carter Center was called "Closing the Gap." In it we sought to analyze definitively the difference between what we know how to do in health care—using available technology, not future discoveries—and what we actually do. The results startled even the experts. We had over a hundred experts here: medical practitioners, public health specialists, research scientists, some Nobel laureates. Using the accumulated information of many people doing the work in many fields, we discovered that two-thirds of all deaths could be delayed just by changes in our personal habits. We discovered that 55 percent of all pregnancies in this country are unplanned and many of these unwanted. We tried to learn how devastating a blow such a pregnancy can be not only to the women but also to the family, and how it precipitates in many cases violence within the home—child abuse, spouse abuse, suicide, homicide.

We learned that the primary killer of American people is cigarettes, the most addictive drug of all, last year responsible for the deaths of 390,000 Americans. Yet little is done; we are silent about this devastating affliction on our society. We watch young people acquire a habit that they cannot break, a habit much more addictive than heroin. They surmise from the silence of church leaders, educational leaders, and parents that smoking is okay. It's sobering for me to know that more Colombians died last year from smoking American cigarettes than did Americans from using Colombian cocaine.

One study was particularly intriguing. An analysis was made of the suffering (early deaths, addiction to drugs, unwanted pregnancy, failure to recover from moderate

illness, and so on) experienced in a certain poor neighborhood. Some of the suffering could be attributed to environmental circumstances, inherited traits, hazards of the workplace, unavailability of health care, or poor nutrition. But about 35 percent couldn't be accounted for. The researchers concluded that the people's lack of hope was the variable that accounted for the "extra" suffering. The people in the community had no faith that they themselves could change their own destiny, that their decisions would make a difference in their lives. They had perhaps never seen their parents use strength and resolve to overcome a major difficulty. If they got ill or were tempted to have illicit sex or take drugs, or even to commit crimes, they passively went along, thinking nothing they could do would make a difference.

How can we possibly separate these circumstances, so prevalent in our poverty-stricken neighborhoods, from the true and unavoidable responsibility of the church? If this is not our responsibility as religious leaders, what is?

Following the "Closing the Gap" conference we constructed a health risk appraisal so that people could do a self-analysis. Today, this health risk appraisal is being distributed at more than 1,500 local centers around our country. About 25 questions are asked concerning one's life history and personal habits, including questions on smoking, drinking, fastening seat belts, and attitude toward firearms; weight and diet; response to stress, strain, disappointment, or tragedy; cause of death of one's parents and grandparents; and so on.

These risk factors are analyzed by computer to determine their effect on one's life expectancy. For example, a 50-year-old man who

smokes two packs of cigarettes a day and is 35 pounds overweight may have the life expectancy of a 63-year-old. An assessment is also made of the consequences of a change in habits: if the same person stops

We need to work together to understand what the issues are, but we also need to minimize the ingrained prejudices that limit the scope of our minds and hearts.

smoking and reduces his weight by 35 pounds, he could add x number of years to his life. This appraisal, which costs just four or five dollars, would be wonderful for church members, for those entering hospitals, for students entering college. It allows people to look at themselves and say, "This is what I am, this is what I'm doing to myself, and this is what I can change to give me a longer, healthier, and more productive life."

In concluding, I want to affirm The Carter Center's interest in participating in follow-up activities of this conference. One way would be for us to provide a constant flow of information about health issues to be used in church bulletins and denominational periodicals. We could be a clearinghouse to let people know of successful health models that might be developed in their own churches and denominations. And we'd like for this to be a continuing process.

All of us are in an exploratory

phase. We need to work together to understand what the issues are, but we also need to minimize the ingrained prejudices that limit the scope of our minds and hearts. It would be helpful if we could set goals that are truly exciting and challenging and adventurous, and perhaps unpredictable, that would catch the imagination of people in our churches and denominations. I don't know what's going to happen, but I want to be a part of it. I hope that we can break down the barriers that exist between ourselves and others about whom we probably don't even know. That effort will require tremendous faith—in ourselves and our capabilities, in those we'd like to serve, and in the God we worship.

Section II

The Role of the Faith Community in Health and Healing

Introduction

The second section of the conference focused on the potential of the religious community for improving the health of Americans.

Professor Martin Marty of the University of Chicago Divinity School led the session with "The Tradition of the Church in Health and Healing." At the center of Dr. Marty's message were six key words: God, fullness, some, faith, liberal, and tradition. A panel discussion ensued including representatives from Jewish, Islamic, Native American, and Catholic groups elaborating on their group—traditional views on health and religion.

Following this session Dr. William Foege, Executive Director of The Carter Center, spoke on "The Vision of the Possible: What Churches Can Do." Dr. Foege concentrated on the philosophical concepts connecting religion and health. Dr. Foege, who has three decades of public health experience, explored ways in which churches could impact the health of Americans. The church, he said, can and must empower individuals to improve the health of themselves and their communities.

Rosalynn Carter, in turn, informed the conference about the potential role of faith groups in caring for the mentally ill. Mrs. Carter pointed out obstacles to the mentally ill such as stigma, insufficient resources, burdens on family members, etc. The church, she said, has a great potential to alleviate

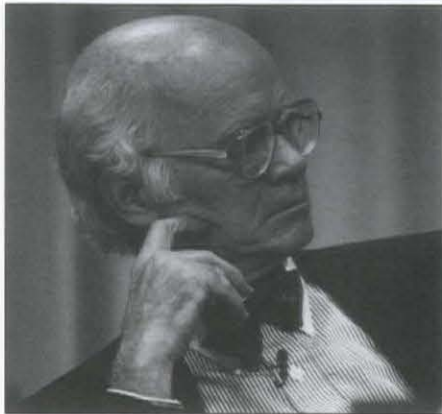
much of the unnecessary suffering by organizing specific actions to aid the mental illness programs and those who have mental illness.



Atlanta Mayor Andrew Young.

The church must continue to serve as an avenue of hope for those without adequate health care. It can work together with government, private business, and other outreach organizations to improve the overall health care situation. The role of the church, regardless of denomination, is to provide comfort and hope to the least of these God's children. — Atlanta Mayor Andrew Young

The Theology and Tradition of the Church and Healing



Martin Marty
Fairfax M. Cone Distinguished
Service Professor,
Divinity School,
University of Chicago

I was assigned to speak about the theology and tradition of the church in health and healing. Therefore, *God* is the first word I must speak. Yet, as we seek fullness and wholeness in this pluralistic culture, the very words from which we draw strength and meaning are also words which may confuse and separate us. Those of us who are Christian may believe that our heritage and calling give us access to a richness of faith in a powerful God that can be genuinely helpful.

People want to know the whither and whence of our lives. Consciously or unconsciously we long for a plumb line in relation to which things in our lives can be righted and ordered. In the uncertainties and anxieties of our complex and dangerous world, people long for eyes to see and hearts to respond to the moving shape of One who is our author and destiny. In our concern for a common language and for a rational foundation for our theologies, let us not underestimate the archetypal and historical power of cross and resurrection, the universal longing for messiah and the deep rationality of our response in kind to

universal love.

Yet, we must remember that ours is only one listing in the "yellow pages" of religions. Therefore, this conference has been set up so that we may also hear insights from a Muslim, a Jewish, and a Native American perspective. This week we have gathered to ask ourselves about *theos* and tradition as they inform our part of the human community. We also seek to understand how our part relates to all the others. It's a way of reminding ourselves that the fullness to which we aspire is at any particular moment in history somehow also marked by brokenness.

Again, the first word is *God*. The first fact is that God is fullness and we aren't. The first decision is to recognize that periodically we have to clarify our own language and seek again the power behind the words. The second word to explore is *fullness*, or *striving for fullness*. We can only strive. Having said "God," we know that we are not God. We know that we ourselves apprehend only part of the whole.

And a striving for fullness brings us into a second dimension of our

partiality. Not only are we chopped up in yellow pages of religions, we are chopped up into specialties. Some at this conference specialize in child care and aged care and AIDS care. Each of these develops a language that doesn't seem always to contribute to wholeness. For each of us to fulfill our vocation, our profession, we have to get very good at specialized language that sometimes distances us from others.

When we use the word "fullness" or "wholeness" or "holism" we are working to overcome mere professionalization, specialization, and separate languages. We who are part of the Christian community must realize that in this broken world, while the fullness and wholeness toward which we strive is the final secret of life, it is offensive and imperial and encroaching for us to pretend that we have all the secrets.

Why should we who are Christian stress that we are only partial, like everyone else? At this moment in history we have a chance to bring religion to bear on health and medical ethics and human care after having been exiled for some time by modern secularization, the power of the media, and academics separated from theology.

Yet we Christians are not the only people who use the language of fullness and wholeness. The secular world has it; the new age religions have it. But they speak in terms of wholeness as a striving which humans themselves fulfill, drawing on an energy that connects everything. In contrast, the believers' word is that energy enters our world through a divine creator, and connections happen between the people based on response to that divine creator.

Most holistic promises are not fulfilled—particularly when they create the illusion that death can be overcome. Lewis Thomas reminds us

that there are 6 billion of us now. Stick around for 90 years, and none of us will be here. All the words said about holism and fulfillment and fullness have not overcome the word of death. The believing community exists because there is suffering; to provide meaning and lessen that suffering. Our word is partial.

And so the third word for us to consider today is *some*. *Some* is an important word for a believing community to remember when it sets up its strategies and its understanding. *Some* is also a biblical word as in Corinthians 13: "The knowledge we have is piece work." Or, to use another translation, as Oliver Cromwell once said to Christians who were sure God was on their side: "By the bowels of Christ have you ever considered that you could be mistaken?"

The third word carries on from what I began to say about yellow pages. We are religiously yellow paged, and we are by professions and care yellow paged. Often the language of fullness neglects the reality of these specializations. We have to learn that people in different circumstances need to hear different messages and have to be cared for in vastly different ways. When people need mercy we specialize in mercy, and when there is injustice we must specialize in justice. This differentiating or chopping up of life into specialty is the key feature of modernization. The search for wholeness is the attempt to overcome specialization by treating the patient as a whole being. The patient is confronted by the language of the medical specialist, the economic specialist, the legal specialist, and the religious specialist, and she, in the moment of her weakness facing suffering and death, must integrate them.

Any therapist or care giver, especially in the religious area, is

tempted to say "We have the thing that the others don't have. We transcend the professions." I think this denies the Christian concept of vocation. We must learn to honor those people of good will who know the name of no God, but whose dedication, long hours, and loving care must surely serve God.

The fourth word is *faith*. I write history, and having lived six decades of it I am struck by the way people talk today about how secular humanism is gaining. Twenty years ago, 30 or 40 years ago, science and

The goal in the Christian faith is to retrieve tradition from the past and then project it into the future, asking what the world would look like if we began to live those stories.

technology were sacred cows; medical and social service professionals were about to usher in a new Utopia. I remember sitting on commissions in the 1950s as a welfare society was expanding and growing, and many of us worried about how the church could ever be relevant, because all human need was going to be taken care of. The world would no longer need religious social work, nursing orders, or even the pastorate itself, since everything was to be taken care of.

Today we find that this public philosophy of a scientifically man-

aged, technically perfected society is in disarray. Medical professionals, academicians, politicians, and the mass media have behaved as though healing, caring, finding meaning, and determining ethics could be accomplished by secular rationality alone. The patients and the parishioners knew it all along; we are catching up with them and listening before we speak. Ours is not an era of increasing secularization but of growing understanding of the importance of the faith dimension.

The fifth word I'm going to accent is *liberal*: we live in a liberal rather than a secular culture. If by "secular" we mean that the world manages to get by without reference to the sacred or the divine or words about God, then there is plenty of secularity going around. And yet the way our society is organized is not steadfastly secular. The public opinion surveyors can't even find secular people. Ninety-six percent of the American people tell the pollster they believe in God, and well over 80 percent in our culture say they believe in the divinity of Christ. If this were a secular culture, we would have secular people all over the place.

I prefer the concept of a liberal culture, as articulated by Robert Fowler, a political scientist from Wisconsin. A liberal culture is characterized by three things: skeptical rationality, religious tolerance, and intense individualism. Skeptical rationality is the mode of the public sphere. Modern science, academics, research, and government have been organized with no reference to questions about God. The world in which we live today can be characterized by Descartes' famous remark, "I think therefore I am." That is a significant break from the world view of our ancestors: "I believe in order that I may understand."

In the public polity, Thomas Jefferson is an analog to Descartes. The separation of church and state, or better in Madison's terms, the drawing of a line of distinction between religious and civil authority, is cherished by the vast majority of us as an achievement, a gift, a grace. Yet it means that ways in which we find meaning in life, that which draws us together, has no official, public standing.

That carries over into our private lives as well: the third feature of our liberal culture is an intense individualism. I suppose Adam Smith matches Descartes and Thomas Jefferson here. Most Americans who say they are individualists mean they're economic individualists using the great gift of freedom that moves the laboratory and the clinic and governmental talk. Most of us have no desire to change that. A few may yearn for what Leszek Kolakowski calls a hierocratic culture—an Iranian-style society ruled by a clergy. But most do not.

We must critique this liberal culture, therefore, understanding that we are in it but are not of it. We are in it but go beyond it. We are in it but provide alternatives to it.

Are we, you and I, living in this liberal culture? Here's a little test. Most religious people in this society have problems with the Christian Science approach to the care of their children. The vast majority of us are relieved when a judge intervenes to save the life of a Jehovah Witness, saying that society's norms about health care take precedence over the parents' practice of their religion. If we were always instinctively on the parents' side, saying "let the kids die," then we would be outside that liberal culture.

We are far enough into the liberal culture we can't imagine alternatives to it, except perhaps in the desert or in a lonely, isolated monastery. But

it is unsatisfying. We know that we don't only move by secular rationality. Our decisions about care and cure and interpretation and ethics are made with the help of intuition, of memory, of story, of community.

Physicians remind us that when people make life and death decisions, they don't call in the philosopher who will tell them what Aristotle says about *non-maleficence*.

They ask "What does my pastor say? What does my family say? What does my physician say? What does my God say?" We do live in a liberal culture, but one in which faith concerns are now taken seriously even within "secular" professions.

The sixth word is *tradition*. After God and fullness and some and faith and liberal: tradition. *Tradition* is from the Latin *traditum*, handing over. God handed over to Israel a covenant and a promise which it grasps, so there is a Jewish tradition. God hands over a new covenant with the incarnation, death, and resurrection of Christ. Here we get a vision of what the bearing of God is toward us. God hands over every word I use, every conversational element. We live by what is handed to us. If I invented the words, you wouldn't understand them. We continue to make new combinations and concoctions and creations out of traditional stories. Pope John used to tell the religious orders: I want you to reform yourselves in the light of the intention of your founders to whom you cannot go back. That's what it is to live in a tradition and to use it.

If tradition is embodied in the lives of people, why was it not heard during the decades when religion was systematically discounted? Why is it so hard today to recover these traditions? Those of us who work on this task of recovery are surprised to

find that it's everywhere but nowhere. The people who were assigned by our Park Ridge Center to write on faith, health, and medicine in their various faith traditions found, one after another, that there were no books on this. Jacob Burckhardt says that most things that are really important to people don't get written down because they are so taken for granted.

Consider Sunday school. I think the history of the U.S. Sunday school has made the front page of the newspapers once—in the Birmingham bombing of years ago. Yet think of the power that institution has had in the lives of people. We don't write it down because it's so obvious. So the acts of prayer and counsel and nurture, the activities listed in the Sunday church bulletin haven't made it into official public discourse, so we have to recover these meanings now. How do we recover tradition?

The essential problem I think is that we are forward-looking beings. Politicians must plan for the future. Science looks forward out of necessity, since it eats up its own past in many respects. A child in the second or third grade today can repeat what it took Euclid or Pythagoras a lifetime to discover. But when we deal with tradition, memory, text, we're dealing with something from the past, and we have to look in a direction that people don't usually look.

The goal in the Christian faith, in the biblical tradition which Islam and Judaism share, is to retrieve tradition from the past and then project it into the future, asking what the world would look like if we began to live those stories. Last night President Carter said computer data revealed that one-third of the New Testament gospel stories are about healing. Or three-thirds are, depending upon what part of healing you're

talking about.

The wholeness and fullness to which we strive, the concepts of salvation and healing are at the heart of our faith traditions. That may come as a surprise to people in a lot of churches where such ideas are seldom spoken or heard. And yet, the churches quietly have been building institutions of care and providing people to staff them. Our task is to make visible what had been obscured; to refine what had been forgotten. Therefore, it has to be an act of memory.

There is power in the narratives of Isaiah and in the Good Samaritan story and in the story of the healing of the leper. There is a power that the world hasn't yet heard. To our study of our own stories, we must then add the Native American vision of health, to see what is to be learned from their tradition. So we must examine other traditions as well as our own, so that we may rediscover those elements which serve healing. Through the ages, many teachings and traditions of the church have left people carrying around unnecessary guilt, being repressed, not feeling free to be adventurous, saying things about the body that limits the necessary research that gives life. We must retrieve those elements in which life

wins out over death, hope over despair, love over hate, healing over neglect, justice over injustice. This is not something that requires a Ph.D. in history. Perhaps it happens best in Sunday school, or in the act of care.

We need more than simply information gleaned from the past and applied to the future. You have to know in a special, discerning way.

Let me illustrate with the story of the disciples on the way to Emmaus with the stranger who expounded the scriptures to them (Luke 24). They knew the old plot, then, in the performance of an act, there came recognition, when "he was known to them in the breaking of the bread." A revelation of the resurrected Lord grasped and changed their whole being and brought them toward fullness of life.

Like the disciples, we today must gain new understandings out of the old stories. For us, as for them, understandings come in the midst of acts of giving and sharing and healing. We go forward understanding that they knew some things back then that we do not know as yet. That's how you use the tradition.

We do not know as yet, not because they were smarter than we, but because our world circumstances have changed. The stories from the past live among people today who

are facing tough questions about the allocation of health resources, governmental policies, the way universities teach medicine, and the way ordinary people come to terms with their suffering.

The world will not stop being scientific, secular, liberal, mindless of theology or church traditions, or neglectful of or often hostile to the dimension of faith. It is one in which alternatives to, refuges from, assaults upon the hegemonies of, and critical corrections to these prevailing tendencies by thoughtful believers have a better chance of getting a hearing than had been the case for many decades. Whether there is a hearing depends upon how the Church meets the challenge—whether it has something to say and some visible things to do to promote the recognition that something revelatory is going on. This prospect would mean that healing and health are part of the story, the charter, and the promise of a faith born in the context of suffering and death—the suffering and death that do not have the last word.

Healing must begin in the soul. One of the greatest diseases described in the Qu'ran is despair; therefore, God says, "Oh my servants who have been too harsh with your souls, with yourselves, despair not of the mercy of God for God forgives all sins."—Dr. Mahmoud Ayoub, Professor of Islamic Studies, Temple University

The cedar tree represents the Indian world, the Native American world; the satellite dish represents our scientific and highly technological world. Native Americans live within both worlds. They must in order to have health and well-being. But sometimes these worlds are in conflict. Alexander Solzhenitsyn has said, "To destroy a people, you first sever their roots." I think that's what's been happening to Native Americans. They have the highest morbidity and mortality rates of any group of citizens in our nation. Their roots are and have been severed.

—Lawrence Hart, Indian Ministries Task Force, Joint Strategy and Action Committee

The Vision of the Possible: What Churches Can Do



*William H. Foege
Executive Director,
The Carter Center of Emory
University*

David Hilton, a physician and director of the Christian Medical Commission, World Council of Churches, has observed that health is primarily dependent not on medicine but on education. I believe that churches have special opportunities to educate their parishioners about health. Most important, they can provide a larger and more complete vision of health. Churches can make a difference in at least five areas of education.

First, the church can teach us about the unity of body and soul and about the damage caused by our inability to see people as whole. There is a unity to the idea of brokenness, whether we are talking about sin or disease or depletion of the ozone layer or homelessness. There is also a unity to the idea of redemption, whether we are talking about forgiveness or healing or environmental improvement. I have learned that there is redemption in a syringe of penicillin, in a syringe of measles vaccine: they make whole what is broken or keep whole what is not broken. I have learned that salvation means wholeness and not

just life after death. For some people these are new ideas, and we know that the mind approaches new ideas the way the body approaches foreign proteins—it tends to reject them. Nonetheless, churches need to be teaching these ideas.

Second, the church needs to do a better job of teaching the unity of people: that we have a responsibility for others and that the idea of loving our neighbor is not just a religious idea but ultimately the measure of civilization. The measure of civilization is not found in knowledge or technology or even happiness. A civilized society is defined by how it treats other people, and a civilized person, a civilized institution, or a civilized church is defined in the same way. It is easy to respond to our neighbor during an earthquake or a famine, but it is harder to respond to the miseries and chronic problems of everyday life. The unexpected may open our hearts momentarily, but for most of us most of the time, avarice is the sphincter of the heart and a challenge to the church.

Third, the church could provide more education on the overlapping

of medicine and religion, of science and religion. Lily Tomlin once remarked that when we talk to God the church says we are praying, but when God talks to us the doctor says we are schizophrenic. The boundaries are artificial; they are defined too narrowly by both sides. Medicine describes, defines, and measures illness. It provides a diagnosis, and it attempts an intervention. Yet the church provides a sense of continuity, a flow of history, a way of explaining health and illness. Theologian Thomas Droege has pointed out that both scientists and theologians have an incomplete view of the world. His new book on the faith factor in healing makes the point that a disease cannot be described outside the story of a person's life, beliefs, family history, and faith tradition. Einstein said that though it might be possible to describe everything scientifically, the description would make absolutely no sense. This admission should not be an opening for medicine-bashing, however. Each of us owes a great deal to medicine, and many of the

The power of interdenominational efforts to promote a health agenda would be tremendous.

seats at this conference would be empty if we didn't have the gift of medicine.

But the church goes beyond that. It brings order, meaning, and purpose into the lives of people, into the lives of communities. It facilitates healing and the maintenance of

wholeness. I walked into my first test in medical school to be confronted by a single question: What is Life? Over the past 30 years I have understood that the boundary between medicine and religion disappeared with that question. I learned in medical school that when you do a study of an unknown drug, you compare it with a placebo that has no action in order to know what the tested drug will do. What I did not learn in medical school is that the placebo is in fact a measure of faith. The person taking it has faith that it will do something positive. So we are testing a drug plus faith against faith alone. The church can enlist that faith; doctors do. As Droege points out, physicians are faith healers but they don't like to say that. They give a positive expectant attitude to patients; they encourage the placebo effect.

The church also brings other resources to bear on healing, and some of these resources are words. Kipling once said, "Words are the most powerful drug used by man." Words can be used to enlist people in their own destinies rather than allowing them to be passive observers. The philosopher Primo Levy, a Holocaust survivor, attempts in his book, *The Sacred and the Drowned*, to understand what he had learned at Auschwitz. He makes the point that believers in any faith better resisted the seduction of power and had the best defense against death.

Thomas Droege has observed that a person with close ties to a faith tradition that has met the test of time is likely to have a strong sense of coherence. Coherence is related to wellness, and fatalism, lacking coherence, lacks wellness. Churches must give parishioners the power to fight fatalism, to be involved in their own destiny, and to be involved in the destiny of the world.

Fourth, the church should be teaching parishioners about prevention. Too often we place prevention and treatment in opposition, when they are actually on a continuum. Hippocrates believed that the obligation of protecting and developing health ranked even above that of restoring health when it is impaired, and this is true. Nevertheless, we don't live that way, and we don't spend our money that way. In the New Testament, illness was healed

Hippocrates believed that the obligation of protecting and developing health ranked above restoring health when it is impaired. But we don't live that way, and we don't spend our money that way.

because sickness was not the desired state, and it would appear implicit that health was the desired state. Therefore, prevention should be the priority. But as Reverend Walter Warrnack has said: Ministers feel more comfortable with repair because prevention feels as though you are fixing something that isn't broken. Quite the contrary. The continuum of illness starts early and only later breaks the surface of consciousness. The football coach Hugh McCabe died at age 47 of lung cancer. Before he died he said, "It's hard to get across the idea to teen-

agers that it's not the last pack of cigarettes that kills you; it's the first." Things are broken with that first cigarette.

So the question is one of perspective. Everything can be seen as healing from one perspective. Everything we do is healing, but the brokenness isn't evident to everyone. On the other hand, all efforts are part of prevention—as we attempt to prevent illness, to prevent the progression of illness, to prevent disability or suffering or pain or death. So there is a continuum that can be appropriately viewed as different levels of prevention or different levels of healing even when we are speaking of the same thing. And as we all realize, some things can't be fixed. Even here, though, the church can give meaning to the partial.

Fifth, the church should teach perspective. Health is not an end in itself. It is not the purpose of life, but it helps serve life's purpose. And we often realize that only when we lose it. Furthermore, the sentence of illness that we allow for others helps to detract from their purpose of life. This week, 30 years after the polio vaccine has been widely distributed in this country and is available on the world market for two cents a dose, 5,000 children around the world are paralyzed with polio. It detracts from their purpose of life.

Be ye doers of the Word and not hearers only. What can congregations do? Every church can review its community's needs in the areas of health, education, primary prevention, secondary prevention, care, counseling, and support and then decide where to begin. For example, the health risk appraisal mentioned by President Carter can be used by a congregation to help individuals learn what they can do for their own health and also to help decide what priority should be given to providing

certain services to the congregation.

We'll need to learn, of course, how to give people information without blaming them for their problems. On the other hand, we can't withhold information because we interpret this as blaming the victim. One of the greatest of earthly blessings is independence, but we don't have it if we are denied the information we need to be independent. We must present information as a way of improving free will.

Life expectancy at birth has increased by 25 years during this century. That doesn't mean that at my age I can expect 25 years more than my grandfather had at this age; by this time we have passed the high infant and childhood mortality levels. At my age, I can expect only six more years than my grandfather had left at the same age. In one sense, then, all of twentieth-century science and medicine can give me only six additional years of life at this age. Yet, a researcher (Lester Breslow) in Alameda County, California, has shown that a person my age doing some simple things can live 11 years longer than a person my age not doing those things. So in another sense, I am twice as powerful as all of twentieth century science and medicine in determining my own health destiny.

That is real power, and the church has a role in showing individuals that power. This role leads immediately into smokers' clinics, Alcoholics Anonymous groups, weight-watching groups, counseling, aerobics, flu vaccinations, and so on. It leads to church suppers that emphasize health foods. It leads into health maintenance and injury prevention for older people. It leads to Sunday school materials that teach about healthy living and to collective action for food kitchens and

world hunger. Congregations need to know what the state of the world is and receive basic training for how they fit into the world. One guide is *State of the World*, published each year by the Worldwatch Institute in Washington, D.C. It helps individuals see what they could be doing for the world environment. UNICEF's annual *State of the World's Children* is another helpful guide. *Contact* magazine from the World Council of Churches and *Seeds* magazine on world hunger are also helpful.

Much can be done at the community level. So far the church has responded only randomly to AIDS—certain congregations, certain people. The school health curriculum is another area. We know that school health curricula can reduce smoking rates by the seventh grade and reduce teenage pregnancy rates. That is no longer a mystery, and churches have a role to play in getting school districts to implement good school health curricula. Churches could become more actively involved in solving problems of drunken driving, child abuse, and spouse abuse.

At the national level we must deal with the problem of 37 million uninsured people in a land of medical plenty. To come up with a reasonable and equitable national health plan will take the best thought and action of churches. A church, worrying about illiteracy and teenage pregnancy, can become the conscience of a community, and a good school health curriculum is needed at the national level, not just at the local level. The power of interdenominational efforts to promote a health agenda would be tremendous.

One example should spur us to action. Bob Sanders, a Tennessee

pediatrician, treated a child who had been injured in an automobile accident while traveling unrestrained. Sanders decided to try to get child-restraint laws in his county. This led to involving the pediatric society in Tennessee, and Tennessee eventually passed the first child-restraint laws, without any federal action. One person's effort affected the security of an entire nation of children, and an interdenominational coalition of the church could improve the system in similar ways.

A few words on the global situation. All the domestic inequities we know about have to be multiplied by 10, 100, 1,000 if we are to comprehend the inequities in the developing world. Today, tens of thousands of children are being born into the sixteenth century. They will be born and live short lives with no benefit from all the medical schools in the world, no benefit because penicillin was discovered, no benefit because we have computers, or even an alphabet. They will receive no benefit because we have an American Medical Association or because we have organized churches.

The basis of public health is to make our science available to all. Yet the U.S. support for health around the world doesn't make up for the disease burden the U.S. imposes through our economic decisions or our tobacco and weapons exports. The U.S. is a net exporter of disease. We need to support the United Nations agencies (WHO and UNICEF), and we need to influence our government. Our government, on the one hand, asks WHO to develop a global plan for AIDS, and on the other hand, doesn't pay its dues. Before President Reagan went to speak at the U.N., our government publicized the payment of its 1987 dues to WHO to avert criticism. But it did not pay

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the arrears.

We can't do everything, of course, but we have to start somewhere. We have to diminish our acts of omission. We have to know what is possible and then select a place to start.

What could our communities of believers become? Henry Ford said that there are two kinds of people: those who believe they can and those who believe they can't—and both are right. The churches have to become communities of people who believe they can. They must plan for a long future and sometimes for a very late harvest. But we the church could become the dominant agent working for the health of our parishes, health equity within the United States, and health equity for developing countries.

In the past churches have identified promising young people, put them through medical school, and sent them out to do important work as medical missionaries. What if we could break out of that mold and identify other important concerns in the world that we have to do something about? We could identify

promising young people, educate them in political science, engineering, medicine, and teaching, and allow them to be missionaries for the church where they could do the most good.

I find the history of the Jesuits inspiring. Ignatius of Loyola was a contemporary of Luther, and he was caught up in the proud tradition of the individualist dedicated to a larger cause and supported by a community of believers. Those early Jesuits fused action with contemplation; they accepted the world with obedience and with discipline. In India they became Brahmans; in China they became Mandarins; and 130 years ago in the Pacific Northwest they became Indians. They took the problems of each culture unto themselves. They believed that body and soul were not distinct entities but interlocking principles of an entity and that the improvement of the economic or social order was relevant to and necessary for optimal spiritual progress.

We have been given dominance of the world, and health is a gift intended for everyone. The dominion is not a dictatorship; as Droege says, we are in the priestly role of caretaker beginning with the care of ourselves and ending with the care of others and the whole creative order. We as the church must have a vision of being responsible for the entire creative order and at the same time understand what needs to be done today at this hour in this small corner of the creative order, believing that God is truly in the details.

A Voice for the Voiceless: The Church and the Mentally Ill



Rosalynn Carter
Former First Lady
of the United States

One of the major causes of unnecessary suffering and death is mental illness. I have worked on mental health issues for almost 20 years. I have seen the suffering and devastation that can come to an individual and a family when mental illness occurs. With treatment, however, most people can be spared the suffering. Some can overcome the illness completely; others can lead more normal lives with the help of medication; nearly all can be helped. This is not known by the population at large, mainly because of the stigma associated with these illnesses.

Mental illness of all kinds presents a tremendous challenge to religious organizations today. In a recent national survey in which 20 religious bodies responded, only two denominations had ministries directed to the needs of mentally ill people. How can religious organizations better minister to the mental health needs of the congregations and the communities they serve?

First, they will need to face the issue of homelessness. Homelessness is everywhere. We see people living

on the streets. We accept it; we walk around them. But these people—often ragged, dirty, wrapped in old blankets, huddling together to keep warm—are real people; they have

We need churches to take on the task of not only caring for the mentally ill, but proclaiming their cause, and loudly.

feelings, but little hope. And 20-30 percent of the homeless are mentally ill. Their stories are of being in and out of mental institutions, with no one to care for them. That reality is part of our everyday life now, along with the addictive disorders which we hear about daily and which are affecting people all over our country.

Ministering to the families of the mentally ill is also critically important. How can we the church shed the fear and ignorance that have plagued us for centuries and ade-

quately reach out to families of mentally ill people? A father of a son who suffered from schizophrenia put it this way: "Caught between the needs of the mentally ill person and the bewildering, elusive services available through public agencies, the family eventually acts as its own doctor, nurse, and social worker." Summing up the situation, he said, "brokenness is the word."

Yes, our churches have a problem reaching out to people who are broken by mental illnesses. Yet if we look carefully, we realize that churches and religious communities themselves may be the victims of this brokenness. Many professional caregivers, including ministers and church workers, discover that after many years of giving all they have, they have nothing left to give. They're burned out. As a result, congregations are left in the uncomfortable position of depending on a healer whose spirit is so wounded that it seems beyond repair. Those in a position to make a decision about these caregivers sometimes respond by pretending that a crisis doesn't exist. Other times they believe that the caregiver's move to another locale will resolve all the problems. Too often churches have sought to ignore a simple reality: that mental illness can come even to those who are providing care.

Perhaps one of the most pressing challenges for the church today regarding mental health is to keep its leaders emotionally and spiritually healthy. The mental health of church leaders is more than just a personal issue; it is a means by which the church can begin to overcome the stigma that surrounds mental illness. If it becomes visible that a congregation recognizes and reaches out to one of its own who is suffering from a mental problem, then it becomes possible for a member of that

church to say, "I have a mental problem, too." When these illnesses are talked about openly, and when people learn that mental illness, like physical illness, can be helped or overcome with treatment—that is when the stigma will begin to disappear, so that we can really

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minister to those who need our help.

Another issue for the church is that of preventive mental health. We assume that being a member of a religious community is restorative for mental health and preventive of mental illness. Yet mental illness does afflict members of congregations, and pastors and church leaders often have little training for ministering to those who suffer. Many churches in this community are doing wonderful work for the homeless—providing shelters, soup kitchens, and so forth. But when those who come into a shelter are both homeless and mentally ill, they're different. Church leaders don't know what to do with them.

We need to look to the examples in this country of leaders and congregations who have become sensitized to the needs, have overcome the prejudices, and have good ministries for the mentally ill. One is the Panthersville Presbyterian Church in

the Atlanta area. This small congregation was approached by an adjacent mental health facility about using church space for an outpatient activity. Since the church was facing the challenge of just surviving, they decided to rent space to the center. Through this cooperation, the church was able to overcome its fears and prejudices and now has a fuller ministry to all people. This happens so often. People resist having a group home established in their community, yet once it's established, fear and prejudice disappear because people realize that mentally ill people are good neighbors.

Druid Hills Presbyterian Church and St. John's Lutheran Church, both in Atlanta, are other examples. These churches have held worship services for homeless people, many of whom have been mentally ill for years. And both churches try to bring healing to people's lives in other ways. In a program at St. John's called Joshua Ministries, a woman offers her home. She provides a loving and caring family environment for anyone who comes, and they pay what they can. Druid Hills has art classes and other activities that help people with mental illnesses feel some self-worth and creativity. Nothing is more

important to a person who is suffering from mental illness.

Finally, churches need to think about their roles as advocates. Mentally ill people are one of our truly powerless constituencies. They don't write letters to their state representatives or their newspapers; they don't picket and demonstrate in front of state capitols; there are not enough advocates on their behalf. It's easy for us to forget about them and their needs. If we see as part of our mission the advocacy of those who are poor and powerless, then advocacy for mentally ill people will become a major concern for churches and religious organizations. Churches and congregations need to take on the task not only of caring for these people in need but of proclaiming their cause.

People with mental problems are our neighbors. They are members of our congregations, members of our families. They are everywhere in this country. If we ignore their cries for help, we will be continuing to participate in the anguish from which those cries for help come. A problem of this magnitude will not go away. Because it will not go away, and because of our spiritual commitment, we are compelled to take action.

The church can reduce the stigma attached to mental illness; address the theme of codependence, defined as any maneuver that fails to recognize the seriousness and the impact of the substance abuse problem; and take care of the people who are in the position of giving the care.

—Dr. Donald Manning, Professor and Vice Chairman, Department of Psychiatry, Emory University

I think of advocacy at three levels. First is one-on-one advocacy for a mentally ill person. Then there's congregation-wide advocacy. Third is political advocacy—taking on the powers that be. Finally, research is a very pressing need. In this time of budget deficits, churches need to stand up for funding of the mental health fight. —Dr. Thomas Bryant, President, Nonprofit Management Associates

Section III

Mobilizing the Faith Community To Respond to Health Needs

Introduction

The overarching goal of the National Church Leaders Symposium on Health was to seek ways in which the religious community could be coordinated to improve access to health care and enhance the quality of life for the congregation and community. Churches could become a major promoter of health and health policy if the religious network was mobilized. With sharing, communication, provision of information, support and networking, the churches can be enabled to be more active in this area.

The goal of the last session of the conference was to present and

explore health initiatives already working in the religious community; address specific questions relating to religion and health; share experiences, impressions, and personal reflections; and foster a commitment to working toward the solution of health problems and the promotion of full and healthy lives.

In presenting the latchnote, Terry Hamilton, President and Co-Chair of the National Assembly of Religious Women, intended to motivate the participants to action in their own communities and congregations. She summed up the spirit of the conference with the quote: "We are the people that we have been waiting for."

I would also like to offer some practical suggestions in the context of Matthew 25. "Then the Holy One shall say to the people on the right: 'You who are blessed by my Maker, come and receive the birthright which has been prepared for you since the creation of the world. I was deaf and you provided sign language interpreters. I was hearing impaired and you provided assistive listening devices. I had a child with Down's Syndrome and you asked my whole family to serve as greeters. I was in a wheelchair and you made a way for me to approach the Communion Table. I was schizophrenic and you welcomed my sharing in your prayer group. I was vision impaired and you bought an enlarging copier machine. I was a recovering alcoholic and you entrusted me with responsibility. I had AIDS and you gave me a place to live. I had no voice and you gave me a funded conference task force. I tell you, indeed, whenever you did this for one of the least of these brothers and sisters, you did it for me.'" —Holly Elliott, President, United Methodist Congress of the Deaf

Rather than serving as an alternative to or refuge from our liberal culture, the church is in the process of assuring the integration of its healing tradition, not only among its own members and its health care and social service organizations, but also to represent those values within the larger social context.

—Sister Kathleen Popko, President, Sisters of Providence

Models: What Churches are Doing

Several model health projects were presented at the symposium. These models were chosen to exemplify how religious organizations can actively play a role as health providers in society. Four different areas were sought: education, advocacy, service, and theological reflection. Although 15 models were presented at the symposium, only one example of each category will be presented in this section.

The model presentations were an important dimension of the conference because quality examples of projects that actually work can serve as catalysts for other initiatives. By learning about others's successes, new initiatives are facilitated.

Education

In 1986, a group of people came together in the San Francisco Bay area to participate in an interfaith worship service for those suffering from AIDS and HIV infection. Marin County, California has an HIV prevalence of one-in-88, and this worship service was a spiritual response to the tragedy caused by a frightening epidemic. Following this worship service, several religious leaders decided to instigate a more ongoing effort to provide for the spiritual needs of those affected by HIV infection. Thus, the AIDS Interfaith of Marin (AIM) was formed to serve such a purpose. In starting the project, Reverend David Martin (Executive Director) notes, "We found in 1986 as we formed, that people in congregations were asking for basic education and information about AIDS before they felt

comfortable and willing to volunteer in a spiritual support capacity. So we engaged the local AIDS service organization and their educational department in assisting us with that task. We set up not only AIDS 101 information activities, but we also began to do preventive education most particularly with youth."

Among the educational materials now put out by AIM is a brochure, "Teens and AIDS: Playing it Safe," which gives basic information about AIDS in the form of illustrative hypothetical cases within a high school setting [published by American Council of Life Insurance, Health Insurance Association of America]. Also distributed is a cartoon narrative, "Rappin," explaining simple preventive measures, culturally sensitive to today's youth. Part of preventive education, according to Reverend Martin, targets those already infected with HIV. Too often these people are faced with only the idea of a 100 percent fatality rate for AIDS. Unfortunately, this attitude breeds a suicide rate for those with HIV infection of over 50 times the national average. The reality, however, is that the study showed 50 percent of HIV infected persons were still asymptomatic after 10 years. This is the radical approach Reverend Martin espouses in that the root issue is the preservation of health: "how do I maintain my wellness given that I am HIV positive?"

AIM provides preventive education for HIV infected persons on

how they may best remain asymptomatic and preserve their state of health. An example of an AIM education program is its Wednesday night sessions. At 6:30 p.m. a meal is served, followed by a presentation from an invited speaker; topics include psychological and social issues, exercise and relaxation, immune system and visualization, nutrition and AIDS, etc. From 8:30 to 9 p.m., six to eight people form small support groups, and the session closes with meditation and prayer. In addition to education, AIM offers spiritual support groups, pastoral care training, and meals programs. AIM is unique in that it is truly interfaith, including Christianity, Zen Buddhism, Judaism, Islam, New Age Religion, Native American, and Channeling. This scope of participating faith groups makes it possible for AIM to reach out to the variety of spiritual needs of people from different religious perspectives. For more information on AIM, contact Reverend David Martin, 1000 Sir Francis Drake Blvd., #12, San Anselmo, CA 94960, (415) 457-1129.



*The Reverend David Martin,
director of AIDS Interfaith of
Marin.*

Advocacy

Dr. Marilyn Washburn, President of the Presbyterian Health Network, presented a model showing the ability of a religious structure such as the Presbyterian Church to advocate for different health issues on a variety of levels. In 1983, the General Assembly of the Presbyterian Church (USA) funded a study on the cost of health care as it affects church and society. A task force was put together of medical persons, pastors, and lay people who met over a period of several years. Seven presbyteries were invited to answer the question "what would it look like if your presbytery took seriously the issues of health and healing within the church?"

The result was the formation of a network. According to Dr. Washburn, "The theory of the network is that those of us at a national level of church have neither the time nor the expertise to resource everything that's going on in the church. So it's a simple way that people who are doing things are put in touch with other people and can become part of a network to share what's going on and to use our resources collectively."

There are four different areas of advocacy of the Presbyterian Health Network. The first is pensions, calling for coverage and accessibility for those with no access to health care among employees of the church. It was realized that the vast majority of Presbyterian employees were part of the 37 million uninsured. Work began on this by initiatives such as including the women's unit of the Presbyterian church in pension committee meetings.

A second area of advocacy is legislative, largely on the national level. The problem was not that there was nothing going on at the state and local level, but that there was a lack

of communication. Thus, through developing a network it is possible to know in Georgia what is happening in the Tennessee legislature. Additionally, communication between church lobbyists in Washington is facilitated through such a network. According to Dr. Washburn, "[The network] is a way we get to be in touch with our lobbyists and repre-

The problem was not that there was nothing going on at the state and local level, but that there was a lack of communication.

sentatives in Washington to let them know where our concerns are. We meet with our representatives in the Washington office face-to-face to let each other know our concerns. We have regular contact now."

A third area is that of advocacy within the church structure itself. This is accomplished primarily through the meeting of the General Assembly. Health related overtures are presented to the General Assembly by seeing to it that people are there to advocate on the floor when a topic comes up. This is a "crisis ministry" since the General Assembly meets only for five days.

Finally, the last area has to do with making advocacy a part of all health related ministries. The best example of this is the Presbyterian policy on alcohol. Twelve consultants were contracted through a national agency so that local presbyteries could invite one of these professionals to help them learn not

only how to set up clinics and develop AA networks, but also how to stop dual licensure—so that establishments in their communities can't sell gasoline and alcohol at the same time. Claims Washburn, "those are things that are cheap and make far more difference than rehabilitation in terms of the numbers and preventive measures." For more information, contact the Presbyterian Church (USA), Presbyterian Health Network, 100 Witherspoon Street, Louisville, Kentucky, 40202.

Service

Dr. Scott Morris, a physician and elder of the United Methodist Church, recognized the potential role the church might play in the health of people who are poor and sick. In September 1987, he founded the Church Health Center in Memphis, Tennessee. This center is a non-profit, ecumenical organization that works with over 100 churches and focuses on the 'whole person' approach to medicine and health. The medical center provides all health care services offered by a family physician: preventive, therapeutic, health promotion, and education.

Dr. Morris believes the church has a biblical and historical commitment to care for the poor and sick—this means an active response on the part of the church in the provision of basic primary health care. Thus, Dr. Morris' organization is a family physician oriented health center staffed by two full-time physicians from 7 a.m. to 9 p.m. during the week, as well as on Saturday mornings for those who cannot afford to take time off from work. Evening hours are staffed by among 80 volunteers, primary care physicians who donate their time to visit on site after normal working hours. Seventy



Dr. Scott Morris examines two sisters at his Church Health Center in Memphis.

patients are seen each day by the center, which gives primary care to the maximum extent possible, including lab work and the provision of medication. If necessary, one of 150 volunteer specialists, who have agreed to see people in their offices and perform necessary diagnostic tests at no charge, can be called in.

Dr. Morris feels that free clinics don't work. Patients are charged on a sliding scale based on their income, with the average visit costing 10 to 15 dollars. Patient fees and Medicaid together account for 50 percent of the \$500,000 operating costs. The other half is covered by churches, foundations, hospitals, and businesses.

A 'whole person' approach is advocated. As Dr. Morris states, "Fifty percent of people who come to the primary care M.D.s have no medical problem; they come because their lives are falling apart. I don't care how good a doctor you are, you can't put someone's life together in a 10- or 15-minute office visit. For this reason we have a full-time pastoral counselor on our staff. We also have volunteer pastoral counselors as well who are backed up by psychiatrists who see patients in

their offices or on site. We also have a full-time social worker, a part-time nutritionist, weight-loss classes, etc...."

In addition, the Church Health Center sponsors a health education program centered around "lay advisors" who are trained in an eight week session to teach churches about hypertension, diabetes, mental health, etc. "Health Watch" is a congregational-level program that helps congregations identify those with medical problems going untreated. For instance, a young pregnant woman can be identified early and pressed to get prenatal care.

Health education, primary care, preventive care, counseling services—all of these serve to bring fullness of life to the needy people of Memphis. For more information, contact Dr. Scott Morris, Church Health Center, 1210 Peabody, Memphis, Tennessee, 38104, (901) 272-0003.

Theological Reflection

Our beliefs about God, salvation, and health reflect theological issues

which tend to direct the course of our action. Theological world views are disseminated to the average lay person through worship and liturgy. The objective of the "Worship and Liturgy" model presented by the Reverend Mark Scott and Dr. Charles Hackett was to show how the way we worship and the liturgy we read can be modified to emphasize the healing aspects of Christian faith.

By tracing the history of the concepts of health, shalom, sin, and evil, Dr. Hackett demonstrated the origins and developments leading to the "rites of reconciliation" liturgy of today. Where do we get this modern notion of making a confession and getting absolution?

Reverend Mark Scott pointed out that connectedness within the body of Christ is the root issue when people come together and worship. "No one can ever explain the healing power of worship." As to specific actions a congregation can do, Dr. Scott recommends:

- 1) Remember that illness isolates people from their well selves and from others.
- 2) Help people find a new sense of connectedness in life. Pray for them, etc.
- 3) Make sure pastors include them in congregational prayers.
- 4) Pay attention to the healing scriptures.
- 5) Preach on healing lessons.
- 6) Choose hymns and anthems emphasizing that worship is healing.
- 7) Make visits, telephone contacts.
- 8) Develop prayer groups with the specific responsibility of praying for the needs of the world.
- 9) Have special healing services.

For more information on the Worship and Liturgy model, contact the Reverend Mark Scott, St. John's Lutheran Church, 1410 Ponce de Leon, Atlanta, Georgia, 30307, (404) 378-4243.

Action Groups and Distillation Committee Report

Each conference participant was assigned to a discussion group to consider specific questions regarding the role of the religious community in health and healing. Examples of some questions addressed by discussion groups are listed below:

- What can the churches and other faith groups do to instill individual responsibility for one's own health and for that of others?
- How do we go about building a stronger religious coalition so that we can collaborate more effectively regarding health concerns?
- How can churches and other faith groups communicate more effectively at the national and local levels regarding health issues of mutual concern and interest?
- What are some specific ways that churches can reach out to minority communities which may be most affected by the gaps in health care provision in the United States?

Distillation Committee Report

A committee was formed to examine the feedback from the discussion groups. Consisting of Father Thomas Harvey, Catholic Charities; Gwen Crawley, Presbyterian Church (USA); and the Reverend Charles Miller, Evangelical Lutheran Church in America, the committee drew on individual reflections from each session of the symposium as well as summaries from the discussion groups. Their report, which was presented as follows on the last day of the symposium, was intended to serve as a motivational piece and to display the common ground that existed among the various faith groups and denomi-

nations.

Both presenters and participants stressed the need for health to be viewed in an inclusive sense as both wholesome lifestyle as well as medical care. In point of fact, those whose lifestyles are limited by poverty, discrimination (including individual and collective acts of racism and sexism), and/or other negative burdens will be at high risk in health matters and in access to medical care when health fails.

This presents a challenge to religious communities to reflect their own capacity to be a source of health and healing. Thus a variety of suggestions were provided for possible congregational programs and other programs which challenge religious bodies to be active catalysts in developing a more equitable national health policy. Such a challenge must address:

- divisions within the religious communities on what should constitute a shared "health" agenda;
- the need for agreement on what is quality basic health care to which everyone should be entitled;
- a realistic assessment of issues of cost as well as access;
- the present lack of knowledge, awareness, and behavior models in too many communities of the dangers of high-risk behaviors such as smoking, alcohol consumption, poor diet, drug usage, and casual sexual activity;
- the need to keep a balance between activities which focus on prevention rather than treatment.

Participants made a variety of programmatic suggestions which

were addressed to local congregations, religious institutions, interfaith efforts and possible follow-up activities to this conference. Major areas for program development were:

- local congregations' opportunity to model positive health practices;
- a variety of educational suggestions targeted at children, families, religious leaders, and people with special needs;
- the opportunity for ethical reflection including the intersection of science and religion;
- empathy with those who suffer;
- the need to model healthy policy and practice within the religious community as a social institution;
- equipping individuals as caregivers;
- offering support to providers of care;
- embracing a global vision at the congregational level;
- participating in the development of community-based programs directed to a variety of health needs;
- building networks among professional leaders with health portfolios;
- providing forums where a variety of public and private sector interests can discuss and formulate health care strategies.

Participants acknowledged that the religious community cannot deal with the full range of current health issues without entering into the public policy arena at national, state, and local levels.

A variety of specific policy initiatives were suggested. However, against a backdrop of 37 million uninsured citizens, participants spoke with a united voice in calling for a national policy of universal entitlement for access to health care and encouragement of religious people to analyze this issue and enter the public debate.

Concluding Remarks



*Terry Hamilton
President and Co-chair,
National Assembly of Religious
Women*

The liberal culture is a gift full of problems, but it doesn't rule out faith, as Martin Marty said. To this, William Foege added that the church must provide a perspective. When I was a child, I could never make a decision between the sun, a blue sky, a country road, irises by the brook, or the dark moments between the deepest shadow and the twilight of dawn. It was right to insist as a child that I did not need to choose. Likewise between medicine and religion we have the luxury of not choosing. But we have the responsibility of using both of them well.

In the tradition that I share, we say in confession, "Bless me for I have sinned." What I have learned over these few days is the need to say some similar kinds of words as the starting point of change. I believe we can do that. As I read the book *Sisters in the Spirit*, I was fascinated. It tells a story of several African American women, and their call to ministry. These women attempted suicide, fell chronically ill, fell into great depression because they could not decide whether the call to ministry was real and of God or false and of the Devil.

Not too long ago, reading about African spirituality, I observed what I thought was a parallel. In the tradition, in the way of the people a child accepts the God of the parent. However, there are occasions when God calls to a particular person, and God like the pangs of hunger gnaws at the mind and heart until proper attention to and recognition of the

*We are the people we
have been waiting for.*

call is given. One essential notion that underlies that kind of reality is the notion of relationship. In the African tradition, supportive relationships are what sustain health: "I am because we are." When relationships are broken is when illness occurs.

I wonder if what I experience when I go down Fifth Avenue in New York and see homeless women

and men sleeping on park benches across from the lighted windows of the comfortable is a similar kind of gnawing. I wonder if it is gnawing that I experience when I am asked, as I was just this week, "what should a pregnant woman do who is HIV positive, has one child who is already seriously ill with HIV disease, and what is the likelihood of serious illness on the part of this new child?" I wonder if what we shall experience once we leave each other here is gnawing that will not let us go until we attend to it. Or will we, as Joseph Roberts said, "study it to justify doing nothing."

Again, in my tradition one of the great events of the twentieth century was Vatican II. And during this process the reaffirmation of the understanding of the Church or, Dr. Ayoub, the faith community as the people of God all called to ministry, and the promise inherent in ecumenical and interfaith dialogue. Sister Kathleen Popko said, "one emerging trend for all of us as religious organizations and institutions is this looking to the future and examining our priorities for advocacy. We're doing this," she said, "as we also critically reflect and dialogue on the theological understandings of our decisions and actions."

This brings me to the theme of prevention and treatment. It was said here that prevention and treatment are held to different standards. To me this is like women and men being held to different standards. Lorraine Hansbury, a distinguished woman writing in the 1950s, said, "until the social/moral structure admitted the equality of women, all ethical questions could not be fully explored, nor could they properly be resolved." This kind of thinking that prevention and treatment are to be held to different standards may be an indicator that the languages of health care and of wellness, need to

be expanded and a new vocabulary put in place.

Maybe the language is something of what Martin Marty described as "the understanding that ordinary people had that the acts of healing could not be separated from providing care and determining meaning."

I was deeply moved when Dr. Ayoub stated that in the Qu'ran it is clearly understood that healing must begin in the soul, and that the greatest disease is despair. He said that God breathed into us the spirit of God which is life with dignity.

This established a kind of right to wellness and is supported also by the Jewish tradition. Rabbi Feldman said he experienced the Talmud and the writings of Maimonides to call for an active restoration of wellness, and that it was urged simply because it was right, and it must be done without prejudice and without condition. I think because of that we can be very, very hopeful. But Kinlaw's analysis reminds me too of the words in the Mass that I hold dear. Those words say, "I am not worthy, but say the words and I shall be healed." I will be healed as an individual surely, but also we who gather shall be healed. Here I think Kinlaw picks up an important theme: only a healed community can be healing. Both Martin Marty and a member of our action group brought to our attention the importance of faith communities as the facilitators and reinforcers of support for one another. We establish meaning and direction in community—especially community enriched by our diversity.

We have said that brokenness is present in our midst. We have said that our faith can and should inform our actions. From scripture to modern systems of health care, religious groups have involved themselves in the well being of the community.

We also have models that are working, among them, Habitat for Humanity, Christ House, and AIDS Interfaith. These are just a few of the many models that were presented here. These are models where lay people and clergy work together. But we also know that we have not optimized what prevention can accomplish.

Public officials who were here yearned to have some kind of partnership. What we need are creative minds and hands to set ourselves to the task. But we must also be very careful and thoughtful about what that response is going to be. Because the increasing cost of services related to some illnesses creates a kind of reluctance to continue to fund payment for health care. One example is AIDS, which Dr. Koop mentioned. On the other hand, Patricia Butler told us that those without health care benefits are subsidizing health care benefits for those that do have health care.

We may have many obstacles to overcome to successfully tackle this. These obstacles are all the understandings that we have shared these few days—the differences that are present in our communities, the sensitivities that some of us lack, whether to sexism or racism or language and culture or to age and social class. Delores Williams says that truth is our way of being human in the world. She says the gift that African American women have given to society is making a way when there has been no way. It seems to me that those two issues, how we are in the world, the decisions we make, and our comfortability with taking the risk to try to make a way when there is no way, are the issues that are fundamental to our grappling together.

Kris Gebbie said, though, that we

don't necessarily make good choices. She noted our insistence on technology over public health nurses. In other cases, as President Carter pointed out, we even export ill-health. As a resident of New York City, I was struck when he said that more Colombians died from our cigarettes than Americans died of Colombian drugs. He said that many times the smaller churches in poor communities are more involved in social and humane concerns than many of us who are part of larger churches. He said too, though, that as a matter of policy we often severely restrict the ability of MA's, PA's, and RN's to provide health care services that might in fact be cheaper and go further toward prevention.

The simple question I have is, can't we do better? And of course I have an answer: I think we can. In Proverbs, there is this scripture: "There is a generation, oh how lofty are their eyes. Their eyelids are lifted up." But it also says this: "There is a generation whose teeth are swords and their jawteeth are knives to devour the poor off the earth, and the needy." It seems to me that the privilege of leadership is our ability to influence people. Gertrude in Hamlet made our reality very clear: "All that lives must die, passing through nature to eternity." The only time we really have is now. I think we must either be the generation with our eyes lifted or we will surely be the generation of the devourers.

Mable Thomas, one of the Georgia state legislators, said, "We are the people that we have been waiting for." If we have the concern, we are the people that need to begin to move that concern. The way to express this is, as stated in Luke's scripture, "our hearts must be where our treasure is." And our treasure must be one another.

Quotes from Participants

"The mood of the conference is one of optimism, of hope, of challenge, of excitement."

—Reverend Robert J. L. Zimmer, President, Wheat Ridge Foundation

"The people feel an urgency about using old structures [like the church] in a new way . . . That is what I hoped would happen here. I think people will not be able to leave here without feeling a large sense of accountability." —Arnold Tiemeyer, President, Lutheran Home at Germantown

"The health crisis feels so overwhelming. What can one church or one person do? Yet, we are seeing at this conference that, yes, one church can do something. We're getting some good ideas and suggestions. When you start lumping some of these churches together, you find in fact that you can have a real impact." —Thomas Peterson, Global Ink

"We've helped one another appreciate the great need that exists all over the land to help people achieve the kind of wholeness and well-being that God the creator had in mind for all of us. What we take back is a renewed sense that faith must be active in love." —Ralph Bohlmann, President, Lutheran Church-Missouri Synod

"Globally, the number one cause of disease is poverty. The United States is not an exception. If we're not doing something about poverty, we're not doing something about health." —Dr. David Hilton, Associate Director, Christian Medical Commission

"Health is a right that we all have and our society must take responsibility. The way our system has evolved in terms of paying for medical care is not conducive to equal access to health."

—Dr. Christine Collins, Health Planner, University of Tennessee Medical Center

"Health is everything that has an impact on the human organism. It involves the gift of life which is a gift from God. To utilize that gift to its fullest means understanding what has an impact on it. So it's very much an issue of trust and movement of the process, the journey of life." —Dr. Kenneth Bakken, President, St. Luke Health Ministries

"We're interested in the churches because we recognize that a lot of systems in our society have broken down. Families aren't what they used to be; therefore, the role of the churches and other community groups and schools really become key to figuring out how to help people socialize themselves in a way that will maximize their health." —Donna Hall, Henry J. Kaiser Family Foundation

"The church is at best a community of the people of faith, and it goes far beyond the church. A more inclusive term could be used to characterize the concern and the efforts and the work that we all must do together, people of the church and people of other communities of faith. My hope is that this would lead to a fellowship of faith." —Dr. Mahmoud Ayoub, Professor of Islamic Studies, Temple University

"Recognizing that the health of all is a responsibility of society in general, the medically poor—including the uninsured and the underinsured and those with catastrophic illness or injury—must be supported at all levels of the church community. All denominations should include programs designed to increase access to health care services for the poor as a primary objective." —Archbishop Eugene Marino, Archdiocese of Atlanta

"What challenges lie before us as we see our neighbors lying out all around us, and what are we called to do? Maybe we ought to look at the Good Samaritan's definition of mercy. Mercy is not a gush of sentimentality. It is not the feeling that one ought to be patronizing and gracious, but at the center of mercy is always justice. Mercy is justice in tears. Mercy is Jesus standing before Jerusalem and knowing it was slipping through his fingers, and saying as tears ran down his eyes, 'How many times I would have embraced you, but you would not.' That is what we are called on to do: to see those in need and to break out of the little parochial parameters of ecclesiastical distinctions that bind us so tightly, and to realize that God has called us to a broad concern." —Reverend Joseph Roberts, Senior Pastor, Ebenezer Baptist Church, Atlanta

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Sister Mary Madonna Ashton
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Dr. Ilham Altalib
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German Institute for Medical Missions

Ms. Donna Hall
Kaiser Family Foundation

Ms. Jane Hull Harvey
General Board of Church and Society
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Father Thomas Harvey
Catholic Charities

Ms. Frances Haskins
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World Council of Churches

Ms. Jamie C. Hilton
American Foundation for the Blind

The Reverend Wayne Holcomb
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The Reverend Glenda B. Hope
San Francisco Network Ministries

The Reverend Richard E. Ice
American Baptist Homes of the West

The Reverend Mwalimu Imara
Morehouse School of Medicine

Dr. Thad Jackson

Mr. Philip E. Jenks
American Baptist Churches in the USA

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Candler School of Theology
Emory University

Dr. Dora Ames Lee
United Methodist Church

Mr. H. Michael Lemmons
Congress of National Black Churches

Dr. Larry Lewis
Home Mission Board
Southern Baptist Convention

Dr. Eugene Linse
Board for Social Ministry Services
Lutheran Church-Missouri Synod

Mr. Lee E. Loder
National Black Church AIDS Council

Ms. Edith M. Lohr
Dakota Hospital

Ms. Lavada Loper
Home Mission Board
Southern Baptist Convention

Ms. Mary Lee Loving
Christian Church (Disciples of Christ)

Dr. Ngina Lythcott
Dartmouth Medical School

The Reverend David Mahsman
News and Information
The Lutheran Church-Missouri Synod

The Reverend Thomas F. Mainor
Presbyterian Health Network

The Reverend Robert Maltzahn
St. Michael's Lutheran Church

Mr. Clinton Marsh
Westhills Presbyterian Church of
Atlanta

Dr. Clair Martin
Dean
School of Nursing
Emory University

Dr. Anne Russell Mayeaux
Aquinas Center of Theology
Emory University

Bishop Lowell H. Mays
Evangelical Lutheran Church in
America

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Ladies Ministries Department
Church of God International

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Rural Health Project
United Methodist Church

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Social Justice and Peacemaking Unit
Presbyterian Church (USA)

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Editor
"The Disciple"

Ms. Betty Merriman
Kaiser Permanente

Dr. Herbert Meza
Presbyterian Church (USA)

Ms. Melanie Minton
Christian Church and Churches of
Christ

Ms. Cecilia Moran
Social Justice and Peacemaking
Presbyterian Church (USA)

Dr. Romney Mosely
Trinity College

Pastor Charles Mueller
Trinity Lutheran Church of Roselle, IL

The Reverend Howard Mueller
Health and Healing Ministries
The Lutheran Church-Missouri Synod

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Houses

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Affairs
Evangelical Lutheran Church in
America

The Reverend Roger Neeb
Peace Lutheran Church of Hurst, TX

Mr. Wilfred Nolen
Church of the Brethren Benefit Trust

Dr. Laurence O'Connell
The Park Ridge Center

Mr. Phil Olson
Center on Rural Elderly

Mr. Robert Parham
Christian Life Commission
Southern Baptist Convention

Ms. Carolyn Parks
Christian Community Health
Fellowship

Dr. Bob Perryman
Baptist Bible Fellowship International

Ms. Mary Lou Perryman
Park Crest Baptist Church

Mr. Thomas R. Peterson
Global Ink

Dr. Hugh D. Pickett
American Baptist Churches in the USA

Ms. Savannah Potter-Miller
African Methodist Episcopal Zion
Church

Mr. Gordon E. Robbins
Centers for Disease Control

Dr. Mary O. Ross
Women's Convention
National Baptist Convention, USA

Mr. Gardner Russell
Church of Jesus Christ of Latter-day
Saints

Dr. Judith A. Ryan
Congregational Health Services
Lutheran General Health Care System

Dr. Lorry Rytting
Church of Jesus Christ of Latter-day
Saints

Lt. Colonel Orville Salmon
The Salvation Army

Ms. Willease Sanders
Teen Pregnancy Prevention Program
Baptist Education and Missionary

Mr. Cayetano Santiago
U.S. Public Health Service

Dr. Donald G. Schockley
University Chaplain
Emory University

Mr. Paul Schultz
Bay Area Native American Ministry

Dr. Thomas F. Sellers
Department of Community Health
Emory University School of Medicine

The Reverend John D. Sharick
Presbyterian Church (USA)

Dr. Stephen J. Sloop
Emory Presbyterian Church

Mr. Corey B. Smith
Evanston Hospital

Mr. J. Robert Spangler
General Conference of Seventh-day
Adventists

The Reverend Thomas A. Summers
South Carolina Department of Mental
Health

Dr. O. Wytch Stubbs
DeKalb Medical Center

Dr. Joseph E. Sutherland
ReSource Unlimited, Inc.

Dr. E. Dawn Swaby-Ellis
Emory University School of Medicine

Ms. Myra L. Taylor
Women's Convention
National Baptist Convention, USA

The Reverend Hubert Temme
Wheat Ridge Foundation

Dr. John A. Terry
Button Gwinnett United Church of
Christ

Mr. Arnold Tiemeyer
Lutheran Home of Germantown

Dr. David Topazian
Christian Medical and Dental Society

Ms. Gabriele Uhlein
Wheaton Franciscan Services, Inc.

Ms. Karen S. Vroman
National Benevolent Association

Mr. James Wagner
General Board of Discipleship
United Methodist Church

Ms. Loretta Walker
Commission for Women
Evangelical Lutheran Church in
America

Mr. James Wall
Christian Century Magazine

Ms. Rose Wallace
Metropolitan InterFaith Association

Major Helen Sue Warnock
The Salvation Army

Ms. Judith Hope Wellington
Bay Area Native American Ministry

Major Charles White
The Salvation Army

Ms. June Whitlow
Women's Missionary Union
Southern Baptist Convention

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Emory University

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Social Justice and Peacemaking Unit
Presbyterian Church (USA)

Ms. Sylvia J. Wilson
Johnson C. Smith Seminary

Dr. James Wind
The Park Ridge Center

The Reverend Henry K. Wohlgemuth
Lutheran Ministries of Georgia, Inc.

Dr. Lee V. Woodbury
Professional Health Services, Inc.

Ms. Bernardette Woodbury
Professional Health Services, Inc.

National Health Policy Meeting

One of the immediate outcomes of the conference was the organization of a follow-up workshop entitled, "National Health Policy: The Faith Communities' Agenda." The task of this new workshop was to explore the role of the faith community in achieving a national health policy.

A design team came together (consisting of alumni from the October *Striving for Fullness of Life* conference), and included Dr. Marilyn Washburn of the Presbyterian Health Network; Reverend Kenneth Grant of the Presbytery of Boston; Savannah-Potter Miller, an Atlanta attorney; and Reverend James Cogswell, consultant to The Carter Center. They helped design and facilitate this workshop of January 25 and 26, 1990. Selection of participants proceeded with the objective of involving as many different faith groups as possible; this would insure that the outcome of the conference would represent as fully as possible the national health agenda of the faith community.

Three goals were set: 1) review one another's health care and social justice policies; 2) discover common ground in policies; and 3) reflect on possible strategies in light of legislative proposals surfacing in state and local governments.

Four expert consultants joined the group: Susan Sherry from the National Health Care Campaign in Washington, D.C.; Dr. Kenneth Frieshof of Physicians for a National Health Policy; Katherine McCarter

of the American Public Health Association; and Reed Tuckson, Commissioner of Health, District of Columbia.

In the first session, "Elements of a National Health Policy," each consultant elucidated key elements of and options for a national health policy. In the other session, "Issues to Consider," each consultant spoke on one of four issues which might destroy the chances of forming a national health policy: AIDS and

There is a tremendous consensus among the faith community on many of the central elements of a national health policy—most important, universal access to health care.

epidemics; funding and revenue; lifestyle changes; and relations with health professionals.

In addition to these sessions, participants discussed the similarities and differences among their denominational policies. A matrix was created comparing each denomina-

tion's policies on 13 criteria for a national health policy, as determined by the American Public Health Association. The result was the discovery of a tremendous consensus among the faith community on many of the central elements of a national health policy—most important, universal access to health care.

Finally, the group brainstormed on strategies for reaching the goal of health care for all. The following distillation report was produced and approved by the group:

The distillation committee was charged with reviewing the actions of the group, seeking convergences, and reporting common ground. In addition, the committee incorporated the material from Session IV, "Toward a Strategy for a National Health Policy," into the report.

A great deal of common ground appeared as members reported on their denominational health policies. With respect to the 13 criteria developed by the APHA, all denominations either answered yes to each, with some explanations about individual faith processes, or were silent. There were no negative answers. Although there is much common ground, this comparison is a complicated process.

While most faith communities have a policy base that would encourage, or at least allow participation in, an advocacy campaign for a national health care system, that policy base would not automatically lead us to a consensus in favor of one national health care plan. Thus, we recommend that each faith group convene discussions to apply their policy base to the current or expected legislative options.

The distillation committee recommends two strategies: first, that we examine the recommenda-

tions for action that emerged from the conference and determine those which can be acted upon in the near future; and second, that we deal with one another with grace, acknowledging that all faith groups will move at different speeds.

Strategies Proposed:

1. Send to all national church bodies the completed "Denominational Health Policies" form with citations from their documents.
2. Add 14th point: role of the religious organizations as health care providers, with special attention to church-state concerns.
3. Add 15th point: role of religious groups in advocacy for public policy.
4. Develop communication process with each other and Congress on issues.
5. Identify and develop constituency in our faith groups for health care reform.
6. Expand and better define ideas of health promotion and disease prevention.
7. We need to define what we mean by "comprehensive benefits."
8. Create a process to involve the congregations and the health-related institutions and agencies of the faith groups in understanding health-related policy issues and involvement within development.
9. Examine the possibilities for coalitions between the faith groups and other organizations that can support the policies of the faith groups.
10. Each faith group must determine the priority of these health issues and provide the necessary resources to implement the group's policy.
11. Develop a process for demonstrating models of lifestyle change.
12. Participate with existing coalitions: IMPACT, Interfaith Action, Health Care Working Group, WISC NCC: Health and Welfare Working Group.
13. Develop constituencies with business, senior groups, etc.
14. Educate Congress on the role and mission of the non-profit provider.
15. Educate provider groups on the effects of various national proposals.

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New York, NY 10016
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Healthfinder

Toll-free Numbers for Health Information

This Healthfinder lists and describes toll-free numbers of organizations that provide health-related information. They do not diagnose or recommend treatment for any disease. Some numbers offer recorded information; others provide personalized counseling, referrals, and/or written materials. Unless otherwise stated, numbers can be reached within the continental United States and operate Monday through Friday.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

Public Health Service
AIDS Information Hotline
(800) 342-AIDS
(800) 342-SAID for information in Spanish

National AIDS Information Clearinghouse
(800) 458-5231

National Gay Lesbian Crisisline
(800) 221-7044
(212) 529-1604 in NY, AK, and HI

ALCOHOLISM

Al-Anon Family Group Headquarters
(800) 356-9996
(212) 245-3151 in NY and Canada

Alcoholism and Drug Addiction Treatment Center
(800) 382-4357

National Council on Alcoholism
(800) NCA-CALL

ALZHEIMER'S DISEASE

Alzheimer's Disease and Related Disorders Association
(800) 621-0379
(800) 572-6037 in IL
Brookdale Center on Aging
Alzheimer's Respite Line
(800) 648-COPE

CANCER

AMC Cancer Information
(800) 525-3777

Cancer Information Service (CIS)
(800) 4-CANCER
(808) 524-1234 in Oahu, HI (Neighborhood islands call collect)
(800) 638-6070 in AK

Y-Me Breast Cancer Support Group
(800) 221-2141
(312) 799-8228 in IL

CHEMICAL PRODUCTS

Chemical Referral Center
(800) CMA-8200 in continental U.S. and HI
(202) 887-1315 in DC and for collect calls from AK

National Pesticide Telecommunications Network
(800) 858-7378

CHILD ABUSE

National Child Abuse Hotline
(800) 422-4453

Parents Anonymous Hotline
(800) 421-0353
(800) 352-0386 in CA

CHILDREN

National Child Safety Council
Childwatch
(800) 222-1464

National Hotline for Missing Children
(800) 843-5678
(202) 644-9836 in DC

National Runaway Switchboard
(800) 621-4000

CYSTIC FIBROSIS

Cystic Fibrosis Foundation
(800) 344-4823
(301) 951-4422 in MD

DIABETES

American Diabetes Association
(800) ADA-DISC
(703) 549-1500 in VA and DC

Juvenile Diabetes Foundation
International Hotline
(800) 223-1138
(212) 889-7575 in NY

DOWN SYNDROME

National Down Syndrome Congress
(800) 232-6372
(312) 823-7550 in IL

National Down Syndrome Society
Hotline
(800) 221-4602
(212) 460-9330 in NY

DRINKING WATER SAFETY

Safe Drinking Water Hotline
(800) 426-4791
(202) 382-5533 in DC

DRUG ABUSE

Drug-Free Workplace Helpline
(800) 843-4971
(301) 443-6780 in MD

Just Say No Kids Club
(800) 258-2766
(415) 939-6666 in CA

National Cocaine Hotline
(800) COC-AINE

National Federation of Parents for
Drug-Free Youth
(800) 554-KIDS
(301) 585-5437

National Parents' Resource Institute for
Drug Education (PRIDE)
(800) 241-7946
(404) 658-2548 in GA

NIDA Helpline
(800) 662-HELP

Target Resource Center
(800) 366-6667

EATING DISORDERS

Anorexia Bulimia Treatment and
Education Center
(800) 33-ABTEC
(301) 332-9800 in MD

Bulimia Anorexia Self-Help
(800) 227-4785

FITNESS

Aerobics and Fitness Foundation
(800) BE FIT 86

GENERAL HEALTH

ODPHP National Health Information
Center
(800) 336-4797
(301) 565-4167 in MD

HANDICAPPING CONDITIONS (see also **HEARING AND SPEECH**)

The Epilepsy Foundation of America
(800) EFA-1000
(301) 459-1000 in MD

HEATH Resource Center
(800) 544-3284
(202) 939-9320 in DC

Job Accommodation Network
(800) 526-7234
(800) 526-4698 in WV

Library of Congress National Library
Services
for the Blind and Physically Handi-
capped
(800) 424-8567
(202) 287-5100 in DC

National Information System for Health
Related Services (NIS)
(800) 922-9234
(800) 922-1107 in SC

National Rehabilitation Information
Center
(800) 34-NARIC
(301) 588-9284 in MD

HEADACHE

National Headache Foundation
(800) 843-2256
(800) 523-8858 in IL

HEARING AND SPEECH

American Cleft Palate Association
(800) 24-CLEFT
(800) 23-CLEFT in PA

Dial a Hearing Test
(800) 222-EARS
(800) 345-EARS in PA

Grapevine
(800) 352-8888 Voice and TDD
(800) 346-8888 in CA, Voice and TDD

Hearing Helpline
(800) 424-8576;
(800) EAR-WELL
(703) 642-0580 in VA

National Association for Hearing and
Speech Action Line
(800) 638-8255
(301) 897-0039 in HI, AK, and MD call
collect

National Hearing Aid Helpline
(800) 521-5247
(313) 478-2610 in MI

HOSPICE CARE

Children's Hospice International
(800) 242-4453
(703) 684-0330 in VA

Hospice Education Institute Hos-
picelink
(800) 331-1620
(203) 767-1620 in CT

HOSPITAL CARE

Hill-Burton Hospital Free Care
(800) 638-0742
(800) 492-0359 in MD

Shriners Hospital Referral Line
(800) 237-5055
(800) 282-9161 in FL

HUMAN SERVICES

Project Share
(800) 537-3788
(301) 231-9539 in MD

HUNTINGTON'S DISEASE

Huntington's Disease Society of
America
(800) 345-4372
(212) 242-1968 in NY

IMPOTENCE

Recovery of Male Potency
(800) 835-7667
(313) 966-3219 in MI

INCOME TAX

Federal Internal Revenue Service for
TDD Users
(800) 428-4732 TDD
(800) 382-4059 in IN; TDD
(800) 424-1040 Voice

LEARNING DISORDERS (see also HANDICAPPING CONDITIONS)

The Orton Dyslexia Society
(800) ABCD-123
(301) 296-0232 in MD

LIVER DISEASES

American Liver Foundation
(800) 223-0179
(201) 857-2626 in NJ

LUNG DISEASES

Asthma Information Line
(800) 822-ASMA

Lung Line National Asthma Center
(800) 222-5864
(303) 355-LUNG in Denver

LUPUS

Lupus Foundation of America
(800) 558-0121
(202) 328-4550 in DC

Terri Gotthelf Lupus Research Institute
(800) 82-LUPUS
(203) 852-0120 in CT

MEDICARE/MEDICAID

DHHS Inspector General's Hotline
(800) 368-5779
(301) 597-0724 in MD

MENTAL HEALTH

American Mental Health Fund
(800) 433-5959
(800) 826-2336 in IL

National Foundation for Depressive
Illness
(800) 248-4344

MULTIPLE SCLEROSIS

National Multiple Sclerosis Society
(800) 624-8236

ORGAN DONATION (see also RETINITIS PIGMENTOSA)

The Living Bank
(800) 528-2971
(713) 528-2971 in TX

Organ Donor Hotline
(800) 24-DONOR

PARALYSIS AND SPINAL CORD INJURY (see also HANDICAPPING CONDITIONS)

American Paralysis Association
(800) 225-0292
(201) 379-2690 in NJ

APA Spinal Cord Injury Hotline
(800) 526-3456
(800) 638-1733 in MD

National Spinal Cord Injury Association
(800) 962-9629
(617) 935-2722 in MA

PARKINSON'S DISEASE

National Parkinson Foundation
(800) 327-4545
(800) 433-7022 in FL

Parkinson's Education Program
(800) 344-7872
(714) 640-0218 in CA

PLASTIC SURGERY

American Society of Plastic and
Reconstructive Surgeons
(800) 635-0635

PRACTITIONER REPORTING

Practitioner Reporting System
(800) 638-6725
(301) 881-0256 in MD

PREGNANCY

ASPO/Lamaze (American Society for
Psychoprophylaxis in Obstetrics)
(800) 368-4404
(703) 524-7802 in VA

Birth Control Information Line
(800) 468-3637

National Pregnancy Hotline
(800) 852-5683
(800) 831-5881 in CA

Pregnancy Counseling Services
(800) 368-3336
(804) 847-6828 in VA

RARE DISORDERS

American Leprosy Missions (Hansen's
Disease)
(800) 543-3131
(201) 794-8650 in NJ

Cooley's Anemia Foundation
(800) 221-3571
(212) 522-7222 in NY

Cornelia de Lange Syndrome Foundation

(800) 223-8355
(203) 693-0159 in CT

National Information Center for Orphan Drugs and Rare Diseases
(800) 336-4797
(301) 565-4167 in MD

National Lymphedema Network
(800) 541-3259

National Neurofibromatosis Foundation
(800) 323-7938
(212) 460-8980 in NY

National Organization for Rare Disorders
(800) 447-NORD
(203) 746-6518 in CT

National Tuberous Sclerosis Association
(800) 225-6872
(301) 459-9888 in MD

Tourette Syndrome Association
(800) 237-0717
(718) 224-2999 in NY

United Scleroderma Foundation
(800) 722-HOPE
(408) 728-2202 in CA

RETINITIS PIGMENTOSA

National Retinitis Pigmentosa Foundation
(800) 638-2300
(301) 225-9400 in MD

REYE'S SYNDROME

National Reye's Syndrome Foundation
(800) 233-7393
(800) 231-7393 in OH

SAFETY

(see also **CHEMICAL PRODUCTS**)

Consumer Product Safety Commission
(800) 638-CPSC
(800) 638-8270 TDD
(800) 492-8104 TDD in MD

National Highway Traffic Safety Administration
(800) 424-9393
(202) 366-0123 in DC

National Safety Council
(800) 621-7619 for placing orders for information on safety and accident prevention
(312) 527-4800 in IL

SICKLE CELL DISEASE

National Association for Sickle Cell Disease
(800) 421-8453
(213) 936-7205 in CA

SPINA BIFIDA

Spina Bifida Information and Referral
(800) 621-3141
(301) 770-7222 in MD

SUDDEN INFANT DEATH SYNDROME

American SIDS Institute
(800) 232-SIDS
(800) 847-7437 in GA

National SIDS Foundation
(800) 221-SIDS
(301) 459-3388 or 3389 in MD

SURGERY

Second Surgical Opinion Hotline
(800) 638-6833
(800) 492-6603 in MD

TRAUMA

American Trauma Society (ATS)
(800) 556-7890
(301) 925-8811 in MD

UROLOGICAL DISORDERS

American Kidney Fund
(800) 638-8299
(800) 492-8361 in MD

Peyronie's Society of America, Inc.
(800) 346-4875
(316) 283-2456 in KS

Simon Foundation
(800) 23-SIMON

VENEREAL DISEASES

VD Hotline (Operation Venus)
(800) 227-8922

VISION

American Council of the Blind
(800) 424-8666
(202) 393-3666 in DC

American Foundation for the Blind (AFB)
(800) 232-5463
(212) 620-2147

National Eye Care Project Helpline
(800) 222-EYES

WOMEN

Endometriosis Association
(800) 992-ENDO
(414) 962-8972 in WI

PMS Access
(800) 222-4767
(608) 833-4767 in WI

Women's Sports Foundation
(800) 227-3988
(212) 972-9170 in AK, HI, and CA