LIFE ABUNDANT:
VALUES, CHOICES AND HEALTH CARE
THE RESPONSIBILITY AND ROLE
OF THE PRESBYTERIAN CHURCH (U.S.A.)

A POLICY STATEMENT ADOPTED BY
THE 200TH GENERAL ASSEMBLY (1988)
PRESBYTERIAN CHURCH (U.S.A.)

THE OFFICE OF THE GENERAL ASSEMBLY
THE PRESBYTERIAN CHURCH (U.S.A.)
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December 1988

Dear Members of Sessions, Presbyteries, and Synods:

Health issues come closer to each of our lives than perhaps any other issue. Almost every Presbyterian has had some direct contact with issues of health, hospitalization, life and death. The 200th General Assembly (1988) has challenged the congregations, governing bodies, and agencies of the Presbyterian Church (U.S.A.) "to become vigorous and conscious promoters of health in all aspects in the life of the church, active advocates and agents of health in social order, and responsible stewards of both health and health resources."

This challenge came in the form of the report of a task force titled: *"Life Abundant: Values, Choices, and Health Care—The Responsibility and Role of the Presbyterian Church (U.S.A.)."*

A copy of this General Assembly Report and a study guide are enclosed.

Additional copies of this report and study guide are available from Presbyterian Distribution Service. If you would like additional information on program aides and study materials related to the Presbyterian Health Policy, please contact Associate for Human Services, Social Justice & Peacemaking Ministry Unit, Room 3201, 100 Witherspoon Street, Louisville, KY 40202-1396. Telephone: (502)-569-5787.

James E. Andrews

James Andrews
Stated Clerk

The 200th General Assembly (1988) took the following action on the report of the Task Force on Health Costs/Policies, "Life Abundant: Values, Choices, and Health Care—The Responsibility and Role of the Presbyterian Church (U.S.A.)":

1. Adopted the policy statement and recommendations and received the background commentary and volume of briefing essays for appropriate implementation and study throughout the church.

2. Directed the Stated Clerk of the General Assembly to reprint the policy statement and recommendations and transmit them to the sessions and middle governing bodies of the Presbyterian Church (U.S.A.), making additional copies available for sale to aid study and implementation efforts in the church.

3. Directed the Stated Clerk of the General Assembly to transmit the policy statement and recommendations to members of Congress, the President, and appropriate officials in the Department of Health and Human Services of the federal government, and to the governor and senior health official of each state, drawing attention to appropriate public policy dimensions and expressing the concern of the General Assembly for access to quality health care and preventive services for all within this nation.

4. Enthusiastically commended the members of the Task Force on Health Costs/Policies, the seven partner presbyteries (Boston, Northern New England, Pittsburgh, Southwest Florida, Minnesota Valleys, Eastern Oklahoma, San Gabriel), and the two seminaries (Louisville, McCormick) who engaged in the research, study, and experimental programs over the three-year period in which the report was prepared.

The report was sponsored by the Advisory Council on Church and Society, along with the Board of Pensions, the Program Agency, and the Division of International Mission.

INTRODUCTION

God's intention of health—*shalom*—for the earth and its people, and Jesus' promise of abundant life—health, healing and restoration to wholeness in body, mind and spirit—are central dimensions of the faith we profess and the vocation to which we are called as Christians. It leads the list in the order of service through which we participate in God's activity through the church's life for others by:

> healing and reconciling and binding up wounds,
> ministering to the poor and sick, the lonely, and the powerless,
> engaging in the struggle to free people from sin, fear, oppression, hunger and injustice,
> giving of itself and its substance to those who suffer,
> sharing with Christ in the establishing of his just, peaceable, and loving rule in the world (Book of Order, G-3.0300).

The health of a society is measured in a very important way by the quality of its concern and care for the health of its people. How provision is made for children in the dawn of life, the elderly in the twilight of life, and the sick, needy, and those with handicapping conditions in the shadow of life are clear indices of the moral character and commitment of a nation. At the minimum, credible commitment to health includes a safe environment; adequate food, shelter, clothing, and employment or income; and convenient access to quality, affordable preventive and curative health services.

We are painfully aware that this vision of health for all is not a reality in our communities, in our nation, or in the world we are called to serve in Christ's name. The people of the United States are confronted by crisis in regard to health.

The Health Crisis We Face Has Many Dimensions

It Is a Crisis of Health Status:

- We are killing ourselves needlessly with substance abuse, highway accidents, violence, and suicide; our health is undermined and continually threatened by pollution of our environment by chemical toxins, nuclear and industrial waste, and ocean dumping of garbage.

- Longevity increases, yet the disparities in life expectancy by race and income remain very large.

- Some areas of our country, particularly urban locations, have infant mortality rates no better than third world nations.

- The number of AIDS cases is rising exponentially. The World Health Organization indicated a worldwide increase of fifty-six percent

Acquired Immune Deficiency Syndrome. The suppression of the human immune systems and resultant inability to ward off opportunistic infections lead almost invariably to catastrophic illness and death. More than half of all cases diagnosed since 1979 have died. Those at risk for this disease range across the social spectrum: heterosexual men, women, children, hemophiliacs, gay males, intravenous drug abusers, and those who may have become infected due to a blood transfusion containing the AIDS virus. It is spread principally through contaminated needles and sexual contact, either heterosexual or homosexual. The AIDS crisis not only threatens to overwhelm the medical care system, it also focuses the need for massive concentration on realistic educational and preventive programs as a vital dimension of a society's health care system.

Health status is undermined and the health care system is heavily impacted by preventable conditions associated with lifestyle practices. Cigarette smoking is one of the major preventable causes of death and disability. Its causative linkage to cancers, heart and circulatory diseases, and lost time on the job is well documented. The most reliable research in the nation estimates that it is the principal avoidable cause of death in our society, with mortality ranging between 270,000 to 485,000 deaths per year. The U.S. Public Health Service estimates smoking to be related to about one sixth of deaths from all causes. Additionally, alcohol use and abuse is related to chronic liver disease as well as many accidents, suicides, and homicides. An estimated 150,000 Americans each year die from alcohol-related causes.

Good nutrition, regular physical activity, and effective stress control are all important ways to prevent disease and promote health. They require personal discipline as well as an environment and work place that encourage and reinforce them. Careful and disciplined attention to lifestyle is a major contributor to health and well being.

The infant mortality rate in the United States, one of the most important measures of a nation's health, is among the highest of the industrialized countries, and improvement has slowed during the 1980s. In 1985, over ten babies of each 1000 died before their first birthday, putting the U.S. in seventeenth place. If the U.S. matched the Japanese rate, 19,000 of the more than 40,000 who die each year would live. It is widely understood that comprehensive prenatal care not only results in healthier mothers and babies and diminishes prenatal deaths but is also cost-effective, reducing the need for expensive hospitalization of sick babies. In spite of that, only twenty-six states have expanded Medicaid programs to cover all poor pregnant women, as Congress authorized in 1986. An investment in comprehensive maternity care would result in significant savings of dollars now expended for neonatal intensive care "graduation" of low birthweight babies, an average extra

cost of possibly $30,000 for each such baby. Congress is now considering legislation to make Medicaid eligibility mandatory for pregnant women and infants below the federal poverty level.

The environment in which we live and work significantly affects our health. Healthy home and work environments make important contributions to health. Acid rain, toxic agents, occupational health, injury control, dental health, and infectious diseases, to name a few, demonstrate the impact of environment on health. Economically deprived persons are less likely to engage in accident prevention, to seek action against poor or dangerous working conditions, or to have preventive health or dental work done. Clearly, the church's concern for the poor must address these issues for the most vulnerable of our population in a special way as it seeks a healthy ecological environment for all. We have witnessed some of the direct health effects of the use of nuclear power for arms and energy, though we do not yet fully comprehend the psychological effect of living in the shadow of nuclear annihilation. In addition, the nuclear industry has saddled the nation with the disposal of nuclear wastes, the detrimental health dimensions of which may be decades in being satisfactorily resolved. These we have passed on to generations yet unborn. It is trite but true that the threat of nuclear war is the leading health risk for our nation and world.

The Church's Perspective and Task

Health has many dimensions: anatomical, physical, spiritual, and mental. An effective address to human health needs requires a comprehensive, whole-person approach to health and health services. *Pneuma, psyche,* and *soma,* spirit-mind-body, are interconnected in complex ways. To ignore the spiritual or mental dimensions of a person while addressing physical injury or illness is as scientifically irresponsible as it is religiously irresponsible to treat spiritual needs and ignore the physical and mental dimensions of the human body.

The understanding and definition of health and health care should be largely derived from this holistic perspective rather than a purely medical one. Health, it can be argued, is the ability to respond effectively to a wide variety of challenges to live up to potential and promise. Illness can be understood as the inability to respond with adaptability to life's challenges or assaults on well-being and balance. Our practice has been to seek solutions in the "medical model," which contains both positive and negative dimensions. The tendency to treat symptoms of ill health and ignore fundamental causes such as lifestyle, stress, and environment, thus raises expectations for "cure" to unrealistic levels. In contrast, certain problems such as chemical dependency, once

important issues. The work and experience of the Health Costs/Policies Task Force with the Presbytery Partners demonstrates the desire, the competence, and the readiness of our connectional system to address these significant health issues.

Because of its unique position and expertise in the church, the Board of Pensions should seriously explore the cost-benefit parameters of becoming a manager of health and medical resources. A purely "insurance" approach, reimbursing various medical systems for the delivery of services aimed primarily at cure or custodial care, is not, in the estimation of the Task Force on Health Costs/Policies, the most prudent stewardship of the benefits resources of the Presbyterian Church (U.S.A.). Research and judgment strongly indicate the wisdom of engaging various health systems in promoting a preventive model of health promotion and services and containing the costs of quality curative care when it is needed. Presbyteries with whom the task force worked have indicated a willingness to explore the potential of this approach with the board, and the same interest was expressed in the Montreat Consultation of Health Professionals and Pastors. The new data resources now utilized by the board make possible the necessary analyses related to costs and benefits of such a health management approach, which is consistent with general trends across the nation in both private and public health systems.

Work environment is also related to health and health costs in the church as well as in the society. Thought and planning should be given to reducing stress factors and promoting health on the work site. The Presbyterian Church (U.S.A.) should demonstrate exemplary attention to the well-being of those who labor in our own vineyards and be a clear and compelling example for others. Current data and experience provide responsible demonstration of the value of work-site health promotion.

The Health Risk Appraisal (HRA), developed by the Centers for Disease Control and others, provides an important health education tool. Currently cosponsored by the Carter Center at Emory University and twenty major health organizations and a network of health departments across the nation, this resource has been tested by the Task Force on Health Costs/Policies in a number of presbyteries, at the 1987 General Assembly, and, in a revised and updated form, at the 200th General Assembly (1988). This significant educational and health promotion resource should be utilized by the Board of Pensions and Church Vocations Unit to serve as both a health data base and a resource for health promotion in the denomination in cooperation with the middle governing bodies.

The HRA itself stimulates personal responsibility for health and modification of potentially risky lifestyle patterns. Long-range, preventable health risks can be identified and preventive and intervention strategies developed to reduce them. Amelioration of long-range health risks reduces long-range costs for medical expenditures. Prevention is far more cost-effective than curative efforts.

The contemporary challenge to the Presbyterian Church in regard to health, then, is to affirm and serve the values of justice, compassion, and service at the heart of our Reformed biblical faith. The role of the church is to be a center of responsibility and motivation for the promotion of health, an advocate for compassionate justice in health in the political economy, and a model which leads by example. Our theological and biblical roots provide ample motivation and direction for such being and advocacy.

Biblical and Theological Reflections

Health and healing were central in the work of Jesus and the early church. The Gospel of Mark early and amply demonstrates Jesus' powerful concern for the total well-being of those he encountered. Lepers and "mad men," outcasts and Samaritans, women and children were restored to health and effective life. The same Greek word, *sodzo*, is translated as "to save," "to heal," and "to make whole." Jesus' effect on those he touched has been described by Lutheran theologian, Krister Stendahl, as a "pushing back the frontier of all destructive and distorting forces," a "mending of creation." The calling of the twelve disciples (Mark 6:7ff), the expectations of healing powers from Peter and John (Acts 3:1ff), Paul's list of gifts (I Corinthians 12), and the letter of James (5:13ff)—all show the central role which healing held in the early church.

In both pastoral and prophetic action, the church is called to be an instrument of God's creative, redemptive activity intended to bring health and wholeness to all. As a prophetic community, the church is required by God to press for a just society where all have access to life-giving resources and, when ill, are provided the care required to return, as much as is possible, to their homes, work, and communities. A focus on health, cleanliness, and well-being is evident in both the Holiness Code of Leviticus and Jesus' miracles of restoration to health and wholeness. The healing miracles often included an act of washing. Thus, baptism symbolizes not only the presence of God's spirit but cleanliness and purity; a ritual washing away and restoration in readiness for readmission to the community of faith and family. It is a sign of God's mercy, compassion, and inbreaking spirit, a model of abundant life made possible

through the generous grace and mercy of the Creator of life—a promise of health to be realized in the midst of a healthy, caring, and healing community.

Jesus, who came in the flesh giving significance to flesh, announced: ". . . I have come that you might have life and that you might have it abundantly" (John 10:10b). It is clear that his understanding of God's purpose is to provide completeness for those whose lives are incomplete. So God's creative and saving activity come together in Jesus Christ. In Jesus, life is seen as complete, whole. Brokenness may exist. However, the healing of that which is broken, the restoration to life in fullness, is clearly a part of what it means "to be in Christ."

The miracles of Jesus were not only signs of the rule of God in human affairs but also a demonstration of God's concern for the wholeness in persons and the communities in which they live. Christ's insistent concern grows out of the Old Testament concept of *shalom*, which means fullness and a healthy balance in body, mind, spirit, and community. His promise is demonstrated in both word and deed. There is overwhelming scriptural evidence that God in Christ was-is concerned with the saving of life in time and in flesh, as well as life beyond time and flesh. The biblical emphasis on creation and covenant, the healing ministries of Jesus and the activity of the early church, continue to call us to seek health and to care for the sick. We are called to be concerned about the health of others and to be certain that the society provides in the best way possible access to resources which provide and promote health and restoration to wholeness.

Jesus was nourished on the Jewish Scriptures which are centered on the covenant relationship between Israel and Yahweh. That covenant had two parts: "I will be your God and you shall be my people" (Exodus 19:4-5). God, in unmerited goodness, *hesed*, saved people from bondage and chose them to be God's particular people. Through a faithful love, expressed in the quality of their lives, they were to keep their part of the covenant. The responsibility of a faithful covenant people is the command: ". . . You shall love your neighbor as yourself" (Leviticus 19:18b). Jesus brought this passage together with the *Shema* (Deuteronomy 6:4-5) in the two great commandments (Matthew 22:37-40). In both the old and new covenants, concern for the well-being, protection and enhancement of the lives of other persons are ways in which one serves God. Of the promised Messiah, ". . . he will neither waver, nor be crushed until true justice is established on earth" (Isaiah 42:4). To Israel, "God has told you what is good; what is it Yahweh asks? . . . to do justly, to love mercy, and to walk humbly with your God" (Micah 6:8).

A strong concern for justice permeates our tradition. Justice and love take human and historical form in caring for the sick, the hungry, the imprisoned. As Matthew 25 states, this imperative partnership with God is a definitive mark of the community of faith. "Inasmuch as you did it to the least of these . . . you did it to me." God's justice liberates from captivity, from bondage—from all kinds of crippling restraints upon wholeness. God's love frees humankind to use their gifts creatively. Charles Swezey, writing in the *Journal for Preachers* in Lent 1986, notes: "It is not possible to serve God without also serving those proximate human causes—political, economic and cultural—over which God is sovereign." Thus, it is natural to look to the instrumentality of public government in addressing public need.

In the *Institutes* of John Calvin, the description of the tasks and burdens of civil government is instructive:

> . . . to think of doing away (with civil government) is outrageous barbarity. Its function among men is no less than that of bread, water, sun and air; indeed, its place of honor is far more excellent. . . . [Here he lists the duties of government to assure that citizens breathe, eat, drink and are kept warm, providing for living together, but also lists the protection of religion, the keeping of public peace, security of property and business intercourse, that "humanity be maintained among men"]

Calvin is principally concerned for secure and ordered liberty as opposed to tyranny and anarchy. He looks to both Tables of the Law of Moses.

> As far as the Second Table is concerned, Jeremiah admonishes kings to "do justice and righteousness," to "deliver him who has been oppressed by force from the hand of the oppressor," not to "grieve or wrong the alien, the widow, and the fatherless" or "shed innocent blood" (Jeremiah 22:3 cf Vg.). The exhortation which we read in Psalm 82 has the same purpose: that they should "give justice to the poor and needy, rescue the destitute and needy, and deliver the poor and needy from the hand of the oppressor." (Psalm 82:3-4).
>
> . . . Justice, indeed, is to receive into safekeeping, to embrace, to protect, vindicate, and free. . . .

In the Reformed tradition, therefore, we have a strong inheritance in teaching and example of response to God by service in the common life. The civil state is to serve the cause of justice and Presbyterians, we believe, must both assist and prod the state to exercise its calling. The promotion of health and the relief of suffering are fundamental aspects then of the calling of the state as well as of the church.

Our biblical faith, however, does not hold that human life will not contain suffering or that pain and illness will not come. We know that these and death finally overtake us all. There are limits on life's duration, on our ability to know; we experience emotional pain and physical suffering or trauma. And there are limits on our ability to bring health, to heal sickness, stop suffering, or maintain life. We acknowledge both

the possibilities and limits to our health and our life. In spite of modern technology and our necessary attempts to cope with suffering and illness, a point arrives after which continued intervention represents not so much a commitment to health as a refusal to acknowledge the finiteness of human existence. Both life and death are set within the structure of a good creation and a loving God. When every reasonable attempt has been made to rescue, to heal, to restore to usefulness and meaning, we must then look differently at the responsibilities to "do no harm" or protect in the midst of enormously stressful situations. When life-support systems are removed, after reasonable and responsible attempts to save have run their course, allowing death to complete its course, we must not confuse that acknowledgment of death with the taking of life. We must be clear about the difference between killing and allowing to die. In our faith understanding, when the capacity for human relationship is irretrievably lost, death has occurred regardless of what biological function can be sustained. In medical terms, that means when brain function ceases and when a flat electroencephalogram occurs, cardiovascular activity ceases or other tests of responsiveness have been conducted and found to be negative. It is then that we recognize that death is in the midst of life, even as we celebrate the life that overpowers death.

A strong theme coursing through the Scripture is one of an intelligent, committed and compassionate stewardship of life as we live, move, and do what needs to be done in history. Both Jewish and Christian Scriptures reflect the covenant partnership of humankind with God in the stewardship of creation and community. The earth is the Lord's and the communities in it. Human life is made in God's image and given value, dignity, and integrity in its full and free expression in healthful community. In the person and work of Christ, the life of God is given that all may have these promises of life. God is served by serving others with our own gifts. Such use of life and its gifts is not easy. The difficulty of the wealthy and the privileged in comprehending the suffering of others is told often in Scripture. The rich man's ability to "enter the kingdom of heaven" is compared to the impossibility of a camel going through the eye of a needle (Matthew 19:24). Those, today, with rich health resources always available often do not comprehend the condition of those without access to even basic care. Stewardship arises from the sense of compassion for another, from the ability to suffer with one's neighbor.

The responsibility for stewardship both of one's own health and the health of the community comes through clearly in Hebrew tradition. Our own stewardship is not only fulfilled through the giving of time, money, and talent. It involves a stewardship as well of our personal health

and the health of our corporate lives and institutions. We have a religious duty to give attention to the health and wholeness of societal institutions where we have the ability to influence them.

God is sovereign over all of life. God in human life is liberating, releasing men and women from all that diminishes or limits life whether this be political, social, environmental injustices, racial prejudice, sexual bias, or absence of health care. With Jesus, the church begins where there is need, seeking to express and work out this liberating faith in both word and action. The Presbyterian Church (U.S.A.) must be, therefore, both a pastoral and prophetic community, exhibiting health in its own life and seeking it for others. We are to be good stewards of creation, including our physical bodies, true to the gospel which liberates from bondage. We must insure, in the name of God's justice and the grace of Christ, that this nation provides for all a full access to health care and communities which promote health and healing.

Commitment and Challenge

Health and healing are central dimensions of the faith we profess. We must reclaim the power and promise of God's gifts of wholeness for our life and work in fresh ways in the face of the current crisis in health status and health care in our nation. Our understanding of ourselves and God is mirrored by the way we do or do not seek health and wholeness for ourselves, our communities, and the world. Our values as a community of faith and a civil community are reflected in the choices we make about how the health of our society, and its people will be protected and maintained. The challenge is evident and urgent: As individuals, too many take neither care nor responsibility for their own health; as a society, we give far too little attention to prevention and public health and tolerate a system of curative medicine that uses vast resources but results in severely unjust access to and availability of care.

Because it is the body of Christ, the church is called to be a community of health and healing at every level and at every location, seeking to manifest, sustain, and protect health in its fullness in its own life and within the wider human community. The church refuses to spiritualize or disembody the gospel, or to isolate its effect to "sacred" space. The church models health in its own life, insuring equity in personnel policies for all employees, creating a wholesome spiritual, liturgical, programmatic, and relational environment for people of all kinds and conditions. The church proclaims and serves the purposes of the sovereign health-giving God, resisting and reforming all that makes for injustice and thwarts healthy life within a just and healthy social

and natural environment. The church joins with others in direct service of the health and justice needs of persons around the world, particularly the poor and oppressed, and vigorously advocates and supports the public policies and programs that mark a just and healthy common order.

The recommendations that follow are intended to give effect to the theological affirmations and biblical values voiced in this statement and to provide guidance and direction for their immediate and ongoing implementation in a coordinated manner throughout the church. They call Presbyterians to a new exercise of concern, compassion, and justice in their own lives, in the church, and in the society toward health and wholeness for all. In response to the gracious God whose gift and purpose is wholeness, let us be about the task.

RECOMMENDATIONS

I. Basic Affirmations

Desiring to give effective expression to the basic values of compassion, caring love, community wholeness and well-being, and justice that we hold to be fundamental in understanding and addressing the health issues and crises that confront the church and the nation, the 200th General Assembly (1988) of the Presbyterian Church (U.S.A.) therefore:

A. Adopts the following Statement of Affirmations to guide the understanding and response of the agencies, governing bodies, and people of the church.

A Statement of Affirmations

The Fundamental Importance of Health. Good health—physical, mental, and spiritual—is both a God-given gift and a social good of special moral importance; one that derives its importance from our biblical and theological heritage and from its effect on the opportunities available to members of society. Good health is a basic need and an essential purpose of human and societal development.

Health Has Many Determinants. Health is determined by what we are born with, how we are nurtured, living conditions, income, education, how we lead our lives, the natural and social environment, access to medical care, our spiritual and psychological state, and our relationships in the communities where we live.

Personal Responsibility for Health. Each person has a moral

obligation—a private and public duty—to value and care for his or her own health and the health of the community. We are stewards of God's creation. For most of us, there is ample room to adopt more healthful lifestyles.

Societal Responsibility for Health. Society and its constituent public, private, and voluntary organizations have a duty—a moral obligation—to promote a healthful environment and to assure the availability of health-giving resources to all people. Free markets alone cannot provide for the adequate supply and equitable distribution of these resources. Society's institutions must always strive for the best achievable standards and the most effective performance of the health care system.

Preventive Care. The indispensable foundation on which both individual and societal responsibility for health rests is a consistent major focus on health promotion and maintenance and on preventive care services, such as pre-natal care, disease control, early detection and diagnosis, mental health services, sex education, and suicide and substance-abuse counseling.

Safeguards Against Unhealthy Working and Living Environments. A community's healthfulness is seriously influenced by the quality of the natural environment and by the interdependent flows of food and materials, energy, and waste products between human beings and nature. Healthy working and living environments are essential to individual and collective health. Clean air, pure water, effective sanitation, nutritious diet, adequate housing, and a safe and nontoxic workplace and living space are all essential to health.

Equal Access to Appropriate and Necessary Care. Every person must have affordable, quality health services. Access should not be limited by income, ethnicity, or geography. It is the proper function of all groups of society including government in their concern for justice to ensure equal access to health services.

Responsible Limits. The worship of physical perfection, no less than of worldly wealth, is idolatry. Mortality is an inevitable part of our creation and is the constant backdrop to our efforts to postpone death and overcome disease. A society is justified in placing limits beyond basics on its health care expenditures, balancing them against other needs such as housing, education, employment, and the elimination of poverty. No principle of justice entitles a patient to every conceivable form of beneficial treatment.

While concerns for the costs of health care are appropriate, these concerns must continually be balanced against the objectives of access to adequate, quality care for all. The sacrifice of access and quality at the

shrine of cost containment is too high a price to pay and should not be tolerated.

Sustainable Resource Supplies. Because good health is a social good of special moral importance, extra care must be taken to preserve and sustain essential sources of strength in the network of health-giving resources, professions, and institutions. These resources include among others: health occupation education and training, biomedical research, and inner city and rural hospitals. Society needs to devise new ways to sustain the development of necessary resources and to assure that these resources are used effectively to achieve our full healthful potential.

Health care systems and medical care delivery require good management and stewardship practices. As disciples and stewards, we are called upon to use our technological and human care skills to provide health for all the peoples of this nation and to do our share in the remainder of the world. Health, healing, and good medical care are a measure of our level of civilization as a nation. For the church, these concerns are absolutely fundamental to our mission. They are a measure of our faithfulness to the central mandate of the gospel: enabling the divine Word to dwell among us, expressing a faith that makes us whole.

Reform for the Sake of Justice. The church's concern for justice, broadly shared, compels us to encourage new financing and delivery systems that better meet the needs of all people. Market strategies that serve only those able to pay are not acceptable. Health ultimately is the product of justice; and justice must be the objective of all attempts to reform the health care system in the United States. The current maldistribution of health services must and can be rectified.

B. Reaffirms the continuing relevance and authority of the following policy statements on health adopted by previous General Assemblies and urges attention to their principles and recommendations along with the statement on Values, Choices, and Health Care of the 200th General Assembly (1988):

-The Relation of Christian Faith to Health—172nd UPCUSA General Assembly (1960);

-Toward a National Policy for the Organization and Delivery of Health Services—183rd UPCUSA General Assembly (1971);

-Health Care: Perspectives on the Church's Responsibility—116th PCUS General Assembly (1976);

-The Provision of Health Care: Obedience to Divine Purpose—195th PC(USA) General Assembly (1983).

C. Urges the agencies of the General Assembly and the intermediate governing bodies to give particular attention to three recent reports of

Presbyterian agencies as planning for health ministries continues in the reunited church:

-Health Ministries and the Church—Program Agency, UPCUSA, 1978;

-New Directions in Health Ministries—Division of International Mission and Medical Benevolence Foundation, PCUS, 1983.

-Report of the Health Ministries Evaluation Team—Program Agency, 1986.

II. Personal Responsibility

Believing that each of us has been created and named by God and set in community, and that as followers of Christ we should accept responsibility for the stewardship of our own health and for the health of all, the 200th General Assembly (1988), therefore:

A. Urges each individual Presbyterian to examine his or her lifestyle and make modifications and choices in daily living which decrease the known risks of stress, illness, and premature death (such as reasonable work schedule, moderate or no use of alcohol, no tobacco, proper nutrition, regular exercise, use of seat belts, and attention to spiritual development).

B. Calls upon Presbyterians who may require the services of the medical care system to be questioning and prudent users of resources, accepting responsibility to explore with health care providers the need for and cost and benefit of proposed tests and procedures and their impact on health.

C. Encourages Presbyterians to claim responsibility for their choice to accept or refuse medical treatment, affirming the right to direct one's physician to withhold medical treatment.

D. Encourages every Presbyterian to seek ways to minister to and empower others within the congregation to attain better health and wholeness; and particularly encourages Presbyterian health professionals to explore ways to assist the congregation and its members to take informed responsibility for health, to develop programs of health promotion and prevention, and to become informed consumers of health services.

E. Calls upon all Presbyterians, as responsible citizens, to work toward elimination of environmental health risks and the enactment of public policies which guarantee full and equitable participation of all in services that promote health and provide adequate medical care.

F. Urges individual Presbyterians to pray regularly for health and wholeness embodied in the shalom of a world free from injustice, greed and the threat of nuclear annihilation.

III. Corporate Church Responsibility

Believing that concern for health and healing should be central dimensions of the life and witness of the church and affirming the unique role the church should play in the health of society and in societies seeking health, the 200th General Assembly (1988) challenges the congregations, governing bodies, and agencies of the Presbyterian Church (U.S.A.) to become vigorous and conscious promoters of health in all its aspects in the life of the church, active advocates and agents of health in social order, and responsible stewards of both health and health resources; and to those ends:

A. Urges Sessions and Congregations to:

1. Claim their role as communities of health and healing by:

a. Establishing appropriate structures and processes to plan and implement an ongoing and coordinated approach to health in the life, program, worship, and witness of the congregation.

b. Providing appropriate health promotion programs, special liturgies, liturgical resources, and faith and health exploration groups;

c. Encouraging members to become faithful stewards of their own health and, when necessary, lovingly confront them with their failure to do so;

d. Employing health professionals as agents of congregational mission, such as parish nurses or ministers of congregational health;

e. Establishing and nurturing organized programs of peer support which assist persons committed to reducing health risks (such as smoking cessation classes, nutrition and fitness programs, spiritual growth groups, and communal meals);

f. Establishing and nurturing organized programs of counseling and support for families and individuals facing hospitalization or long-term institutional care or coping with serious mental illness and other long-term disabling conditions;

g. Caring for the dying and their families through the establishment of hospices and other congregational ministries of counseling and support.

2. Utilize confidential health education and assessment tools, such as a Health Risk Assessment, to inform members of their own health

risks, to encourage members to lower risks and consequent health care costs, and to assist sessions and diaconates in developing congregational programming and ministries to the community.

3. Educate all members about the responsibility of individual Christians and of church bodies in health promotion and health care, with particular attention to:

a. Identification and reduction of health risks as an act of Christian stewardship;

b. Ethical dilemmas facing families and professionals in modern medical care;

c. The variety of health delivery systems in which Christians participate as providers and consumers; and

d. Prudent use of the health care system, including limitations of health care costs.

4. Affirm the work of health professionals as a part of the mission and witness of the congregation by:

a. Encouraging congregational members who are health professionals to understand their professions as Christian vocations and to structure their practices and inter-professional relationships as an expression of Christian discipleship;

b. Providing opportunities for individual health professionals to use their expertise and share their gifts with the congregation and through congregational programs and mission projects;

c. Supporting and encouraging health professionals in career, term or supplementary practice in the public health sector, church mission programs, and other voluntary, nonprofit health delivery programs serving in areas and among people of great need;

d. Supporting personal, institutional, and public policy efforts to decrease the gaps in income, respect, freedom to practice, and opportunities for service between physicians and other health professionals.

5. Evaluate congregational structures, policies and practices for their impact on the physical, spiritual, and emotional health of individual members and employees, including the relationship of these factors to stress and addictive lifestyles.

6. Establish clearly defined personnel policies which include employee assistance programs and health and pensions benefits through the Presbyterian Pension Plan or at a level commensurate with it, for all regular full-time and part-time employees.

7. Focus particular attention on the medical, social, pastoral, and spiritual challenges presented by epidemic and (or) severely disabling illnesses, such as AIDS, Alzheimer's, serious or chronic mental illness, etc.

8. Organize for effective advocacy and participation in public policy formation and implementation efforts which affect the health of surrounding communities, such as the establishment of smoke-free environments, the regulation of advertising of health-threatening substances, access to health care for poor persons, Medicaid standards, sex education programs, etc., and in national legislative proposals for improvement and reform of the health promotion and health care efforts of the United States.

B. Urges Middle Governing Bodies to:

1. Establish health ministry coordinating groups to support and encourage congregations as they pursue the recommendations above, to develop and implement a coordinated approach to the governing body's ministry and mission in health and to provide linkage with the health ministries and coordinating groups of the other governing bodies and to the Health Ministries Coordinating Group at General Assembly Council level.

2. Utilize confidential health education and assessment tools (e.g., Health Risk Assessments) to encourage lower health risk behaviors, develop health promotion programs, and reduce medical expenses.

3. Cooperate with the Board of Pensions and Church Vocations Ministry Unit in any efforts to gather data on the health status and health risk assessment of church employees covered by the Presbyterian Pension Plan and in the implementation of any programs of education, health promotion, or lifestyle modification that may result in the attempt to improve the health of church employees and reduce health care costs for the church.

4. Evaluate governing body structures, policies, and practices for their impact on the physical, spiritual, and emotional health of participants and employees, including the relationship of these practices to stress and addictive lifestyles.

5. Urge units and committees which sponsor health education events and offer health assessment instruments to share learnings and findings with others.

6. Sponsor educational and training events and seminars on health issues and programs in mission rallies and leadership schools and, particularly, plan and conduct consultations involving a variety of health professionals and their pastors, using the model developed by the Task Force on Health Costs/Policies.

7. Participate, in collaboration with other governing bodies and ecumenical agencies, in the prophetic witness and action of the church, seeking the reduction of environmental health risks, increased attention to health promotion and prevention programs, guaranteed access

of the poor and dispossessed to quality health care, and legislation that guarantees a national health policy and health care system compatible with the values and principles adopted by the General Assembly.

8. Establish personnel policies which provide equitable benefits, including employee assistance programs and health and pension benefits for all regular full-time and part-time employees, through the Presbyterian Pension Plan or commensurate with its provisions.

C. Recognizing that a comprehensive approach to health in the life and mission of the Presbyterian Church (U.S.A.) will involve the efforts of many of the units and committees of the General Assembly, as well as the commitment of congregations and middle governing bodies, the 200th General Assembly (1988):

1. Urges the Units on Church Vocations, Education and Congregational Nurture, Global Mission, Social Justice and Peacemaking, and Theology and Worship to develop educational and programmatic resources to assist the people, congregations, and middle governing bodies of the Presbyterian Church (U.S.A.) to explore the issues and undertake the mission responsibilities outlined in this report. Particular attention should be given to congregations as centers of health and wellness, to spiritual development and health, to the integration of health and healing into liturgy and worship, to responsibility for employees, and to participation in the shaping of local and national health policies and institutions to insure access by all to a healthy environment and quality health care within affordable social costs.

2. Requests the Social Justice and Peacemaking Ministry Unit to consider developing living will and other model directives to physicians concerning the right to withhold medical treatment.

3. Requests the Social Justice and Peacemaking Unit through its Washington Office to advocate for public policies based on the principles adopted in this report and the policies adopted by the 1971 and 1976 General Assemblies, and to consider including an emphasis on health and wholeness themes and on health ministries in the Presbyterian Peacemaking Program. This might include not only involvement in health promotion and health care mission at home and abroad as a means of shalom but also a recognition that the threat of nuclear war is the ultimate global public health problem, diverting resources that could bring a fuller life to people and polluting the environment with dangerous radioactive products.

4. Urges the Committee on Social Witness Policy, in cooperation with the Social Justice and Peacemaking Unit and its Washington Office, to monitor studies and proposed policies and legislation concerning

the health status and health care needs of the nation and prepare recommendations for additional policy response as needed.

5. Requests the Church Vocations Unit to develop models and materials for worksite health promotion, and health risk intervention programs for church employees in the agencies, governing bodies, and institutions of the Presbyterian Church (U.S.A.), working in cooperation with other units and drawing on information concerning health care utilization and health risk factors supplied by the Board of Pensions.

6. Requests the Board of Pensions to:

a. Study and develop appropriate policies and procedures, in consultation with pilot presbyteries, regarding the use of managed health care delivery systems (e.g., Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and other prevention-oriented prepaid plans) for the Benefits Plan members who wish to participate in such alternatives. The results of the study with any recommendations for appropriate changes should be reported to the 203rd General Assembly (1991).

b. Analyze and report, on an annual basis, using the statistical capabilities of the board, the top ten health care utilization cost areas for Plan members. The report is to be addressed to the Church Vocations Unit and the Health Ministries Coordinating Group for the development of educational and health promotion programs.

c. Evaluate the use and feasibility of various Health Risk Appraisals and implement, if appropriate, the use of HRA with pension plan members to gather data on risk factors that effect health and illness, which could be used to develop educational and health promotion programs as noted above, in consultation and with the cooperation of presbyteries.

d. Continue to provide, in consultation with the Church Vocations Unit, a Retirement Planning Program which includes, but is not limited to, housing, health care, health promotion, entitlement programs, and retirement financial planning.

7. Urges the Global Mission Unit to assist the Presbyterian Church (U.S.A.) to recognize and respond to the interconnections between health status and health issues in the rest of the world and in the United States, and to continue and expand efforts to link the people, congregations, and governing bodies of the church in the health and healing mission of the gospel around the world, both through financial support and through direct involvement.

8. Urges the Committee on Theological Education to explore with the theological schools the possibility of establishing one or more

"seminary- or university-based Center(s) for Religion and Health." These would be centers of study and research, arenas for dialogue between theologians and health practitioners around ethical issues of medical research, technology, and practice, and locations of events, seminars, continuing education, and encounter for the people and pastors of the church and community.

9. Encourages the colleges and seminaries related to the Presbyterian Church (U.S.A.) to engage in worksite health promotion, sponsor student research and reflection on health issues and health ministries, and develop field education opportunities in health care settings, involve the health professionals in the church in college and seminary programs, and emphasize the Christian understanding of health as wholeness and the church's call to personal and social responsibility for health in the life and curriculum of the school.

10. Requests the Committees on Theological Education and Higher Education to explore with the seminaries and colleges respectively means by which the institutions may communicate and interact with each other on a continuing basis in considering the issues above and others related to health and healing.

11. Requests the Committee on Mission Responsibility Through Investment (MRTI) of the Social Justice and Peacemaking Ministry Unit to research the Presbyterian Church (U.S.A.)'s investments in for-profit health care corporations to ascertain their policies and practices in relationship to equal access to health care services for all regardless of their ability to pay and to take appropriate action to promote General Assembly policy with these corporations, based on its findings.

12. Instructs the Stated Clerk of the General Assembly to insure implementation of the 199th General Assembly (1987) Policy Statement on the Use of Tobacco in the planning for meetings of the General Assembly. This policy prohibits the use of tobacco products in the assembly hall, committee rooms, and eating place and limits the use of tobacco to designated areas.

13. Instructs the Office of the General Assembly, the General Assembly Council, and all the General Assembly units and committees related to it to implement the policy of the 199th General Assembly (1987) on the use of tobacco products in all their meetings and in the meetings of committees or task forces they may sponsor. Such implementation shall include smoke-free worksite regulation as implied in the policy statement.

14. Requests the Office of the General Assembly, the General Assembly Council, and all the General Assembly units and committees

related to it to implement the policy of the 198th General Assembly (1986) on the Social and Health Effects of Alcohol Use and Abuse. Research demonstrates the serious threat to health, safety, and the quality of life in our nation related to alcohol-related problems. Total health and social costs are immense, and the attendant health services required are significant.

D. Because "certain functions impact the entire work of the Council and require regular and relatively permanent contact, collaboration and coordination with several other functions in order to provide information, advocacy and perspective," the Structural Design for Mission authorizes the General Assembly Council to "insure appropriate mechanisms, in consultation with the units involved, to provide interaction." Concern for health and health ministries is clearly such a function, therefore, the General Assembly Council is requested to coordinate health ministries among its various units and enable them to interact with, support, and respond to the staff and health ministries councils of presbyteries and synods.

1. In coordinating health ministries, at least three presbyteries should be invited to meet in consultation from time to time with representatives of the appropriate ministry units.

a. Two units, Global Mission and Social Justice and Peacemaking, have defined functions and staffing in health ministries and each envisions coordination with other units and governing bodies as part of the task. The General Assembly Council need not, therefore, consider the need to secure and assign additional staff to insure the effective discharge of this linkage responsibility.

2. In coordinating health ministries, the General Assembly suggests the following functions be considered:

a. Provide an arena for exchange of information, development of direction, and coordination of effort on health concerns and health ministry issues among the units and committees of the General Assembly Council in interaction with presbytery partners.

b. Provide a point of sponsorship for programs or events that need to be holistic or multi-unit in identity, such as consultations for lay health professionals, clergy and chaplains, and others in health-related business or academic settings; a "Health and Wholeness Newsletter"; or periodic curriculum reviews involving education and health professionals.

c. Facilitate assistance and cooperation among units and committees of the General Assembly Council as they pursue their individual responsibilities (i.e., identifying writers for curriculum, furnishing overseas perspective in preparation of social policy recommendations, etc.).

d. Develop a mechanism to review and evaluate the response of the church to the policy and recommendations adopted in this report and to prepare or coordinate preparation of a report on such response to the 203rd General Assembly (1991).

IV. Societal Responsibility

Life in community requires a just order, and collective institutions of government are important to the well-being of society. Like all human creation, however, they can act sinfully. Reformed Christians, therefore, hold governments accountable for their actions and engage in the task of civil reform that promise better results.

A. Affirming that medical care is only one of several determinants of health, which is also affected by genetic endowment, income, nurture, and education, how we lead our lives, and the quality of our physical and social environment, the 200th General Assembly (1988) recommends that local, state, and national governments:

1. Strengthen legislation and increase programmatic commitment to environmental protection and to work-site and agricultural safeguards (e.g., OSHA, EPA, NRC, FDA, etc.).

2. Expand and accelerate programs of health education, wellness promotion, and preventive medicine in both public and private sectors.

3. Develop policies and programs to assure access to adequate nutrition for every individual, based on scientifically established nutritional standards.

4. Strengthen and implement policies in other areas (e.g., housing, employment, education, transportation, income distribution) that will contribute to a more healthful living environment for all.

5. Implement programs that will encourage and assist individuals to take fuller responsibility for their own health, such as sex education, nutrition planning, lifestyle modification, stress management, etc. In such approaches, it is important to avoid the error of blaming individuals for health problems that are properly attributable to society at large.

B. Believing that policies in both the public and private sectors should affirm the central importance of health and should be comprehensive in design and implementation, assuring that no one is denied access to basic health care by reason of income, age, disability, ethnicity, or geography, the 200th General Assembly (1988) reaffirms the call of the 183rd General Assembly of the United Presbyterian Church (1971) for "a national policy leading to a comprehensive system of health care which shall be accountable to the general public, make all services and

benefits to all persons in the United States, and be administered" by an agency with power to enforce standards of quality care (*Minutes*, UPCUSA, 1971, Part I, pp. 586-587); and to that end, the General Assembly recommends that:

1. Every effort be made to establish reasonable and effective controls of cost in such a system without sacrificing universal access or quality of care.

2. The Congress define, by 1990, a National Health Standard of adequate, quality health care including prevention and health promotion; acute care; chronic care; long-term institutional care; rehabilitative care; and care for catastrophic illness.

3. The Congress enact legislation to assure universal access to health care by:

a. Requiring all employers, public and private, to provide insurance or direct coverage for all employees and their dependents for health care that meets or exceeds the National Health Standard;

b. Amending all current governmental and publicly subsidized health care programs to meet or exceed the National Health Standard;

c. Providing subsidized health care coverage meeting the National Health Standard for all persons not otherwise covered by *a* and *b* above.

4. The Congress, by 1993, formulate policies and programs needed to develop and deploy the health resources required to implement the National Health Standard. These policies should provide for:

a. An adequate supply of qualified health professionals, facilities, medications, and supplies;

b. Guaranteed equal access to educational programs for individuals regardless of race, sex, or economic, status;

c. Adequate funding of biomedical research and studies relating to the delivery of health services;

d. Appropriate distribution of health personnel and other resources by region and specialty;

e. Licensing and regulatory systems which assure competence of providers, promote quality health care, and assure equitable compensation for all health providers.

C. Believing that responsible use must be made of the resources allocated to health and health care and that reasonable limits on health care expenditures can be justified when balanced against other needs of society, the 200th General Assembly (1988) asserts that these objectives must be met without compromising the critical objective of equal access to quality care, and to that end, calls upon the federal government to:

1. Establish a national clearinghouse to accumulate and disseminate information about the effectiveness and consequences of initiatives to contain health care costs.

2. Create a national program of health services research to establish practical standards of quality care and revise them as necessary, to develop measures and tools for assessing the quality of care and the outcomes of treatment, and to publish periodic reports on the effectiveness of the various components of the health system defined in the National Health Standard.

3. Strengthen and expand the national program of technology assessment to include larger questions of resource allocation among health activities, and between health and other social purposes.

4. Redouble congressional efforts to hold all health care providers responsible for meeting a fair share of the health services needs of the poor and uninsured and to seek new cost-effective ways to reimburse health care providers for the cost of caring for disproportionately large numbers of poor patients.

5. Create a national commission with representation from the religious community to address the problems of high-cost illness, particularly at the beginning and the end of life.

6. Review and reform laws and procedures pertaining to medical malpractice with the objective of reducing the costs associated with this problem and the consequent dissipation of health resources.

BACKGROUND COMMENTARY TO THE POLICY STATEMENT AND RECOMMENDATIONS OF THE REPORT ON HEALTH COSTS/POLICIES

Health and healing are central dimensions of Christian faith. What would happen at a personal, denominational, and public policy level if the Presbyterian Church (U.S.A.) sought to make health and wholeness truly central commitments and live them out fully? The Task Force on Health Costs/Policies posed this question to itself, its presbytery and seminary partners, and to a broad sampling of Presbyterians across the nation. The report and recommendations to the 1988 General Assembly are intended not as a final answer to that question but a stimulus to the church to keep asking it until the gospel promise of health shapes personal lives and social reality.

The 1983 General Assembly called for a study of the problem of continually rising medical costs, motivated in no small part by heavy increases in the church's own Benefits Plan. A design consultation recommended and the 1984 General Assembly requested the Advisory Council on Church and Society (ACCS), the Board of Pensions, and the Program Agency to form a task force to "incorporate educational and church strategy objectives along with the analysis of the issues, resulting in a report that would include recommended strategy for the church in the promotion of health, attention to the rising health care costs for the church's employees, and directions for public policy witness." In 1986, the General Assembly Mission Board joined with the other agencies in the support of the task force and participation in its work through membership and staff.

Task force members were selected to reflect professional competence, a broad diversity of health professionals, pastoral care and parish clergy, a balance of women, men, racial ethnic, geographic, and economic perspectives, and a diversity of theological and philosophical viewpoints within the Presbyterian Church. Each sponsoring agency had direct representation through elected members as well as staff on the management team. In addition to its share of task force expenses, the Board of Pensions provided office costs and space for support staff and the staff associate employed for the task force.

A partnership between seven presbyteries and the task force provided a very important research and action model to test concepts in middle governing bodies and congregations. The presbyteries selected were Boston, Northern New England, San Gabriel, Pittsburgh, Minnesota Valleys, Eastern Oklahoma, and Southwest Florida.

Two seminaries, McCormick and Louisville, were invited into a similar partnership, exploring the questions posed by the task force in the arena of theological education. In addition, Pittsburgh Seminary worked, as it had in the past, with Pittsburgh Presbytery through partnership with the East Liberty Presbyterian Church's health center to provide basic and preventive health care for a selected segment of Pittsburgh Seminary students and their families.

Over the life of the task force, a number of changes took place in membership and staff. These changes are reflected in the complete listing in Appendix A. The September 1985 death of Robert Barrie, public policy consultant to the task force, is noted particularly. Retired from service on the Washington office staff and the Board of National Missions in New York, Bob had helped to shape General Assembly health policy and program in several previous efforts and was a highly knowledgeable and energetic advocate for compassionate health policy.

The Process Followed by the Task Force

Initially, task force members read widely on all aspects of health and health care and reviewed studies and policy statements from the PCUS and the UPCUSA. Through its life, the task force heard and entered into discussion with a number of invited resource persons. In the first meeting, Dr. Sandra Brown of Princeton Theological Seminary made a presentation, "Toward a Theology of Healing"; and the Reverend Lee Hancock of Judson Memorial Church in New York City, and the Reverend Wally Fletcher, director of a church-based care center in Philadelphia, described their ministries of holistic health care.

In March of 1985, the task force heard a presentation by Arthur S. Flemming, Secretary of Health, Education and Welfare in the Eisenhower administration. Dr. Flemming chairs the Citizens Board of Inquiry, publishers of *Health Care USA: 1984*, promoting citizen action in health care at local levels. The campaign emphasizes cost containment, a major focus on national health insurance, and the recognition of health care as a right. In addition, Dr. Flemming pointed to the need for more accurate information on the health systems of other modern, industrialized nations, affirming the need for a presentation of the facts as opposed to the rhetoric concerning "socialized medicine" which ignores plus and minus factors inherent in the health systems of other nations as well as our own.

To obtain a closer look at the Canadian health system, the task force sponsored a consultation in Toronto, Canada, in October 1985, hearing from Canadian health professionals, public and private, public health planners, and governmental health experts, as well as leadership from

the Canadian Presbyterian Church, the Canadian Catholic Health Association, the Christian Medical Commission of the World Council of Churches, the United Church of Canada, and the Canadian Council of Churches. The proceedings were published in the United States in the *Journal of Public Health Policy* in the summer of 1986. The task force observed an effective partnership between national, regional province, and local resources, public, religious, and private, which provides health care to virtually all Canadians. While the Canadian system is not without flaws, there is a clear dedication by all parties to provide high quality health care to all Canadians. The meeting was dedicated to the late Robert Barrie, who arranged the consultation with Dr. Milton Terris, editor of the *Journal of Public Health Policy* and Dr. John E. F. Hastings, Professor of the Department of Health Administration, University of Toronto. Sixteen distinguished physicians, health educators, church men and women from across Canada took part in the presentations.

Dr. James Nelson of the United Theological Seminary of the Twin Cities spent a major period of time with the task force in its October 1986 meeting exploring the biblical and theological concepts of body, spirit, and wholeness and their implications for faith and life today. In that meeting, for which Abbott-Northwestern Medical Center was host, and in nearly all its meetings the task force also made on-site visits to health and health care projects and facilities in both religious and secular settings.

The task force also sought information about Presbyterian attitudes, practices, and activities regarding health and health care issues. In January 1986, the Presbyterian Panel queried 3,700 Presbyterian members and ministers. The results contributed significantly to the formulation of policy and recommendations for the life of the church as well as for public policy reform. Appendix C contains a summary of the findings.

Using the Annual Statistical Report to the General Assembly, the task force surveyed the 1,836 congregations that reported some form of participation in health ministry, using a questionnaire developed by New Covenant Presbytery. Results revealed a wide variety of efforts: holistic health clinics, food pantries, self-help groups, hospices, and services to persons with handicapping conditions or who are homeless, pregnant, or elderly.

The partnership and presence of the seven presbyteries in the work of the task force brought a particularly effective mode of "dialogue with the church," since it not only presented a reliable measure of "where the church is" but also a way of exploring where it might go. From early 1986, at least two representatives of each partner presbytery

participated fully in task force meetings. With strong support from the executive presbyters and through special task force structures, the presbytery partners explored church-based clinics, pastoral care education and chaplaincy, hospice and support groups for special needs, health care for the homeless and older citizens, and health issues for pastors and staff. Issues were explored in studies and presbytery forums: the Christian vocational responsibilities of Presbyterian health professionals, bio-ethical issues and a theology of health. Other projects tested the use of health risk appraisals and preventive health maintenance, as well as alternative delivery systems such as Health Maintenance Organizations and Preferred Provider arrangements. In addition, National Capital Presbytery contributed to task force research efforts through its newly formed Health Ministries Division. A fuller report on the efforts of the presbytery partners is found in Appendix B.

As the task force exploration of the implications of the biblical centrality of health proceeded, a growing awareness of the significance of our own health practices led to individual and corporate behavioral changes. Some who had smoked before, stopped. We gave greater attention to what we ate and drank, where we had our meetings, the stressful "workaholic" weekend meetings after and before full weeks of work. And, while we did not break all of our unhealthy habits, we did seek to incorporate stress reduction techniques in our agendas. We scheduled more time for relaxation and did stress reduction exercises in some of our breaks. When possible, we met in retreat centers, discovering that the lower costs and more conducive atmosphere of conference and retreat centers were important health resources for the denomination.

The Health Risk Appraisal (HRA), as developed by the national Centers for Disease Control and others, provided us a significant health education tool. After examination and testing by the task force, presbytery partners, and the Advisory Council on Church and Society, we offered it to the 1987 General Assembly in Biloxi. Over 750 commissioners, staff, and visitors saw in immediate and personal terms the statistical connections between "do-able" lifestyle changes, personal responsibility for health longevity, and the risk of crippling diseases. A new, expanded version of the HRA will be utilized in St. Louis at the 1988 General Assembly.

This educational tool is potentially very effective if it is part of a comprehensive approach based on genuine commitment to health maintenance and preventive care. The task force sought continuing communication with the Board of Pensions as the new Benefits Plan was designed and implemented, advocating the cost-benefit values of a

managed health care approach, with special emphasis on worksite health promotion and prevention. The HRA, if utilized by the Board of Pensions in cooperation with governing bodies, could provide a health profile of the ministers and lay employees of the church at every level. Such a profile, paired with a profile of current reimbursements for medical care for Plan members, could provide important data for developing a denominational approach to reduce costs and improve health by emphasizing personal responsibility for health and preventive care.

The church should be a model employer in our society. The Presbyterian Church must manifest the love, justice, and compassion of Christ in its corporate lifestyle if our "preaching" is to be taken seriously in the communities where we live out our faith daily. How the church functions as employer is a very important witness to the faith.

The deep involvement of Presbyterian health professionals in the life and work of the task force significantly assisted in the understanding of health care as a mission and ministry responsibility of all of the church and not merely a "market product" to take its place among other products in the marketplaces of our nation. At Montreat in August of 1987, a portion of the task force met with thirty-five health professionals, their pastors, chaplains, and presbytery staff persons. The consultation focused on many areas: the global nature of the church's health ministry; areas of value conflicts in medical-health educational pursuits; and the need for health concerns coordination at the General Assembly level. The participants clearly affirmed that the church's advocacy on health questions is not a matter of partisan politics but a moral imperative springing from a Christian understanding of the centrality of health and healing in faith and life. The interest in repeating these consultations across the denomination was strongly emphasized. After another such consultation in a major metropolitan setting in the spring of 1988, a report on this model will be shared with the church. A preliminary report of the Montreat Consultation is found in Appendix D.

As the task force completed its work in late 1987, Chairperson John Sharick summarized both its journey and its commitments in the following way:

> We are agreed that health and healing are central to the faith; that the church has a need to reclaim this dimension in its own life and work in a fresh way. We acknowledge that the poor, the seriously mentally ill, the diversity of minorities, women, infants, children, the homeless and dispossessed have serious health needs to be addressed, not only by the church in mission but also by the society of which we are a responsible part. We understand that if we want to be taken seriously in the public policy and advocacy arena, we need to get our own house in order. We affirm that, as employer, the church often falls far short. We need to do much better than we have.

We are also agreed that this nation, with its abundance of resources, skills, technology—and its great, God-given wealth—can do far better than it has in providing health care for all its citizens. We have it within our power. The potential is often already in place but is rationed by the ability of individuals to pay, or to gain access to needed resources. What we need is the compassion, the sense of justice and mercy, and the political will to do it. And the church, as part of the larger community, has a responsibility to contribute to the solving of these problems at every level of our life—local, state, national and global. We affirm previous General Assembly positions on nuclear weapons and waste-disposal, noting the strong health dimensions involved. We urge continued educational and programmatic efforts to diminish the major health risks posed by some of our nuclear-oriented policies as a nation. We affirm the vision of health as wholeness and the commitment to a comprehensive quality of health care accessible to all that undergirds both the 1960 and 1971 General Assembly policy statements. We affirm the "fundamental priority of preventive care in the planning and resourcing of a system of health care," as voiced in the 1976 General Assembly policy statement. Resources invested in prevention—concern for impure water, toxic wastes, inadequate sanitation, rodents and overcrowding, addressing substance abuse, poor nutrition, inattention to resource allocation—enlarge the possibility for all persons to assume personal responsibility for their own, family, and neighbor's health. Health promotion and prevention go significantly beyond the boundaries and responsibilities of medical care.

We are unapologetically for a national health policy that does justice for all, shows mercy in the way we care for the least of our brothers and sisters, and which walks humbly with the God we know through Jesus Christ, our Lord. We can do no less in our personal and ecclesiastical areas of opportunity and responsibility. We profess a Christ who came that humanity may have life, and that more abundantly; and a faith that makes us and those whom we serve whole.

The Debate Over the Nation's Health Policy

The rising costs of health care, gaps in health care coverage, distortion of health policy priorities, and ethical issues related to health care economics and clinical practice, which were the principal catalysts for General Assembly concern and task force exploration, are not new issues for the society or for the Presbyterian Church. A number of policy statements and studies have been undertaken by the General Assembly or its mission program agencies in the last twenty-five years:

-1960 The Relation of Christian Faith to Health

-1971 Toward a National Public Policy for the Organization and Delivery of Health Services

-1976 Health Care: Perspective on the Church's Responsibility

-1978 Health Ministries and the Church

-1983 The Provision of Health Care: Obedience to the Divine Purpose

-1983 The Report of the Task Force on New Directions in Health Ministries to the Division of International Mission and Medical Benevolence Foundation

-1986 The Report of the Health Ministries Evaluation Team of the Program Agency Board

To insure contemporary data and analysis for its own work and for the church at large, the task force commissioned a book of "Briefing Essays" focusing on health policy issues across the spectrum. Research on Reformed history, Bible and theology, health ministries and the Sacraments, as well as the church as employer, concern for the quality and access to health resources for the poor and uninsured, and the vast array of public and private health policy and economics issues are represented in this resource. The essays also explore the values inherent in personal, ecclesiastical, and community decisions about health and health care. Since operational values tend to express themselves in behavior and policy, such analysis is of as much importance, if not more, as the technical analysis of costs, quality, or efficiency in attempts to understand why our system works as it does and how it might be reformed.

The task force is persuaded that concern for health in the life of the church and in the society are essential and central to the mission and ministry of Christianity. Perhaps because of that, our experience and research reveal that Presbyterians have strong and passionately held convictions about health policy. The potential scope of any study is greater even than can be included in the book of briefing essays, so there is focus and limit to the research and recommendations. The task force came to respect and affirm the statements of earlier Assemblies, but did not wish simply to say "Amen" to the good work done previously. We came to the strong conviction that, unless the church demonstrates in its own life the convictions so compellingly expressed in this and previous policy statements on health and health policy, the moral force of its public policy advocacy will be greatly diminished. In short, unless we learn and manifest more deeply than we have what it means to make health and healing central to the life of a community of people, we are not likely to contribute helpfully to the ongoing public debate over health policy.

A study of the costs issue led to such questions as: "What factors cause health costs escalation?" "What has already been done to seek to curb costs?" "Who gets health and medical care and what is the relationship between the care received and health?" "How is the church most effectively to be involved?" The task force learned that the U.S. health care system has been subject to several factors that caused these costs to rise at a rate far exceeding inflation.

During the World War II period of wage freezes, health insurance benefits began to increase as another way of "paying" employees. This coverage expanded so that over the years the standard for industry

became "full dollar coverage" for hospitalization and major medical needs. Thus, a system developed which removed both doctor and patient from worrying about the cost of care, creating a climate in which the best and most comprehensive care available could be delivered essentially without reference to cost. From 1945 to 1960, the number of people with hospital insurance rose from thirty-two million to one hundred twenty-two million, and those with coverage of physician expenses escalated from five million to eighty-three million. These major changes in health care financing regularized payments for the cost of medical treatment, increased both the extent and ease of access, and significantly increased the demand for medical care, with no effective restraint on costs.

Medicare and Medicaid legislation passed by the Congress in 1965 provided health care coverage to millions of both older and poor Americans. In 1970, Medicare expenditures were $16.3 billion, rising to $36.7 billion in 1975 and $72.3 billion in 1985, approximately $2,500 per person enrolled. Federal Medicaid expenditures rose from $7.9 billion in 1970 to $14.6 billion in 1975 and reached $23.2 billion in 1985, with state governments spending another $19 billion in that year. Government now pays approximately 40 percent of all health care expenses, business pays another third, and patients the rest out-of-pocket.

A technological explosion made it possible to keep alive longer persons who in the past might have died sooner—premature infants, the terminally ill, older persons, accident victims. Both the technology and the extended care it makes possible have contributed to the precipitous rise in health costs. The task force learned that 56 percent of all Medicare expenditures are in the final ninety days of life and that for the Board of Pensions the largest single expenditures have been for care of premature infants. The expansion of potential diagnostic tools and life-sustaining technology and treatment with their promise of more precise information related to a greater range of treatment choices also require more complex decisions by more persons, thus dramatically increasing costs for both "good" and "bad" results. Expectations for cure or rescue escalate. Unrealized expectations and greatly increased numbers of tests in the face of malpractice suits not only increase risks but result in an increasingly litigious climate in health care. More tests are ordered to protect the provider and provide backup for difficult decisions. Soaring malpractice insurance costs to health professionals and delivery systems are in turn reflected in significantly higher charges and rising health care costs.

The increase in the segment of the nation's population that is over sixty-five years of age (2 percent increase per year) is also a significant factor in the increase of health care costs. This population requires more

medical care for chronic illnesses associated with aging, with the overall costs being compounded by the growth in technology noted above. Though the statistic does not refer simply to the elderly, it is estimated that 80 percent of lifetime health costs are expended in the final year of life.

In both dollar and percentage terms, the increase in overall health care costs is breathtaking. In 1965, the per capita amount spent for health care was $205 nationally; in 1980, $1,054; and in 1986, $1,837. In 1965, national health expenditures were $41.9 billion (5.9 percent of GNP); in 1980, $248.1 billion (9.1 percent of GNP); and in 1986, $458 billion (10.9 percent of GNP). There is not a "magic percentage" of Gross National Product that should be expended on health and medical care. Concern must be focused on the rate and amount of increase and what it does or does not provide in terms of coverage and quality of health care for our people.

The nation is faced with a serious crisis of access to basic services. Approximately thirty-seven million persons in our nation are uninsured at any one time and the number appears to be increasing at a rate of about one million per year. Three times as many poor as nonpoor have no public or private coverage, making up the hard-core "medically indigent" for whom both financial and human suffering is greatest.

A number of efforts have been undertaken by government and business providing health coverage for employees to hold down the increases. Such efforts have included reducing eligibility for Medicaid so that fewer persons qualify (70,000 children were dropped in 1983, according to *Health Care USA: 1984*, shifting more of the cost of Medicare payments to the participants; instituting or increasing co-payments so that coverage begins only after a patient first pays a certain portion of the charges, and requirement of second opinions before elective surgery. Other cost-containment efforts have included the development of various prepayment provisions, such as Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs), and the limitation of both amount of payment and length of hospital stays through DRGs (diagnostic related groupings), by which reimbursement is based on an average cost and stay for treating a particular diagnosis or medical condition. The effect has been very mixed. Patients are often discharged "sicker and quicker," often necessitating nursing home or home care which is less expensive but not usually covered by health insurance. The increased need for this type of care has not been fully met, so reentry to the hospital due to complications or deterioration has become an increasing problem. However, average hospital stays have stabilized at about 6.6 days, increasing by only 2 percent in 1986.

The net effect of these efforts has been some shifting of costs from government and business to the consumer: the poor and near poor in the case of Medicaid, the elderly (both rich and poor) covered by Medicare, and the employee paying the new or increased co-payment charges. Such techniques can decrease the "frivolous use" of the medical system by some persons but, for the one in six Americans with no health insurance coverage, it can mean no care at all.

The result of these strategies is both to raise new ethical concerns and upset traditional economic arrangements. The nation's inability to reach consensus on distributional ethics creates a significant national dilemma. There has been a radical rearrangement of relationships among health professionals, the social order, and their patients and clients. In the 1970s and 1980s, the move from a "sellers" to a "buyers" market, from a perceived shortage of health resources to an overall surplus capacity, has created further moral and value dilemmas. The language used is that we are forced to "ration" health and medical resources. The reality is that buyers—i.e., corporations, third-party payers, and patients—are not faced with a true rationing of limited resources. There is a kind of rationing, not by a central authority but rather by the willingness to pay in some instances and not in others: by disease, as in federal dollars for renal dialysis and Hanson's disease; by age, as in Medicare; or by race or ethnic background, as in the Indian Health Service. But the cost-containment and cost-shifting strategies of the government and business are not occasioned by the need to ration scarce resources. They are first of all attempts to limit their own financial costs and they are able to squeeze the providers of health services because of their enormous leverage as the payment source for 75 percent of all bills. The "buyers market" has been created quite as much by the tentative and limited exercise of this "monopoly" power as by any "surplus capacity." In this situation, there is a steady increase of classic rationing by price for those who are uninsured or underinsured, by the ability to pay rather than simply the willingness to pay.

No one "decided" to exclude the poor, under- or uninsured. Their lack of financial resources, their work at a job providing no insurance coverage, working less than "full time" (some hire half- or part-time employees, in some cases for thirty-nine hours a week, in order to avoid paying the health benefits), permit these "medically indigent" to "fall through the cracks" of the safety nets currently perceived to be in place. Allowing access to health care for the uninsured to be determined by the ability to pay for that care is simply an extension of the prevailing economic philosophy of the nation, but the result is an unjust distribution of services. In the process of seeking cost-containment, the "deck has been stacked" against charity care. In the past, cost-shifting in

hospitals generated funds for indigent care. Current financing mechanisms do not allow this. As affirmed in the policy statement, "indigent care, earlier financed by cross-subsidization, has come up against the 'prudent purchasing' price-competitive medical marketplace."

Because medical care is being squeezed out for poor citizens and for many others of moderate income where co-payment percentages of their insurance policies become excessively burdensome, preventive measures or early attention to illness is often put off, with the result that conditions worsen and in the end become more difficult and more expensive to treat.

If these cost-containment strategies had achieved the primary purpose of lowering health care costs or appreciably slowing their rapid escalation, this "side effect" of the squeeze on care for the poor might then have been addressed in a direct programmatic way. However, in spite of public and private cost-containment efforts over the past five years, health care expenditures in the United States continue to increase much faster than the annual rate of inflation. These expenditures, in either per capita or percentage terms, exceed those of other comparable industrial nations: Canada, Finland, Japan, Germany, Switzerland, and the United Kingdom. While the United States was spending almost $1,800 per capita on health care in 1985, Canada expended $1,300, Japan $800 and Britain only one third as much at $600. Health care in all three nations is both universal and sophisticated, life expectancy at least as high as ours, and infant mortality lower in all cases.

According to a survey by the Hospital Corporation of America and Equicorp, hospital charges increased by 19 percent in 1987, with daily costs rising to a national average of $698, an average increase of 16 percent. The median cost of a hospital stay was $4,551. This occurred during a year in which the inflation rate was less than 5 percent. In addition, average ancillary charges rose even faster than room and board charges, with an increase of around 20 percent. In seven states, these ancillary charges increased by between 32 percent and 66 percent. Average charges per stay increased, as noted, by 19 percent in forty-six states. The average patient days per bed indicates that in thirty-five states, hospital beds were empty at least 150 days per year. In thirteen states, the typical hospital bed was empty as often as it was occupied!

Bernard Tresnowski, president of Blue Cross Blue Shield, estimated in a recent *New York Times* "Op Ed" piece that 20 to 60 percent of lab tests, X-rays, and electrocardiograms may not aid in the diagnosis or treatment of an illness. In a recent Rand Corporation study of 4,564 case histories, medical experts reviewed research on effectiveness of three fairly common procedures and established criteria for judging appropriateness. They found that 26 percent of coronary angiographies

(a procedure to determine blockage of coronary arteries); 28 percent of endoscopies (a procedure to diagnose stomach problems); and 64 percent of carotid endarterectomies (a surgical procedure to remove blockages in the artery serving the brain) were clearly inappropriate or of uncertain value. In a tacit recognition of such findings, the American College of Physicians, representing more than 65,000 doctors of internal medicine, has developed guidelines for its members to eliminate "the use of diagnostic tests when they do not contribute to the effective practice of good medicine."

All these statistics indicate that in spite of cost-containment initiatives, the rate of increase in health costs has not been slowed. In fact, there are indications that current cost-control mechanisms have themselves contributed to rising costs by establishing incentives to increase admissions and readmissions, unbundle services and charge separately for small items that were included in general categories previously, and discharge patients prematurely. In 1984, according to the American Medical News of April 26, 1985, the profit margins of both "for profit" and "not for profit" hospitals reached the highest level in twenty years. This occurred during a period when the denial of care and the controversial practice of "dumping" patients reached disturbing levels.

In short, efforts to contain costs have not had the intended effect; the way the efforts were structured may well have contributed to the continuing increase rather than controlling it; and in the process, access to health care has been shut off or severely limited for more and more Americans.

We like to get what we pay for. If the increased costs for medical care resulted in demonstrably improved health status, we might conclude it was worth the expense. In some ways, the nation's health has improved over the last fifteen years but, because of lifestyle change, not the medical care system. We have cut down on smoking in the United States. There is less lung cancer. There has been a decline in cardiovascular disease—the leading cause of death—not because of by-pass surgery or technological intervention, as valuable as those interventions are, but because we have come to be more aware of the effects of alcohol use, smoking, diet, and exercise. The utilization of seat belts and tighter controls upon driving under the influence of alcohol have reduced death and trauma and injuries from vehicle accidents.

In other important indices, such as infant mortality, nutritional standards, and equitable access, we have stood still or gone backward as costs surged ahead. When Americans examine their health care system in the light of their own values and needs in regard to health and the experience of other nations, many are coming to feel that we are not

getting what we pay for. That is why many feel that we are entering a period of intense discussion and change in health policy and health care.

THE CHURCH'S PERSPECTIVE

The Meaning of Health

The church's understanding of the meaning of health emphasizes a comprehensive perspective. The complexity of human body-mind-spirit-community-individual interactions is truly awesome. To ignore some dimensions while seeking to maintain or restore the others is unrealistic and counterproductive.

Health is the ability to respond to a wide variety of challenges, living up to potential and promise. Illness can be understood as the inability to respond with adaptability to life's challenges or assaults on well-being and balance. Typically, Americans tend to define health as a state of robust physical fitness. One is healthy until something goes wrong, and then the medical care system is asked to do the necessary "repairs." For Christians, the definition of health goes beyond curing disease or trauma, beyond even a preventive and wellness model, to embrace a concept of wholeness. Jesus not only restored persons to physical health but, in the process, righted relationships with others in the community and with God. The burden of sin and alienation was overcome along with the physical or mental impairment by the gracious action of God in our Lord's ministry.

Health and wholeness, however, are not dependent on the absence of impairment or on physical perfection. One can be injured, possessed of a disabling condition, malformed of body, and yet be "healthy," quite able to function well if given assistance and opportunity by the community. Those facing a terminal illness, with the physical body failing, but possessed of good spiritual and mental support and love, can be said to be "healthy." Physical healing may be out of the question. Yet suffering and death can be faced with a degree of confident assurance, however sad and painful the dying, that one is loved and whole and possessed of a faith-supported hope in God's continuing presence.

Can we be economically deprived, malnourished, and live in an unhealthy environment and be healthy? Statistics suggest that poverty and sickness go hand in hand. The Christian understanding of health focuses upon the person and community within a total environment. We are called as good stewards to ensure that natural and social environments do not endanger human health and, failing that, to protect, rescue, and treat the resultant wounds or trauma.

The environment in which we live and work has significant impact upon health. Healthy home and work environments make significant contributions to well-being. The presence of toxic agents, occupational health hazards, work-related injury, dental problems, and infectious diseases all demonstrate the impact of environment on health. It has been demonstrated that the economically deprived are less likely to engage in accident prevention, to seek action against poor or dangerous working conditions for fear of losing their jobs, or to have preventive health and dental work done. Presbyterian concern for health must address these issues for "the least of these" brothers and sisters in the human family with and for whom we are called to minister.

The focus on nuclear armaments and an enormously expensive nuclear power industry has had negative effect upon the environment and health. The beneficial and cost-effective dimensions of preventive approaches here have yet to be fully explored. We have not yet evaluated or understood the psychological effect of living within the shadow of nuclear annihilation. Discoveries about the long-term effects of nuclear wastes and exposure to radioactivity from the last four decades raise even stronger indication of the significant health risks posed. The disposal of nuclear wastes in a safe manner, which does not put future generations at risk or endanger the safety of the vast aquifers that provide fresh water to the nation, continues to be a major, unresolved health issue.

"Lifestyle" is a major factor in personal health status in the United States. The consumption of tobacco products, particularly cigarette smoking, is one of the major preventable causes of death and disability. The causative link to cardiovascular diseases, cancers, pulmonary complications, and lost time on the job is well documented. The most reliable research in our nation estimates that it is the principal avoidable cause of death in our society, with the mortality attendant ranging from 270,000 to 485,000 deaths per year. The U.S. Public Health Service estimates smoking to be related to about one sixth of deaths from all causes. Alcohol consumption is strongly related not only to chronic liver disease, but also to automobile accidents, suicide, and homicide. It is estimated that 150,000 Americans die each year from alcohol-related causes.

Good health is a dynamic, creative, and integrating dimension of life. It is not merely negatively defined. We should not diet, watch our cholesterol level, or take flu shots to "keep from getting sick" but to be well and to continue to function in the healthy state of being God intended for us. We run and pay attention to stress reduction not only in order to maintain fitness but to be effective witnesses to our life in the faith.

For, indeed, health is not an end in itself. It is not an idol to be worshiped. As the Christian Church (Disciples) stated in its Interim Report in October 1986, "A perfectly developed, superbly conditioned (and exquisitely tanned) body is the end goal for too many devotees of the wellness 'gospel.' The biblical view of health is not that it is the end goal, but rather that it is the means by which we are able to live happy, active, energetic lives of love and service. Health is an 'enabler.' "

The volume of "Briefing Essays" documents other causes of death and poor health and examines the issues and values underlying current health policy debates.

Biblical and Theological Context

Twenty percent of the Gospels are related to healing and restoration to wholeness and community. For Jesus, healing was a sign of the in-breaking of God's rule in human history ("Go tell John the things you have seen and heard: The lame walk . . ."). Jesus moved with no indication of discontinuity from sick bodies ("Rise and walk . . ."), to sick minds ("the man from Gadara was sitting, clothed and in his right mind"), to sick souls ("your sins are forgiven . . ."). The extent of healing went beyond the expectation of those who sought him. It was seldom the mere restoration to the way things were before. The individual came to be whole in body, mind, and spirit; relationships were renewed and community restored.

The biblical record is clear that the people of God are intended to be both illustration and instrument of God's creative, healing, and redemptive activity. "Your faith has made you whole." ". . . and they anointed many that were sick and healed them." The Sacraments of Baptism and the Lord's Supper are not only "intra-mural" symbols for the church but "extra-mural" symbols for our life in the world. As God's stewards of life and health, to manifest its reality and seek its cleansing and nurture for others is part of our calling. In the Old Testament tradition, the focus on health, cleanliness, and healing is clearly expressed in the Holiness Code of Leviticus. The prophets and the Psalms are suffused with the wider sense of health as wholeness or shalom in personal and social relationships and in nature. The healing miracles of Jesus, restoration to health and wholeness, at times involved a ritual cleansing, a washing or baptism, symbolizing not only the presence of God's spirit and cleanliness and purity but also restoration or admission to the community of God's "whole" people. This was and is a model of the abundant life made possible through the grace and mercy of the Creator, realized in the midst of a healing and caring community. The

command to go and baptize all nations is thus a commission to the service of health in its fullest terms.

Jesus, coming in human flesh and thereby giving human life greater significance, announced, ". . . I have come that you might have life and that you might have it abundantly" (John 10:10b). The Gospel of Mark amply demonstrates the central concern for the total well- being of those Jesus encountered in his journeys across his homeland. Lepers and "mad men;" outcasts, Samaritans, women, children, people of all sorts were objects of a healing presence and ministry which restored them to health and effective relationships in their communities. Lutheran theologian Krister Stendahl describes Jesus' ministries as a "pushing back the frontier of all destructive and distorting forces;" a "mending of creation." In the calling of the Twelve, the expectation that the disciples and apostles of Jesus would have healing powers is often reiterated (Mark 6:7ff; Acts 3:1ff; I Cor. 12; and James 5:31ff).

Sacrament and Limit

Health clearly exists at the center of God's dealing with human beings in history and therefore has unique power as a mediating metaphor, a sacramental encounter with the source and meaning of life. Bernard Lee, S.M., general editor of *Alternative Futures for Worship*, in Volume 7, observes that all of life "has the possibility of mediating the transformative encounter between God and human history. That is its sacramental character." This sacramental understanding should be applied to ministry and mission in health and health care settings where pastoral care and prophetic witness are acted out. This does not mean that we should pay less careful attention to the experience and findings of both the human and medical sciences. When combined in a healing partnership, a sacramental approach and these sciences can transform a situation of extreme vulnerability, tragedy, or incapacitation to one which brings order from chaos, meaning from confused circumstances, or restoration to integrity.

There are limits to life. We die, and the path from birth to death is intersected by accident, illness, and suffering as our daily experiences attest. There are conditions that can be only partly remedied, if at all, and illness for which there is no immediate or long-term hope of cure. In such situations, we look for meaning, for causes, cures and, failing those, for comfort. In spite of the limits familiar to us and in the face of tragedy or absurdity, beyond those things which seem reasonable to us, life continues to have meaning and we continue to hope. As we acknowledge physical, emotional, and spiritual boundaries and the limitations of human and cybernetic intelligence, we need rituals and

ceremonies that express the "sacramental character" and enable us to bear up under the most bleak of prospects. The Sacraments of Baptism and the Eucharist and the practices of prayer, laying on of hands, and annointing of the sick have great potential power in this regard, explored by more and more Presbyterians. These liturgies, in the context of a community committed to wholeness, have significant healing potential for both the recipients and givers of care. We need both to recover and rethink our liturgical resources for seeking health and dealing with unhealth in the context of both parish and clinical care. Private means of grace and public ritual meanings need to intersect, mediating the transforming encounter between ourselves and God, on the one hand and, on the other, the lives of those under the ministrations of contemporary health and pastoral care givers.

Justice and Health in the Public Order

The strong stewardship of life theme that courses through both the Scriptures and Reformed history has both private and public dimensions of responsibility. There is a covenant relationship between humankind and the Creator-Redeemer-Sustainer God who called us into being. All human lives and all of human life have value, dignity, and integrity. God is served by serving others with our own gifts. It may be as difficult for the wealthy and healthy to understand and enter this calling as it is for a camel to pass through the eye of a needle (Matthew 19:24), but the fullest measure of compassion and service to those in need is one of the clearest testimonies of Scripture. This strong concern for justice, mercy, and compassion permeates our tradition. Justice and love take human and institutionalized form in concern and care for the sick, the imprisoned, the hungry, and the oppressed and poor. In Matthew 25:31ff, this partnership with God is seen as a mark of the faithful community: "Inasmuch as you did it to the least of these . . . you did it to me." God's concern for the created order commands a justice which liberates from captivity, from bondage, from all manner of crippling restraints upon human health and wholeness and it requires that justice be expressed in effective and concrete historical institutions and forms. Professor Charles Swezey, in the *Journal for Preachers*, Lent 1986, observes, "It is not possible to serve God without also serving those human causes—political, economic, and cultural—over which God is sovereign." To serve those proximate causes, one must be able to feel and comprehend the suffering of another. John Calvin defines justice as "to receive into safekeeping, to embrace, to protect, vindicate, and free. . . ."

In Book IV, Chapter 20 of the *Institutes*, Calvin wrote that civil government is ordained by God to order and serve the human community and therefore to be held in respect and honor. Following Calvin, who wrote that service in the public order was the highest vocation for Christians, Reformed Christians have a strong tradition of responding to God by service in the political order. The civil state, by its own definition and tradition, is to serve the causes of justice, the common well-being. As Presbyterians, we believe that the church must not only call upon the political order to serve the causes of justice but actively participate in efforts to shape public policies and institutions so that they serve human needs effectively and equitably.

Calvin, in the same section of the *Institutes*, reminds us that this entails a special care for the most vulnerable and needy: ". . . Jeremiah admonishes kings to 'do justice and righteouness,' 'to deliver him who has been oppressed by force from the hand of the oppressor,' . . .The exhortation which we read in Psalm 82 has the same purpose: that they should 'give justice to the poor and needy, rescue the destitute and needy, and deliver the poor and needy from the hand of the oppressor' " (Psalm 82:3-4).

There is overwhelming scriptural evidence that God was and is concerned with the ordering of human life and community for health and with the physical healing and restoration of human life as dimensions of intended wholeness. The biblical emphasis upon creation and covenant, the healing ministries of Jesus and the activity of the early church, continue to summon us to care for the sick, the injured, the health of our communities. We are called to serve health—for ourselves and for others—both through the ministry of the church and by insuring that the social order of which we are responsible citizens provides, in the best way possible, access to health resources which provide and promote health and restoration to wholeness when health is impaired.

History and the New Situation

When the history of the church's role in health and healing is retraced, direct efforts to relieve suffering and treat illness are the most prominent dimensions through much of its life. Throughout the centuries, hospices and hospitals were built, missionaries with medical and teaching skills gave immense sacrifices of time and resources to health care and healing ministries abroad. In the United States, hospitals and clinics were started by the Presbyterian Church and other denominations, particularly in isolated areas. Hospital chaplaincies, counselors, and clinical pastoral educators have developed more recently, and many congregations continue direct service through crisis support ministries, alcohol

and other drug abuse groups, and similar programs. The prevailing interpretation of "health ministry," in short, has been the delivery of either pastoral or medical care in the face of illness or health risk; "health" has been seen very largely as a dimension of "mission program."

There are yet opportunities for the church in the direct delivery of health care, particularly in other parts of the world. But the growth of large scale and extensive health care systems under private and various governmental auspices and dramatic advances in disease prevention and scientific and technological medicine have led the Presbyterian Church and others away from the operation of medical care institutions. It thus becomes both necessary and possible to rethink and refocus the role of the Church in relation to health and healing. The Task Force on Health Costs/Policies believes that it is imperative for a contemporary and comprehensive approach to health and wholeness for the Presbyterian Church. This will involve a new focus on personal responsibility for health as a basic dimension of Christian discipleship; a serious commitment to become communities of health and wholeness at every level of the corporate and institutional life of the denomination; and a vigorous advocacy for basic reform in the public policies and institutions of the United States related to health and health care.

Faithfulness to the gospel and the pastoral and prophetic calling of the people of God requires that we model health in our own lifestyles; that we seek a focus on health within the congregations and governing bodies of the denomination which gives credence to our profession of centrality for health and healing; that we inform ourselves about health policies, resources, and costs and seek to reform the health system of our nation to give, as far as possible, equal access to adequate, affordable, appropriate, and necessary health care for all. Access should not be limited by income, ethnicity, or geography. Good health, physical, mental, and spiritual, is both the intention of God and a social good of special moral importance.

Communities of Health and Healing

At the heart of its inquiry, the Task Force on Health Costs/Policies set the question, "What would it mean for the Presbyterian Church to place concern for health and healing, in all wholeness, at the center of faith and life?" Though some of the Briefing Essays probe this question, the task force recognizes that its implications are yet only superficially explored. It would, we are agreed, produce profound changes in Presbyterian worship, program, and "lifestyle" among members as well as in our corporate existence. Such changes could well, in and of themselves, affect the society.

The Reverend Granger Westberg, writing in one of the Briefing Essays, calls a congregation that takes health and healing seriously a "wellness center where people come regularly for prayer, worship, spiritual inspiration as well as for social activities and serious discussion of life issues from a Christian perspective." It is a group of people who are learning that the chief ingredient of health has to do with one's outlook on life. This is another way of saying that what one believes about the nature of the universe, about the Creator who made and sustains us, and about our daily relationship with [God], must be seen as of central importance in understanding the makeup of health or illness."

In such communities, there is a dynamic interaction between the community and its individual members. As Gwen Crawley writes in another Briefing Essay, "It encompasses the lifestyle of both the individual and the organizaton and calls them to look at who they are and how they relate to all of God's creation. When the goal is health and wholeness, the desires of the individual are examined and reconciled against those of the larger community, not in an effort to limit personal choice or rights but to understand the interdependence and shared responsibility for each other."

During its life, each member of the Task Force on Health Costs/Policies wrote a paper on the question, "What would a church look like that saw health and healing as central to its faith and life?" From this exercise, ten characteristics of such a church emerged:

(1) It has a sense of well-defined purpose and commitment centered in Jesus Christ.

(2) There is both individual and corporate responsibility, accepting and using the diverse gifts and talents of all.

(3) It maintains a caring, nurturing, loving, and forgiving network.

(4) Its organizational style is open and inclusive.

(5) There is a sense of questioning, struggling, learning, and seeking creative responses to health needs.

(6) Conflict is openly dealt with, not avoided.

(7) There is a sense of inner health and outer reach, understanding that with God we care for all creatures and creation and seek to empower as we serve.

(8) The family in all its forms is supported as key to physical health, self-image, and the transmission of values.

(9) There is support for the individual discipline required to change unhealthy lifestyle but recognition that aging and death are a part of God's plan.

(10) The joy and gratitude of sharing God's grace is felt in worship and congregational life.

The activities of the presbytery partners explored ways in which the concern for healthy congregations and governing bodies could be reflected and expressed in practical ways. Their continuing work, hopefully expanded by the addition of other presbyteries, will be an immensely important "laboratory" for testing and evaluation as the Presbyterian Church seeks new focus on health and healing as central dimensions of life.

The Presbyterian Church as Employer

In congregations, middle governing bodies, General Assembly agencies and institutions, the Presbyterian Church (U.S.A.) employs tens of thousands of persons. The church daily confronts the issues and makes choices about health and health care for those who are called to work as secretaries, administrators, maintenance personnel, educators, musicians, missionaries, and pastors. Many of those choices and issues revolve around questions of coverage, costs, and "workplace" practice and style.

Coverage: A survey in 1983 showed that only 25 percent of church secretaries and 17 percent of custodians and sextons of the total of over 6,700 employed by the church "full time" in these occupations were covered by health insurance. Another 11,797 were employed more than twenty hours a week but less than full time. Within the latter group, 55 percent of part-time secretaries (about 2,000) had no health care coverage. Thus our denomination, which has for years advocated health care for all at the congregational level, failed to meet employee needs for basic health care coverage. The reason for this failure: cost. We assumed the sacrificial response of those who helped keep our congregations' ministries coordinated, liturgies printed, letters sent, churches kept clean, and phones answered.

It is true that within a church budget, dollars spent on employee health may not be available for mission or building renovation. But, as John McAnlis notes in the September-October 1986 issue of *Church and Society*:

> The church has to take seriously how it manages the stewardship of human resources. Of highest priority is to examine the values upon which the church of Jesus Christ was founded. It must be learned and understood that the church can be a caring and loving organization responsible for people, and at the same time be an efficient and effective manager. The church has a responsibility to manage its mission to see that it treats all of its resources as sacred and precious. In this way, the Church of Jesus Christ is healing, redemptive and striving toward wholeness. . . . Robert K. Greenleaf, in his book *Servant Leadership*, says: "The healthy society,

> like the healthy body, is not the one that has taken the most medicine. It is the one in which the internal health building forces are in the best shape." . . . For us to be effective in our witness publicly, our own standards need to be found in good order, that what we say and what we are as employers of all God's servants be found consistent with our own deepest held values.

What answer is there to the question, "Why does the church not mandate health and pension coverage for all employees as it does for ordained clergy?"

Costs: As noted in the Introduction, the impact of continually rising medical costs for church employees was a major factor in the request of the 1983 General Assembly for a new study of health policy. The Benefits Plan of the Presbyterian Church (U.S.A.), managed by the Board of Pensions, spent $4.7 million in 1976 for covered medical expense. In 1986, the board spent $21 million which, when adjusted for inflation, represents a 220 percent increase over an eleven year period. The Plan in 1986 expended $3.5 million in excess of dues allocations set aside for medical expenditures.

Cost-containment efforts, such as precertification for nonemergency surgery, increased co-payments for covered medical expenses, and incentives to encourage the use of less expensive health care options have been instituted along with improved coverage for preventive and health maintenance approaches such as annual physicals and out-patient psychotherapy costs.

While there have been complaints concerning some of these changes and cost-containment provisions, the task force believes that they will be effective in promoting responsible engagement of health care providers by Plan members in both preventive measures and in more careful monitoring of costs at a primary care level. This will result in some reduction in the rate of increase of the church's costs but, as the experience of 1987 indicates, those costs will continue to escalate dramatically unless changes are made in the structure of health policy and institutions in the United States. For lower income church employees, both pastors and lay workers, the co-payment provisions can become excessively burdensome. Middle governing bodies need to work with the General Assembly Council, Church Vocations Unit, and the Board of Pensions to address these important health care issues which are of concern to the whole church and not simply to Plan members. Allowing congregations who can afford it to cover their own pastors with extra insurance does not serve justice and may have a long-term detrimental effect on the Plan. Task force work with the seven presbytery partners and seminaries indicates the desire, the competence, and the capacity of our connectional system to address these health care management issues on a denominational scale.

The continued escalation of medical costs, in the face of all efforts to slow them as noted above, indicates the urgency of a fresh approach in this area by the whole denomination. The Board of Pensions, in close cooperation with the middle governing bodies should begin to explore and analyze the costs-benefits of moving from an "insurer of medical benefits" orientation to a "health management" one. The "insurance" approach, which primarily reimburses various medical systems for the delivery of curative or custodial care, has proven to be an ineffective social policy for containing costs and does not seem to be the most prudent stewardship of the benefits resources of the Presbyterian Church. A combination of strong denominational emphasis on personal responsibility for health, coordinated focus on health maintenance and prevention in program activity and the Benefits Plan, and an aggressive attempt to manage curative care in the most effective and least expensive way, through ecumenical coalitions if possible, holds promise both for improving the health status of church employees and for significant reduction in costs.

As noted, presbyteries with whom the task force collaborated indicate a willingness to explore the potential of such approaches with the board. In the consultation with health professionals and pastors at Montreat, North Carolina, the same interest was expressed. These proposals are consistent with general trends across the nation in business and health systems, both public and private. Prevention works. The new data resources now utilized by the Board of Pensions make possible the necessary analyses related to the costs and benefits of such an approach.

The Carter Center at Emory University examined fourteen health problems which accounted for 70 percent of hospital days, 85 percent of direct personal health expenditures, and caused 80 percent of deaths. The estimation was that 66 percent of these deaths were potentially preventable. The chief problems where this preventive approach was possible were in the use of tobacco and alcohol, high blood pressure, poor nutrition, injury (especially automobile accidents), unintended pregnancy, homicide, and suicide.

The Health Risk Appraisal is a very helpful tool in the maintenance-prevention approach. It was tested by the task force in several small groups and then used in June of 1987 with over 750 commissioners, staff, and guests at the 199th General Assembly. The recommendations to the 200th General Assembly (1988) urge that this resource be utilized by the Board of Pensions, the Church Vocations Unit, the Unit on Stewardship and Communication Development, and presbyteries to provide both a health data base for the denomination and a resource for the proposed health promotion strategy. Long-range projections on principal health risks can be effectively identified, and preventive strategies

can be developed; which, in turn, will lead to lower costs in the area of medical expenditures.

"Workplace" Practice and Style: The very dedication that leads persons to want to work in the church and motivates them to work hard and long can itself be a threat to health. The Protestant heritage of hard work and self-sacrifice can place both employees and their families under considerable stress, with "not enough time" for relaxation and exercise. The three top "killers" in the United States, heart disease, cancer, and cerebrovascular diseases, are all subject to greatly diminished risk through proper diet, exercise, stress reduction, and health checkups—all relatively inexpensive activities compared to the intensive treatment costs of persons affected by these conditions.

One of the presbytery partners, Southwest Florida Presbytery, implemented a health-promotion program to encourage all church employees in the presbytery to identify health risks and to modify lifestyles. Other presbyteries utilized the computerized Health Risk Appraisal (HRA) as a health education and motivational tool. In some presbyteries, one staff member is assigned to work with pastors and their families. An Employee Assistance Program (EAP) at a national level has been established to assist employees or members of their families to deal with the stress of physical, mental and (or) emotional illness, to get assistance in dealing with marital or family problems, alcohol or drug dependency, or other problems. Where there is evidence of deterioration in the performance or health of the employee, self-referral without prejudice is available.

The Board of Pensions and other agencies have initiated some steps in "work-site health promotion." That relatively new term covers such matters as a smoke-free work environment; careful attention to ventilation, humidity, etc.; procedures for dealing with substances potentially hazardous to health such as solvents and cleaners; and both physical and schedule access to health and exercise facilities. It can also include "flex" scheduling to reduce family tensions and commuter stress; nutrition counseling and smoke-ender sessions during employment hours; replacement of "junk-food" vending machines; and similar measures.

The Task Force on Health Costs/Policies was engaged in its work at a time of significant transition—and stress—for the denomination. Reunion brought anxieties and uncertainties as well as joy; it also brought a round of extraordinarily intense and stressful work requirements for staff and elected members in denominational agencies and several presbyteries and synods as a new Structural Design for Mission was developed and moved toward implementation, a new national office location was chosen and the relocation from Atlanta, New York, Charlotte,

and Philadelphia begun, and synods and presbyteries developed new configurations.

There is no particular usefulness in an attempt to analyze whether or not the necessary changes and upheavals of the past five years could have been managed in a more "healthy" manner. However, as new structures and styles are implemented in the new location, the General Assembly has a unique opportunity to model work-site health promotion and a health-conscious organizational lifestyle. It will require a vigorous and conscious effort to do so, and the task force recommendations include several designed to provide both the impetus and organizational capacity for such attention.

Advocates for Reform of Health Policy

Health and healing are central to the faith, and the Presbyterian Church must reclaim this dimension in its own life and mission in a fresh way. This is the indispensable basis for the church's witness in the world and its involvement in public policy. The Reverend Bert Keller, a task force member, puts it this way:

> Whatever the church has to offer the wider community always results from the overflow of that reality being experienced by that community of faith. For a ministry of health to be a genuine article, it will necessarily emerge—and not in a contrived way—from the sense of health and healing at work within the congregation itself; and the ministry will be sustained and given content by that inner reality.

It is morally imperative that the United States address the serious health crisis outlined in this paper and in the volume of Briefing Essays—a crisis in which runaway costs flow to a system that has little impact on basic indices of health status and leaves large numbers of Americans with little or no access to health care, including the most vulnerable among us.

In the best of the Reformed tradition, reflected in Calvin's writing, we recognize government as a legitimate instrument to see that those in need are cared for. This may mean that in this nation as in many others, the government could become a provider of services. But at the minimum it means that government must establish the policies and guarantee the means by which all the nation's people will have access to quality health care in a manner that reflects prudent and effective use of resources. As one of the participants in the Montreat consultation of pastors and health professionals put it: "The church's advocacy is not a matter of partisan policies but a moral imperative springing from a Christian understanding of justice and Christ's call to heal."

This nation, with its abundance of resources, skills, and technology

can provide health care for all of its citizens. We have it in our power. The potential is already in place, but the realization is impeded by a complex series of traditions, values, and interests and the absence of the political will to confront and change them. As part of the larger community, the Presbyterian Church (U.S.A.) must bring its vision, values, and sense of justice and compassion to the discussion and solution of these problems at a local, regional, and national public policy level.

Joseph A. Califano, Jr., former Secretary of Health, Education and Welfare and author of *America's Health Care Revolution*, described the situation and the challenge in a vivid illustration in the *New York Times* in March 19, 1988:

> Picture our health-care system as a mountain-climbing team struggling to scale an extremely steep cliff en route to a Mount Everest of quality care for all.
>
> The lead climber is our spectacular scientific genius and superb doctors and medical centers. But then come those who have lost their footing. One dangling climber is the hospitals, with the empty beds. Another is technology, swinging loose on the rope, unbridled by considerations of the relationship of cost to benefit. Next come lawyers and judges, dragging the team down with malpractice litigation. Then the enormous load of patient expectations, crying out: Do something, Doctor, up to the limit of my health insurance—and don't hold me responsible for my own health. Finally, comes the politician, pandering to providers, needlessly adding to the cost of care.
>
> Our lead climber must negotiate this slippery cliff in a blinding snowstorm of uncertainty about which medical and surgical procedures truly affect the medical outcome for patients. In a sense, it's remarkable that our health-care system is still scaling the cliff. But it cannot hope to reach the heights of quality care for all unless we get all members of the team to do their share. Bluntly put, we are talking about the continued viability of America's top-quality medical system.
>
> Whether we maintain and enhance that system—and make it available to all our citizens—is not a decision to be left in the hands of physicians and politicians. It is a decision for all of us—employers and unions, patients and citizens.

A major focus on prevention and health maintenance must be a basic element in health policy reform. Health policy statements by the 1971 UPC General Assembly and the 1976 PCUS General Assembly called for this. The 1976 PCUS statement explicitly recognized the importance of this approach in relation to those trapped in poverty:

> At its common face with medicine, preventive care includes disease control, early detection and diagnosis, mental health services, pre-natal and well-baby care, and other services. In respect to education, programs in nutrition, basic health instruction, family planning, and counseling are important. . . for the poor, preventive care does what curative medicine cannot do: it breaks the poverty-ill health cycle (*Minutes*, PCUS, 1976, Part I, pp. 204, 206).

There is every reason to seek early intervention for a host of health-related issues as one essential and effective approach to the problem of poverty. Resources invested in prevention—pure water, control of toxic waste, adequate sanitation, control of rodents and overcrowding, addressing substance abuse, and attention to careful and well-planned resource allocation—are not only cost-effective but enhance the health status of the larger community.

Recent General Assemblies have adopted comprehensive actions on the Social and Health Effects of Alcohol Use and Abuse (1986) and on tobacco (1987). Both have strong public policy sections and advocacy on these issues should be continued as part of an overall strategy to focus on health maintenance and prevention.

Research and prevention measures in regard to Acquired Immune Deficiency Syndrome (AIDS) should be strongly supported. The catastrophic effects of this disease have yet to reach their peak. More than half of all those diagnosed since 1979 have died. Those with the disease range across the social and economic spectrum: men, women, infants and children, hemophiliacs, young gay males, intravenous drug abusers (who make up over 50 percent) and persons who have become infected by their sexual partners, those who have contracted the disease through blood transfusions, and others. The potential demand on health care resources because of this disease is enormous; indeed, it is already evident, though the spread of the epidemic is in its early stages. A March 22, 1988, report indicates that "the flood of AIDS cases" is a major factor in the "extraordinary shortages of beds, workers and money [in New York's health care system] that are curtailing access to treatment and jeopardizing the quality of patient care."

Focus on prevention and health maintenance and on personal responsibility for health are important areas of reform for health policy because they will both improve the health of Americans and reduce use of the costly curative care medical system. But illness, accident, and death will not disappear and nearly everyone will require curative care as well as preventive care. How can equitable access to it be assured while quality care is maintained and costs are kept within prudent limits? In these discussions, highly sensitive issues of the organization and financing of the nation's health system arise.

The House Select Committee on Aging released its *World Health Systems Report* in May of 1984, early in the work of the task force. Its purpose was to provide description and data for the United States on the health policies and systems of other industrialized nations with values similar to those of the United States. Through study of this report and a major seminar on the Canadian system, the task force sought

insight as to how the United States might reform health policies to improve quality of care, breadth of access and contain costs. In the light of the spiritual and theological values of the Christian faith as outlined in this report, the Public Policy section of the task force examined the economic factors and operational values in health and medical care delivery in our nation. Some of the results are incorporated in the "Briefing Essays" which supplements this report. The recommendations of the task force to the 200th General Assembly (1988) include a number of general principles and initial directions looking toward fundamental structural changes.

The specific outlines of a reformed health care system can only emerge through a process of open public dialogue and political debate. The manner in which health and medical delivery has developed in the United States and the political and economic interests at work make it difficult to foresee any easy transference from the systems of the six nations studied to our own. In commentary on the domination of the political process regarding health by health-care providers, Joseph Califano reports: "During the two years leading up to the 1986 elections, those in the health-care industry channeled more than $8.5 million through various political action committees to members of Congress. Next to financial services, this is more than any other industry—more than the handgun and tobacco lobbies, the oil companies and the one hundred largest defense contractors. And that $8.5 million does not include direct contributions made by doctors and hospital administrators."

Many have contended for years that the cost-plus reimbursement for hospitals and the prevailing fee-for-service pattern of payments for doctors in the original Medicare program provided no incentives to provide care efficiently and were an invitation to runaway costs. Indeed, President Johnson sought to change these provisions in 1968, warning that without change, health costs could reach $100 billion by 1975. (Though he was ridiculed for the projection, 1975 costs actually exceeded $130 billion.)

Similar questions are now being raised about some of the cost-containment strategies. In a recent issue of the *New England Journal of Medicine*, Alan Hillman, MD, MBA, raised the question, "Do financial incentives used by health maintenance organizations (HMOs) to restrain the use of health care resources represent a conflict of interest between physicians' concern about their income and their concern about their patients?" As health maintenance organizations were formed to promote a preventive focus, thus lowering the higher costs of later expensive curative interventions, the instinct for income maintenance may indeed represent a conflict, thus raising significant ethical issues.

In spite of the difficulties, we must press for agreement that a government of the people has the responsibility to promote health and ensure health care for all its citizens. In its foundational report on universal health care in 1983, the Government of Canada stated,

> The government of Canada believes that a civilized and wealthy nation . . . should not make the sick bear the financial burden of health care . . . the cost of care should be borne by society as a whole.

The current concern for health policy and containment of health care costs should include an open, national debate around this value in our own nation. Given the rich diversity of resources, gifts, and talents possessed by this nation and its people and our professed values, we can and must develop a more just and caring system of health care for all Americans.

Many Presbyterians are well-positioned to influence the directions this nation takes in response to the crises in health and medical care. They are administrators, physicians, managers of health and reimbursement mechanisms, health professionals at every level. In communities across the land, health policy and services can be influenced, developed, or rearranged by Presbyterians who join with their neighbors to seek just and compassionate solutions, based on the clear commitment to the provision of health resources for all.

SUMMARY

Because it is the body of Christ, the church is called to be a community of health and healing in every level and location of its common life, seeking to live out, sustain, and promote health within its own life and within the wider human community. The body is not "spiritualized" or disembodied. In Christ, it is whole. It does not simply retreat into "sacred space" but models health in its own life. We are called in our life as a community of faith to insure equity in personnel policies and promotion of a healthy working environment. The church creates a wholesome spiritual, liturgical, relational, and programmatic space for persons of all kinds and conditions. We are called to proclaim and serve the purposes of a sovereign, health-giving God, resisting and reforming that which makes for injustice or that thwarts healthy life within a just and healthy social and natural environment. The church joins with others in direct service of the health and justice needs of persons around the world, particularly the powerless, poor, and oppressed. We are called to become vigorous advocates and supporters of public policies and programs that mark a just and healthy common order.

We are clearly and unapologetically for a national, regional, and local health policy that insures justice for all, shows mercy in the way in which

we care for the least of our brothers and sisters, and that enables us to walk humbly with the God we know in Jesus Christ. We profess a Christ who came that humanity may have life, and that more abundantly; and a faith that makes us and those whom we serve whole.

Appendix A

Biosketches of the Task Force

Task Force Members

Howard L. Bost, MA, PhD—Former Assistant Vice President, University of Kentucky Medical Center, Lexington, Kentucky; Specialty in Health Economics; retired.

The Rev. Emily Chandler, MS, RN—Graduate Studies, Claremont School of Theology, Claremont, California; Psychiatric Nurse Practitioner.

Stephen C. Crane, MPH, PhD—Program Director of Pew Health Policy Doctoral Program, Assistant Academic Vice President-Health Affairs, Boston University, Boston, Massachusetts.

Gordon K. Douglass, PhD—Vice President and Dean of Franklin and Marshall College, Lancaster, Pennsylvania; International Economist; Advisory Council on Church and Society; Presbyterian Elder.

The Rev. William T. Hancock—Pastor, Northminster Presbyterian Church, St. Louis, Missouri.

Martha Hargraves, MPH—Minority Intervention Specialist; Centers for Disease Control, Atlanta, Georgia; Committee on Women in the Church; Presbyterian Elder.

The Rev. Ann L. Hayman—Director of the Mary Magdalene Project, Reseda, California; Advisory Council on Church and Society.

The Rev. Carl G. Howie, PhD, ThM—President, Center for Theological Exploration; Old Testament scholar; Treasure Island, Florida.

The Rev. Albert H. Keller, Jr.—Associate Professor of Ethics, Department of Family Medicine, Medical University of South Carolina, Charleston, South Carolina.

Annette Kriner, RN, MRE—Missionary, Kinshasa, Zaire, on furlough 1977-1978; organized health centers, including the first urban health center in Zaire; GAMB representative.

John W. MacKenzie, MD, ABFP—Physician; Medical Director Blue Care Network, East Michigan; Presbyterian Elder.

The Rev. Max Maguire—Executive Director, Health Care Ministries, Abbott Northwestern Hospital, Minneapolis, Minnesota; President of Association of Clinical Pastoral Education (ACPE).

Elisabeth McSherry, MPH, MD—Physician, Coordinator of the National VA Pilot Hospital Clinical Management Control System and of Health Promotion Programs, VA Medical Center, West Roxbury, Massachusetts; Presbyterian Elder.

C. William Metcalf, MD, FACP—Physician; Specialty in Internal Medicine; Medical Director CliniCare HMO; Program Agency Board; Rockford, Illinois.

*Thomas B. Morehart, PhD—Associate Dean of the College of Business Administration and Economics, New Mexico State University, Las Cruces, New Mexico; Member of Benefits Committee of the Board of Pensions; Presbyterian Elder.

Edward L. Perrine, MPH—Executive Vice President, MGT of America, Inc., Tallahassee, Florida.

Haynes Rice, MBA, FACHE—Hospital Director, Howard University Hospital, Washington, D.C.; former Deputy Commissioner, Department of Health, City of New York; Presbyterian Elder.

The Rev. John D. Sharick—Executive Presbyter, Eastminster Presbytery, Youngstown, Ohio; Board of Trustees; Adjunct faculty Pittsburgh Theological Seminary.

*The Rev. Joy D. Skeel, RN—Associate Professor of Medical Humanities, Medical College of Ohio; Director, Program in Medical Humanities, Departments of Psychiatry and Medicine, Toledo, Ohio.

The Rev. Marilyn Washburn, MD—Physician; Community Health Faculty, Emory University; Staff Physician, Dekalb Grady Clinic, Grady Memorial Hospital, Atlanta, Georgia.

The Rev. Jan Willette—Executive Presbyter, Presbytery of San Gabriel, Azusa, California; Member of the Board of Pensions.

Sterling B. Williams, PhD, MD—Physician; Professor and Director, Department of OB/GYN, Harlem Hospital, Columbia University, New York City; Council on Theology and Culture; Presbyterian Elder.

Staff Team

* Harold Clark, PhD—Psychologist; former Vice President, Benefits, Board of Pensions.

Paul S. Crane, DSc, MD—Physician, Director Health Ministries, Division of International Mission, General Assembly Mission Board.

Gwen Crawley, MA—Associate for Health Ministries, Program Agency; former Executive Director, Southeastern Minnesota Health Systems Agency.

The Rev. Dean H. Lewis—Director, Advisory Council on Church and Society.

The Rev. John S. McAnlis, MBA—Homes Administrator for the Board of Pensions.

The Rev. Thomas F. Mainor—Staff Associate; former Hospital Chaplain and Medical School Faculty, Norfolk, Virginia.

Abbe M. Effron—Administrative Assistant.

Consultants

**Robert Barrie—Former Associate Director of the Washington Office of the United Presbyterian Church.

Stanley B. Jones—President, Consolidated Consulting Group, Washington, D.C.; former Director, Senate Subcommittee on Health.

Seminary Representatives

The Rev. Homer Ashby, PhD,—Professor of Pastoral Care, McCormick Theological Seminary, Chicago, Illinois; former Clinical Staff, Center for Religion and Psychotherapy, Chicago, Illinois.

The Rev. Louis Weeks, PhD—Dean of the Seminary, Paul Tudor Jones Professor of Church History, Louisville Theological Seminary, Louisville, Kentucky.

Presbytery Representatives

The Rev. R. Thomas Beason—Pastor, Lakeview Presbyterian Church, St. Petersburg, FLorida.

*Joan Blankinship, BSN—Planning Coordinator, State Health Department of Vermont, Burlington, Vermont; former Executive Director, Caledonia Home Health Agency, St. Johnsbury, Vermont.

The Rev. William M. Clark—Deputy Executive of Southwest Florida Presbytery, St. Petersburg, Florida.

The Rev. Joseph Cochran—Executive Presbyter, Eastern Oklahoma Presbytery, Tulsa, Oklahoma.

The Rev. Lawrence Cole—Pastor, Community Presbyterian Church, West Covina, California.

The Rev. Douglas G. Edwards—Associate for Congregational Ministries, Presbytery of San Gabriel; Pastor, Westminster Presbyterian Church, Temple City, California; Licensed Marriage, Family and Child Counselor.

The Rev. Kenneth G. Y. Grant, MBA—Executive Presbyter, Presbytery of Boston, Framingham, Massachusetts; Member, American Association of Pastoral Counselors.

The Rev. John C. Kauffman—Retired Presbyterian Pastor serving as Health Coordinator, Presbytery of Minnesota Valleys, Willmar, Minnesota, and Chaplain in State Mental Hospital.

*Suzan Krauland, MPH—Program Administrator, Living-at-Home Program, Montefiore Hospital, Pittsburgh, Pennsylvania.

The Rev. Robert Lambert—Executive Presbyter, Presbytery of Minnesota Valleys, Willmar, Minnesota.

The Rev. Archie V. Lawrence—Chaplain, Pastoral Care Ministry, Hillcrest Medical Center, Tulsa, Oklahoma.

John A. Minnielly, MD—Physician; Associate Lab Director and Chief of Anatomic Pathology, St. John's Medical Center, Tulsa, Oklahoma; Presbyterian Elder.

The Rev. William R. Newman—Clinical and Executive Director, Seacoast Counseling Centers of Danvers and Gloucester, Massachusetts; President, Stress

Management Vacations International, Inc; Licensed Psychologist.

Martha J. Perry, MA MSW—Associate Executive Presbyter, Aging and Strategy, Pittsburgh Presbytery, Pittsburgh, Pennsylvania.

*The Rev. Lowelle Simms—Former Interim Executive Presbyter, Eastern Oklahoma Presbytery.

Carolyn J. Smith, RN, MS—Director, Allegheny Home Care and Allegheny Home Care Hospice, Allegheny General Hospital, Home Care Division, Pittsburgh, Pennsylvania.

The Rev. John M. Wall—Co-chairperson, Joint Task Force on Health, Northern New England/Boston Presbytery, Haverhill and Framingham, Massachusetts.

The Rev. Jane Wick—Executive Presbyter, Presbytery of Northern New England, Haverhill, Massachusetts.

Organizational Chart
Task Force on Health Costs/Policies

John D. Sharick, Task Force Chairperson

Public Policy Subgroup

Howard Bost, Stephen Crane, Gordon K. Douglass, C. William Metcalf, Edward L. Perrine, Haynes Rice, Sterling B. Williams.

**Robert Barrie, Dean H. Lewis, Stanley B. Jones.

Vocations and Pensions Subgroup

Martha Hargraves, John W. Mackenzie, *Thomas Morehart, Max Maguire, Jan Willette, *Harold Clark, John S. McAnlis.

Theology and Ethics Subgroup

Emily Chandler, Carl G. Howie, Albert H. Keller, Jr., *Joy D. Skeel.

Thomas F. Mainor

Mission and Ministry Subgroup

William T. Hancock, Ann L. Hayman, Annette Kriner, Elizabeth McSherry, John Sharick, Marilyn Washburn, Paul Crane, Gwen Crawley.

Presbytery Partners Subgroup

Presbytery of Boston/Northern New England: *Joan Blankenship, Kenneth Grant, William Newman, John M. Wall, Jane Wick.

Presbytery of Eastern Oklahoma: Joseph Cochran, John Minnielly, Archie V. Lawrence, *Lowelle Simms.

Presbytery of Minnesota Valleys: John Kauffman, Robert Lambert.

Pittsburgh Presbytery: *Suzan Krauland, Martha Perry, Carolyn Smith

San Gabriel Presbytery: Lawrence Cole, Douglas Edwards

Southwest Florida: Tom Beason, William Clark

Seminary Partners

Homer Ashby, Louis Weeks

Appendix B

Presbytery Partners

Each of the presbyteries formed a health committee which explored needs and the ways in which they might be addressed. All received some level of staff support from the presbytery as well as a $5,000 a year grant from the task force to use for programmatic purposes.

While their activities varied with the part of the country and individual concerns, in general they began their work initiating projects, then became interested in the individual responsibility for personal health. As they studied health issues in their communities they moved more toward advocacy.

Several ideas begun by one presbytery were picked up and modified by another. Mutual projects were also undertaken to develop health and healing worship material, survey medical benefits on non-clergy employees and conduct health risk assessments at presbytery meetings and among interested churches.

Boston/Northern New England Presbyteries

These two presbyteries, one rural and the other urban, joined forces in a number of activities:

A Health Risk Assessment of persons attending a joint presbytery meeting; a project through the Maine Mission at the Eastward (MATE) which provides counsel and care for pregnant teenagers; a Good Grief Center at the Caledonia Home Health Care Agency, providing counsel and group support to the bereaved and a series of classes ("Wholehearted Living") to reduce risk factors in heart disease and to promote spiritual growth; a Health Promotion Program at the Roxbury Presbyterian Church, with various activities such as aerobic classes and a health fair; and a Chaplaincy Support Program at the Needham Presbyterian Church to help chaplains and otherwise to promote adult health and spiritual integration. The presbyteries also provided worship and workshops on health issues at a joint presbytery meeting in the fall of 1986.

Eastern Oklahoma Presbytery

Eastern Oklahoma, centered in the Tulsa area, worked ecumenically on a community based day shelter for homeless persons which provided health

*former member
**now deceased

services and health education as part of the 87,000 visits to the center.

Presbytery of Minnesota Valleys

Minnesota Valleys Presbytery in rural west central Minnesota is made up of small churches, many of whose members are elderly and hard hit by the farm crisis.

The presbytery surveyed congregations to learn about benefits to church employees and with the Committee on Ministry, planned a follow-up conference which resulted in exploration of securing health services through health maintenance and preferred provider organizations.

Congregations were supplied materials and encouraged to have a Health Sunday to make members more conscious of both physical and spiritual health and what is a healthy congregation.

The church's support of the elderly was surveyed and programs were planned, including participation in the Gift of a Lifetime for older volunteers and a workshop on "Who Lives, Who Dies, Who Decides."

Pittsburgh Presbytery

Pittsburgh Presbytery's initial mission was divided into four designs:

- Develop, implement and evaluate a variety of models for caregivers support groups. This was actively pursued in fourteen different churches and in two hospitals.

- A comprehensive healing ministry and health care plan for theological students at the Pittsburgh Theological Seminary, with care delivered in the East Liberty Family Health Care Center, a church-sponsored health care center for the immediate community.

- Establishment of a model health cabinet within a local church. The Beulah Presbyterian Church in Pittsburgh was selected to develop this model. Taking its lead from the response from the congregational survey, the health cabinet developed classes, groups, and programs tailored to the health and healing needs of the congregation.

- Began the development of a plan to help health care professionals who deal with life and death situations, help clergy persons become more comfortable in today's health care world and establish a mechanism of ministering to ministers.

Whereas the Pittsburgh Presbytery Health Task Force initially began its work focusing on designs, it also accomplished a great deal more. Of major importance is the background paper it collaborated to write entitled "The Church as a Healing Community." This paper presents a theological framework for the church's involvement in healing, an explanation of the holistic health care approach, an analysis of the nation's health care system, an analysis of the health care provisions for the poor, and suggestions as to how the church can impact the health care system while becoming itself a healing community.

This presbytery encouraged many of its congregations to look at their own health ministry, and as a consequence, many exciting ideas are coming to fruition.

In September 1987, the Health Task Force of the presbytery administered a HRA (Health Risk Assessment) to all ministers attending the fall meeting.

The presbytery is also in communication with the Board of Pensions about developing an experiment with some form of HMO or PPO plan to serve members of the Pension Plan in the presbytery.

Presbytery of San Gabriel

This presbytery has produced a videotape for training deacons in the care of parishioners who need help in the face of illness, recovery, or death itself. The presbytery helped sponsor, through an ecumenical effort involving thirteen churches, the Mid-Valley Crises Center, directed primarily at the older Asian population. They are also attempting to establish a Preferred Provider Organization (PPO) for employees of the Presbyterian Church under the benefits plan of the denomination. In addition, many of the concerns of the older adult advocate programs are health related.

Presbytery of Southwest Florida

The main focus of Southwest Florida has been the Johnnie Ruth Clarke Health Center, which is housed in Lakeview Presbyterian Church in St. Petersburg. This holistic center provides spiritual counseling, health care, and referral services in a low income Black area. The presbytery prepared a twenty-minute videotape to introduce the concept of such centers to other congregations. More recently, they embarked (with Eckerd College as partner) on a health promotion program, with a pilot project for clergy and presbytery staff in the Tampa Bay area who will take a computerized Health Risk Appraisal, have a medical check up, develop a personal health plan, and participate in workshops on specific health issues.

National Capital Presbytery

In the presbytery located in our national capital, a health ministries division was formed in 1984. Its work, often ecumenical, has included workshops, educational courses and (or) training in parish programs of substance abuse, adolescent stress and suicide, AIDS, equipping church officers and parish visitors to reach out to persons in need and developing a network among other programs within the nation's capital, including genetic counseling for pastors, an interfaith volunteer health care network and holistic health center. In 1988 they plan to publish a directory of health ministry programs across the country.

It is the only presbytery health ministries program in the denomination with its own administrative budget and paid staff.

Seminary Partners

The initial question posed to Louisville and McCormick Seminaries was "What would a seminary of the Presbyterian Church (U.S.A.) 'look like' if it took seriously the health and healing ministry of the Christian faith?" Curricula, lifestyle of students and faculty, and ethical issues related to health and health care were studied.

Louisville Seminary

At Louisville Seminary an emphasis was placed on physical health and stress reduction through exercise. Also field placement assignments provided

seminarians opportunities to make presentations on health and healing and focus on issues of wholeness.

A new course began in the fall of 1987 using the task force's briefing papers. Several chapel services were planned around "sabbath" and "healing" and additions were made to the library of books and periodicals on the subject.

McCormick Seminary

McCormick formed a wellness committee and began with a faculty, administration, and students retreat to study health and wellness, ways of increasing space for such concerns, and a particular program to lessen the "spring quarter blues."

They investigated National Wellness materials, such as Health Risk Assessment for all students and alternatives ways of providing health insurance for seminarians and their families. In 1988 a workshop was planned using Loren Mead of the Alban Institute discussing how to balance one's call and one's health. Finally, a wellness statement has been drafted which will be presented to the board for possible adoption. It states, "Wellness is the ability to cherish the gift of life given to us and make optimal use of it."

As graduates of these two seminaries enter the leadership of the church, they will have more information, models, and motivation to bring to health care needs of church employees and members. A further benefit hoped for is the increased durability and flexibility of clergy involved in their own health care.

Appendix C

Presbyterian Panel Findings
January 1986 Questionnaire

	Members	Elders	Pastors	Sp. Clergy PCUSA Rel. Min.	Sp. Clergy Non-PCUSA Rel. Min.
Number	1,160	883	1,085	311	319
Number Responding	730	606	767	223	224
Percent Responding	66%	69%	71%	72%	70%

The January 1986 questionnaire was developed for and in consultation with the Health Costs/Policies Task Force of the Advisory Council on Church and Society. That task force is concerned about the health of Presbyterians. They are interested in finding out the health status of Presbyterians and how Presbyterians relate religion and health. They are also concerned about the cost of medical care and want to find out what panelists think about the various proposals to limit costs and improve health care.

Presbyterians Are Happy and Healthy

In general, Presbyterians are a happy lot, in fact, somewhat happier than the general public. Thirty-four percent of the members and 38 percent of the elders and clergy said they were "very happy," and only 8 percent or less of

any sample said they were "not too happy." That compares to 13 percent of a national survey taken in 1983 who said they were "not too happy" and 31 percent who said they were "very happy."

Similar results are obtained when the panelists are compared to the general public in terms of their health. Thirty-five percent of the members and 45 percent or more of the elders and clergy say their health was "excellent" and only one percent or less said their health was "poor." Among the general public (1972-1982) 31 percent said their health was "excellent" and 7 percent said it was "poor."

Healthy Presbyterians Are Happy Presbyterians

Not surprisingly, health and happiness are related. The better you think your health is the more likely you are to say that you are happy. For example, 55 percent of those in excellent health are "very happy," compared to 15 percent of the members in fair or poor health who report that they are "very happy." Happiness is also related to commitment to the Presbyterian church. Among members and elders, the more committed persons are to the Presbyterian church, the happier they say they are.

Concern for Health Has Resulted in Some Changed Behavior

Concern for their health has resulted in a large percentage of Presbyterians having changed their diet—from 55 percent of the elders to 68 percent of the clergy in PCUSA specialized ministries. A large percentage have also "started to exercise regularly"—43 percent of members, 41 percent of elder, and 52 percent of the clergy.

In addition, this concern for their health has caused 28 percent of members, 26 percent of elders, 30 percent of pastors, 27 percent of clergy in PCUSA specialized ministries and 29 percent in non PCUSA specialized ministries to "increase the time I spend in prayer-Christian meditation." A slightly smaller percentage said they have begun to spend more time with family and friends.

Panelists Smoke Less Than the General Public

There is very little difference among laity and clergy in the percentage that presently smoke or who have ever smoked. However, there is a large difference between panelists and the general public. A significantly smaller percentage of Presbyterians than the general public smokes cigarettes. Presently only 14 percent of the members, compared to 28 percent of the general public (based on a 1984 Lou Harris Poll) say they smoke cigarettes. Over 50 percent of the panelists reported that they have never smoked a cigarette. What is interesting is, of the Presbyterians who have quit smoking, a very large percentage smoked more than ten years (60 percent of members, 68 percent of elders, 40 percent of pastors, and 54 percent of each group of specialized clergy).

Views of Panelists Towards General Assembly Involvement Are Mixed

As expected, the views of the panelists on whether the General Assembly should take action to support an activity varies according to the activity. The attitudes of the laity and clergy are more similar than may have been expected.

Table 1: PERCENTAGE OF PANELISTS WHO SUPPORT OR OPPOSE ACTION BY THE GENERAL ASSEMBLY TO SUPPORT THE LISTED ACTIVITIES.

Question: Please indicate if you would favor action by the General Assembly to support:

	Members	Elders	Pastors	Sp.Clergy PCUSA Rel. Min.	Sp. Clergy Non-PCUSA Rel. Min.
	yes no	yes no	yes no	yes no	yes no
Mandatory jail sentences for people convicted of selling drugs to minors	93%4%	94%3%	90%4%	89%5%	4%9%
Raising the drinking age to 21	*86%8%*	86%10%	84%11%	79%13%	77%17%
Offering reduced insurance rates for people who don't smoke	84%7%	87%6%	91%5%	89%6%	92%4%
Laws that limit the amount of money awarded in medical malpracticecases	80%7%	84%6%	83%7%	82%7%	86%6%
Offering reduced insurance rates for people who wear seat belts	80%8%	82%7%	86%6%	85%5%	88%3%
Elimination of subsidies to industries that produce hazardous substances	76%10%	78%10%	87%6%	84%6%	89%6%
Penalties for doctors or hospitals who are found to have refused emergency treatment to people unable to pay	74%9%	71%10%	78%7%	77%9%	79%10%
Participation in wellness programs	71%9%	73%7%	83%6%	78%6%	80%8%
A ban on all cigarette advertising as recently proposed by the AMA	70%19%	66%24%	74%17%	75%18%	73%19%
Control on fees doctors and hospitals may charge for treatment.	61%19%	58%21%	64%14%	66%10%	70%16%
Creation of a national health care system that would better assure access to care by the poor, the disabled and young adults—the groups least served by today's system	45%27%	41%32%	60%16%	71%13%	68%12%

Health Care Should Be Available to All Without Regard to Ability to Pay

About 70 percent of the laity and about 85 percent of the clergy either "strongly agree" or "agree" that health care should be made available to all without regard to ability to pay. Less than 10 percent of any sample either "disagrees" or "strongly disagrees" with that statement.

National Health Care System Not Supported by Panelists

Less than 10 percent of the members and elders responded "definitely yes" when asked if a national health care system should be established. However, 19 percent to 31 percent of the clergy said "definitely yes." Interestingly, the specialized clergy are both the most likely to say "definitely yes" (23 percent or 24 percent) and the most likely to say "definitely not" (31 percent and 36 percent). This, then, would appear to be a very divisive issue.

A Large Percentage of Panelists Would Reduce Cost by Postponing Visit to MD

A disturbing finding was a possible willingness of panelists to neglect their health to save medical expenses. From 23 percent to 33 percent of the panelists said either "definitely yes" or "probably yes" they would delay seeing a physician unless they were severely ill. That is almost the identical percentage that said "definitely yes" or "probably yes" to paying more of the cost of health care themselves. Does that say something about our values, or can we hope

that it means that some panelists define "severely ill" in some very loose manner?

Faith Seen As Making Largest Contribution to Health

When the panelists were asked what contributes the most to the total health of an individual, the largest percentage said faith, followed by genetics and then environment. The only exception was with the clergy in specialized ministries not related to PCUSA, which put more emphasis on environment (20 percent) than on genetics (12 percent).

Spiritual Health Is Seen As Supportive of Physical Health

Hardly anyone—2 percent or less—"strongly agrees" or "agrees" that a person who is ill has done something that displeases God. Similarly, very few panelists—10 percent or less—"strongly agree" or "agree" that religion has very little to do with how a person feels every day. However, 90 percent of the panelists agree that spiritual health is supportive of physical health, and a similarly large percentage of panelists think that trying to maintain your health is a Christian responsibility.

Almost One Half of Pastors Have Attended a Faith Healing Service

Pastors are the most likely (46 percent) to say that they have attended a faith healing service. A slightly smaller percentage of clergy in specialized ministries have attended such service. Only 16 percent of members and 18 percent of the elders have attended faith healing services. For all groups the most likely place to have attended a faith healing service was a local church.

The Congregation Is Seen As Having an Important Role in Health and Wholeness

Very few panelists—6 percent or less—are willing to say that health and wholeness is not an important part of their congregation's life. From 55 percent to 69 percent see this dimension as either "very important" or "important." The remaining 8 percent to 18 percent are either undecided or only see the dimension as "somewhat important." Around 64 percent of the members and elders and 84 percent of the clergy say they would expect "educational opportunities, such as wellness, health care promotion and (or) preaching on physical health" in congregations that take health and wholeness seriously.

Panelists Satisfied with Their Health Care

Without question the panelists are "very satisfied" or "satisfied" with the availability of medical care for themselves or their families and the quality of care provided by their physicians. Only 10 percent or less register any sign of dissatisfaction. On the other hand, only around 40 percent of the members and elders and 33 percent of the clergy are "very satisfied" or "satisfied" with the total cost of health care. In all samples the panelists are slightly more satisfied with the quality of care provided by their physician than by their pastor. What may be of some concern is the fact that the youngest panelists are the least likely to say they are "very satisfied" or "satisfied" with the quality of care provided by the pastor or the congregation.

Most Say They Do Not Know Why
God Allows Terrible Things to Happen

The panelists were also asked why they thought a merciful and all-powerful God allows terrible things to happen. The three reasons that at least 10 percent of the panelists agreed with are listed below with the percentage of each sample agreeing.

Table 2: WHY GOD ALLOWS TERRIBLE THINGS TO HAPPEN

Question: People often wonder how a merciful and all powerful God can allow terrible things to happen, such as the recent airline crashes and the painful mental and physical illness some people suffer. Which statement comes closest to your view of why these things happen?

	Members	Elders	Pastors	Spec. Clergy PCUSA Rel. Min.	Spec. Clergy Non-PCUSA Rel. Min.
We don't know why these things happen, but we know that God is able to use them for good.	47%	47%	55%	54%	43%
People, not God, cause these things to happen, but God is with us.	27%	30%	23%	24%	22%
It is a part of the human process.	13%	12%	12%	11%	22%

A complete report of these findings has been sent to all synod and presbytery offices. A report can be purchased from the Research Unit for $3.00.

Appendix D

CONSULTATION FOR HEALTH PROFESSIONALS AND PASTORS

Montreat, North Carolina, August 14-16, 1987

Forty Presbyterian health professionals and their pastors brought to a weekend retreat August 14-16, 1987, at Montreat, North Carolina, a wide range of concerns and insights to explore with the Health Costs/Policies Task Force. The consultation was a first for the Presbyterian Church (U.S.A.) in exploring the stress and conflicts faced by its own Christian health care workers and identifying ways which the Presbyterian Church (U.S.A.) can play a stronger role in health and healing in today's society as well as provide support to its members who serve in a broad range of health care occupations.

Concerns ranged from questions of access and equity in health care, particularly for the poor, problems of the "faceless physician and numbered patient," to ethical issues relating to who decides, and the need for a sound theology of mortality. Issues of high tech versus low touch, linking a healthy body to spirituality, global interdependence, and the special needs of vulnerable groups such as homeless, persons with AIDS, elderly, poor children all surfaced. The diversity of interests found unity in the conviction that these were important issues for Christians to address. The group affirmed that the church, corporately as well as through individual members, could and should

play a significant role in seeking solutions. It was noted that the church's advocacy on these questions was not a matter of partisan politics, but a moral imperative springing from a Christian understanding of justice and Christ's call to heal.

The global nature of the church's health ministry was acknowledged through recognition that all humans share the need for health and wholeness and that events and decisions in one part of the world can so strongly impact another. The issues of empowering persons, educating to promote health, providing health services, and seeking healing and wholeness are universal.

Areas of value conflicts in vocational pursuits were numerous. Conflicts between the various "actors" were cited: the doctor's concern for autonomy and doing all possible for the patient in the light of legal liability, limitations on payment which influences decisions on tests, treatment and length of stay, family requests for withholding treatment or differing views of the patient's needs held by nurses or peer reviewers.

There was concern over the erosion of altruism among medical students, the shortage of and burnout of nurses who found their orientation toward advocacy for and holistic approach to patient care difficult to carry out in an impersonal high tech system.
While acknowledging the imperative for the church as an employer to provide health and retirement benefits to all employees, a conflict was seen over the cost this would pose on small congregations.

The present medical care system does not always incorporate the pastor's potential to play a healing role, accept patient's self perceptions or respect racial and cultural diversity. A need was seen to demystify medicine and acknowledge all gifts which could contribute to healing including self healing, the ministries of lay and clergy persons and such factors as humor, the environment, plants and animals.

Those present recommended that the task force push for a "health council" or liaison mechanism at the national level of the Presbyterian Church (U.S.A.) in order to provide linkage for the work within the various ministry units and with the rest of the church. Of particular concern was increasing understanding of the impact of lifestyle on the stewardship on one's body, a gift from God, and the role of compassion and caring in promoting healing and reconciliation with God and others.

The consultants urged the church to speak boldly at all levels relating to access and quality services for those squeezed out of the present system.

Those attending felt personally invigorated and affirmed in the shared fellowship and the interest of their church in their vocational choices and pressures. Their hope was for continued use of Presbyterian conference centers for similar retreats and for regional meetings coupled with the development of health committees or teams within presbyteries and individual congregations. Networking through organiztions such as PHEWA was considered important and it was hoped that even after the task force officially completed its work that individual members would be committed to assisting presbyteries and congregations interested in making health and healing more central to their being and mission

The participants deemed it important that congregations understand caring and healing ministries as among their major roles and that seminaries help

students understand holistic health. They suggested that the report of the task force be made broadly available to congregations for study.

A high point for most attending was a final worship service in which each of five subgroups, which had met several times during the weekend, prepared and led one segment of the liturgy which reflected on their understanding and hopes for health and healing, and the experience of the weekend.

THE JOURNEY TOWARD LIFE ABUNDANT

THE PARTICIPANTS' INTRODUCTION

This study explores *Life Abundant*, a policy statement of the 200th General Assembly (1988). Through this document, the General Assembly of the Presbyterian Church (U.S.A.) invites you and your community to renew the church's healing ministry.

Your participation in this journey is timely. Medical care costs are rising. The Presbyterian Church is reeling from increased health insurance charges. Health professionals, political leaders, and people like you and me are crying for ethical guidance. Congregations and church organizations are experimenting with new health ministries.

Your response is needed. It is time to start the journey.

LEADERS' INTRODUCTION

Your task as a guide on the journey toward life abundant is to engage the church, through this study program, in a renewal of healing ministries.

You will be leading your group through the 200th General Assembly document, *Life Abundant: Values, Choices, and Health Care.* It asks the Presbyterian Church (U.S.A.) to reclaim its ancient capacity to heal, to make whole.

The five-session study is built upon Mark 5:24b-34. Each session will return to the Gospel story. Activities and discussion will arise from the story. Therefore, preparations will begin with biblical study.

Each of the five sessions requires ninety minutes to complete. You may want to use all five sessions during a leadership retreat. Or, you may wish to gather once a week for five weeks. All segments can be expanded or reduced.

Preparation suggestions for each session are provided. Essential supplies are noted. (Make sure you have plenty of newsprint, markers and tape.) Don't become a lonely guide on this journey. Engage other members of your group in preparation and leadership rolls. Suggestions for engaging other people are offered.

There are additional resources which may help you prepare for and enrich the study. The Task Force on Health Costs/Policies, authors of the *Life Abundant* report, also published *Health Care and Its Costs: A Challenge for the Church,* edited by Walter E. Wiest. Ordering

information can be found in the Resources List on page 83. This study guide will refer to *Health Care and Its Costs* as HC&C.

Other resources can be found in Presbyterian Reformed Education Ministry (PREM). This study is designed to be used in your PREM adult education series.

Session One: The Impossible Health System

AIM:
To introduce this study and its biblical source.
To identify participant expectations.
To gain an understanding of current health system issues.

Shorter Preparation:
+**Read** Mark 5:24b-34.
+**Read** *Life Abundant: Values, Choices, and Health Care.*
+**Gather** news articles that highlight cost of, access to, quality of and theological content of contemporary health care.
+**Ask** an elder or deacon to prepare an opening prayer seeking God's intercession for health.

Longer Preparation
+**Read** "The American Health Care System, 1986" by Stephen Crane and Phyllis Kaye in HC&C.
+**Read** "The Body of Christ and the Human Body" by James Nelson in HC&C.
+**Ask** the director, medical practitioner or social worker at your local Head Start (or other children's poverty program) to join you for this first session. She or he can highlight the plight of children without insurance and access to medical care. If your group is willing to travel, you may arrange to meet at the Head Start (or other program) office. This would introduce your group to a health promotion center and it mission.

Setting:
+**Post** the gathered news articles around the meeting room. Mount the articles on newsprint. Highlight human interest stories. Invite participants to add their own articles for the succeeding sessions. Provide each participant with a Bible and the report, *Life Abundant.* Prepare newsprint for the health coverage survey (see below). Place furniture in a conversational circle.

The First Event:
+**Open** the first session with introductions. Ask each person to share his/her name and a brief statement about what they want to gain from this study. If your

group is larger than twelve, this can become lengthy. Use small sub-groups.

+**Share** *your* goal for this study. Let the group know that the document, *Life Abundant*, was created, in part, out of a desire to renew Presbyterian health ministries.

+**Ask** the elder or deacon to introduce prayer concerns to be highlighted. Invite additions from the group.

+**Ask** a participant to read Mark 5:24b-34. Invite the group to clarify the meaning of the following key words: (A transliteration of the original Greek is followed by its location, chapter and verse. Three or more possible translations are suggested. Find the word that brings alive the passage for your group. Don't hesitate to call on the biblical scholars in your midst for help.)

WORD	LOCATION	POSSIBLE TRANSLATIONS
AIMA	5:25	Blood, hemorrhage, death
PASCHO	5:26	Suffer, endure, desire, passion
IATROS	5:26	Physician, healer, doctor
APTOMAI	5:27	Touch, embrace, hold on
SOMA	5:29	Body, reality (whole), physical
IAOMAI	5:29	Heal, restore, cure
DUNAMIS	5:30	Power, virtue, ability, strength, miracle
PISTIS	5:34	Faith, steadfastness, trust, believe
SOZO	5:34	Whole, made sound, saved, cured, rescued
EIRENE	5:34	Peace, unity, concord, harmony
UGIES	5:34	Whole, sound, wholesome, healthy

+**Write** The group's best translation on newsprint. Post the result. Tell the group that they will be returning to this passage each week.

+**Take** a stretch break. If a participant can lead the group through a quick, low impact, aerobics exercise, do it! If not, invite the group to join you in simple stretching exercises. Talk about it afterwards.

+**Review** the Introduction and Crisis sections of *Life Abundant.* Introduce information from the "The American Health Care System, 1986." Graphically detail the data on newsprint. Do it well. This is your best chance to present factual information.

+**Survey** the group to bring the crisis home. Quickly ask:

1. How many have insurance coverage?

2. How many have a choice of doctor?
3. How many have pharmacy coverage?
4. How many have co-payments for all services?
5. How many must pay fully or proportionately for their coverage?
6. How many will be covered at retirement? If laid off? If divorced?

+**Post** the results. Draw comparisons with the data provided in *Life Abundant.*

+**Invite** the speaker from a poverty based program for children to speak. She or he can put a human face on the statistics. Draw the connections between poverty and health.

+**Point out** that the church is not always the best employer. Many people who work for the church do so without adequate health protection and little health promotion.

+**End** with a prayer circle and an assignment: Read *Life Abundant,* Introduction through Basic Affirmations.

Teaching Tip: For the Reformed community, reconciliation and education walk hand in hand. Each week you are confronting the church's healing ministry through another's experience. This week it was with someone from a poverty program. Later, you will be dealing with a hospital chaplain, politician, health professional and minister. Plan ahead. Prepare the group by sharing your lesson plan and copies of key documents.

Session Two: The Roots of Renewal

AIM: To identify biblical and theological sources of health within the community of faith.

Shorter Preparation: +**Review** The Church's Perspective in *Life Abundant.*
+**Ask** an elder or deacon to prepare an opening prayer.
+**Invite** a hospital chaplain to join you for the Second Event and to prepare a ten-minute presentation on the Christian roots of a healing ministry.

Longer Preparation: +**Read** "Healing Changes Everything" by Albert H. Keller and "A Biblical and Theological Basis for the Church's Health Ministries" by Thomas Mainor in HC&C.

+**Arrange** to meet at a hospital chapel, if your group is willing to travel. This will give the group a "feel" for another health ministry setting.

Setting:

+**Provide** each participant with a Bible. As new people join, provide them with a copy of *Life Abundant.* Place the furniture in a conversational circle. Post the group's translation of Mark 5:24b-34.

The Second Event:

+**Open** the second session with brief introductions. (At least the hospital chaplain is a newcomer!) Ask each person to give her/his name and a passage of Scripture that brings comfort during illness.

+**Invite** prayer concerns and have an elder or deacon pray.

+**Ask** a participant to read Mark 5:24b-34 as "translated" by the group. Discuss the passage using the following questions:

1. What was the nature of the healing sought before she turned to Jesus? Who defined the treatment? Medical professionals? A community of faith? Did she?

2. To what extent was her condition made worse by isolation and social segregation? Was society's condition made better by her isolation? Who, today, is isolated?

3. Can healing be accomplished without touch? Without faith? Whose touch? Whose faith? The healer's? The patient's?

4. Can one who heals do so without depletion? Could you? A hospital chaplain? What does that mean for the church?

+**Record** the group's consensus on newsprint. Take a stretch break with aerobics, if possible.

+**Ask** a hospital chaplain to talk about the roots of a healing ministry. Invite questions of clarification and debate.

+**Ask** the group to complete the following sentence: "Healing comes of . . . . "

Record and post answers on newsprint.

+**End** with prayer and an assignment: Read Background Commentary to the Policy Statement and review Basic Affirmations in *Life Abundant.*

Session Three: The Call for Healing Hands

AIM: To identify the church's prophetic, peacemaking ministry in the midst of the contemporary health crisis.

Shorter Preparation:
+**Review** the Basic Affirmations section in *Life Abundant.*
+**Read** "Ethical Implications of the Revolution in Health Care Finance" by Gordon Douglass in HC&C.
+**Invite** a local politician to join you for the Third Event and to prepare a presentation on the Christian roots for health policy.

Longer Preparation:
+**Read** "Theology and Ethics: A Feminist and Liberation Theology Perspective" by Emily Chandler in HC&C.
+**Read** "Medical Ethics and Christian Ethics" by Walter Wiest in HC&C.

Setting:
+**Provide** each participant with a Bible. If new people arrive, provide them with a copy of *Life Abundant.* Place the furniture in a conversational circle. Post the group's translation of Mark 5:24b-34 and the sentences "Healing Comes of . . . " from the Second Event.

The Third Event:
+**Open** the Third Event with brief introductions. Ask each person to share his or her name and one health care agenda item that the church has with the state.
+**Invite** prayer concerns. Ask an elder or deacon to pray.
+**Ask** a participant to read the group's translation of Mark 5:24b-34. Discuss the passage using the following questions:

1. In what ways was the woman isolated by the social, political and economic structures of Jesus' society?
2. What was Jesus' response?
3. Who among us is isolated by the social, political and economic structures of today? How does that isolation affect the health care received?
4. What is the church's response? What ought its response become?

+**Record** responses and take a stretch break.
+**Ask** a politician to reflect on the Christian roots for health policy. Invite questions of clarification and debate.

+**Test** the viability of the Eleven Basic Affirmations listed in *Life Abundant.* To do so, ask the group to enter into a simulation. Pretend that you are the General Assembly. Have each affirmation moved and seconded. Ask for debate, pro and con. Seek out disagreements. Ask people to play stereotypic roles. Encourage the politician to join in. Call for a vote, affirmation by affirmation. Don't worry if you run out of time. Have fun.

+**Draw** the conclusion—this study cannot end in silence. It invites action. Ask the group to talk about its next steps. End in prayer.

Session Four: The Healing Vocation

AIM: To rediscover the place of healing professionals in the church.

Shorter Preparation:

+**Review** *Life Abundant,* Recommendations II and III: Personal Responsibility and Corporate Responsibility.

+**Read** "What a Congregation Looks Like That Takes Wholistic Health Seriously" by Granger Westberg in HC&C.

+**Ask** a health professional to share his/her understanding of Christian vocation at this session.

Longer Preparation:

+**Read** sections on the ministry of the laity in *Baptism, Eucharist and Ministry.*

+**Review** chapters three and five in the *Book of Order.*

Setting:

+**Provide** each participant with a Bible. If new people arrive, provide them with a copy of *Life Abundant.* Place the furniture in a conversational circle. Post the group's translation of Mark 5:24b-34 and the worksheet "Healing Comes of . . . . "

The Fourth Event:

+**Open** the Fourth Event with brief introductions. Ask each person to share his/her name and one way in which her/his work is/was a healing ministry.

+**Invite** prayer concerns and have an elder or deacon pray.

+**Ask** a participant to read the group's translation of Mark 5:24b-34. Discuss the passage using the following questions:

1. Who are the healing professionals of our day? Why? How spiritually healthy is their work? How

wholistic? Can health professionals become more skilled in technique *and*, at the same time, become more faithful? How?

2. Is the loss of power a sign of the true healer? What power? Does the "medical laity" have the same power?

+**Review** *Life Abundant*, Recommendation III, particularly III, A. 4 which affirms the work of health professionals. Introduce the health professional.
+**Take** a stretch break.
+**Invite** the health professional to speak. If the presentation drifts into technical reflections, gently refocus the speaker on the call to a healing ministry. Encourage blunt comments on life/death decisions, access and cost questions, AIDS, spiritual practices, living wills, drug dependencies, mental illness and theological resources.
+**Ask** the group, with help from the health professional, to imagine what a congregation (governing body) that renews healing ministries might look like. How can that setting become a place of care and support for health ministry? Record and post all brainstorming ideas.
+**End** with prayer and an assignment: Read the full Recommendations section of *Life Abundant.*

Session Five: The Healing Church Renewed

AIM: To identify characteristics of the healing church.

Shorter Preparation: +**Read** "The Minister as Healer, The Healer as Minister" by James Knight in HC&C.
+**Read** "Font, Table, Pulpit, Cross, Nave: Symbols and Substance for Health and Health Care" by Paul Hammer in HC&C.
+**Ask** the ministerial leader of your community to talk about worship, program and health.

Longer Preparation: +**Host** a pre-event review of health ministries in your setting with key leaders. Encourage the leadership's informed participation in session five.

Setting: +**Provide** each participant with a Bible. If new people arrive, provide them with a copy of *Life Abundant.* Place the furniture in a conversational circle. Post the group's translation of Mark 5:24b-34 and worksheet "Healing Comes of . . . . "

The Fifth Event:

+**Open** the Fifth Event with brief introductions. Ask each person to share his/her name and one step the church should take to renew its healing ministry.
+**Invite** prayer concerns. Have an elder or deacon pray.
+**Ask** a participant to read the group's translation of Mark 5:24b-34. Discuss the passage by completing the following:

1. This church models Jesus' healing ministry best when it . . .
2. Our worship life illustrates Jesus' concern for the body when it . . .
3. Our outreach and evangelism programs reveal a concern for those who wish healing when . . .
4. We might better become a source of healing by . . .

+**Record** and post the answers. As in prior sessions, take a stretch break.
+**Invite** the group to assess its corporate life. Are caffeine, alcohol or sugar the menu here? Are there healthy breaks in meetings? Are muscles and minds both exercised at educational events? Are prayers for health common? This study has modeled a pattern of balance. What is yours?
+**Ask** the ministerial leader to discuss worship, program and healing in your community life. Invite questions of clarification and feedback. Push the discomfort button by asking about Health Risk Assessments, church-based community health ministry, and parish nursing teams. (With permission, you might ask about his or her personal stress management, meditation practice, and health patterns.)
+**Point** out the obvious. This study is coming to a fast end. Ask the group to list "Next Steps for This Community." Post on newsprint. Invite the minister(s) and leadership team to comment.
+**Review** the Recommendations in *Life Abundant* that are listed for your governing body (i. e., session or synod). Recall the intent of this study: a renewal of health ministry in the Presbyterian Church (U.S.A.). Thank the participants. End with prayer.

Resource List

Baptism, Eucharist and Ministry: Faith and Order Paper No. 111. World Council of Churches, Geneva, 1982.

The Constitution of the Presbyterian Church (U.S.A.), Part II: Book of Order. The Office of the General Assembly, 1988.

Gennemann, Jon P., "Justice and the Good of Health." Found in *Crisis: Danger and Opportunity.* Association for Clinical Pastoral Education, Inc., 1986.

Hessel, Dieter T., editor, *Shalom Connections in Personal and Congregational Life.* Alternatives: Ellenwood, 1986

Kelsey, M.T., *Healing and Christianity in Ancient Thought and Modern Times.* Harper & Row, 1973.

Life Abundant: Values, Choices and Health Care—The Responsibility of the Presbyterian Church (U.S.A). The Office of the General Assembly, 1988.

McSherry, Elizabeth, "The Crisis in Health Care: Pastoral Care in the DRG World." Found in *Crisis: Danger and Op portunity.* Association for Clinical Pastoral Educa tion, Inc., 1986.

Ministry to the Sick and Dying. Supplemental Liturgy Number 6. To be published in 1990. Westminster/John Knox Press.

Wiest, Walter E., editor, *Health Care and Its Costs: A Challenge for the Church.* University Press of America, 1988.

Teaching Tip: *Health Care and Its Costs: A Challenge for the Church* is available through your Presbytery Resource Center. Reserve a copy for use during your study. It is also available in many local bookstores.

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