

No. 8764

**INTERIM REPORT: RECLAIMING THE HEALTH MINISTRY OF THE CHURCH**

**RECEIVED by the General Assembly**

**I. RATIONALE, THEME AND PURPOSE**

Through the ages the religions of the world have been concerned about the well being, mentally, physically and spiritually, of their adherents, and have reflected this concern in their theologies. For centuries, Jewish theology has taught that God calls the people of Israel to a covenant relationship between themselves and the Creator who called them into being. When faithful to the Covenant (I will be your God. You will be my People...), the community of faith did well. To fall away from the covenant promises was to invite disaster, or suffering. The Holiness Code, along with the Ten Commandments and laws of purification, was a code that had strong overtones related to the health of the community of faith, both physical and spiritual. Many of the laws of the Holiness Code were then as now possessed of strong preventive measures.

In the New Covenant, the life, teaching and ministry of Jesus focused strongly on health. The Gospel of Mark is strongly oriented towards the healing ministry... "Go your way, your faith has made you whole..." As he went about with the first disciples, "teaching and healing," he assisted persons in ways which were restorative of one's life physically, emotionally, spiritually and to one's community of faith and family.

The early church continued Jesus' ministry, constantly working to improve the status of individuals in every aspect of their lives. Healing seemed to be a visible and tangible consequence of the life of the church's understanding of the resurrection and the community's own expression of Christ's continuing presence after the trauma of the Cross and the good news of triumph over death. Early miracles (cf. Acts 3:1ff) were healing miracles. Through the years, the Church built hospices and hospitals, missionaries with the medical and teaching skills were sent out, and health and healing were of central importance to the mission of God's people.

For a variety of reasons, including the rapid growth of scientific and technological medicine, churches allowed others to assume the delivery of care. To be sure, there was strong support for hospitals, physicians and nurses, but as a central dimension of the church's own understanding of mission, less importance was placed on health care ministry. In addition to chaplains in hospitals, medical missionaries, homes for our aging members and for children, the Christian Church (Disciples of Christ) operated but a single hospital.

In 1971, the Disciples at the Louisville Assembly stopped to consider what it was doing in the health field. The Church passed resolution #7136, "Concerning National Health Care," stating that it had a "responsibility" to aid in the creation of a national health care system, that certain specified features are important in such a national system, and that the General Assembly instruct its general staff and units to cooperate with those groups working towards such goals as the following:

1. "Social Context for Health Care" — a) fight poverty, etc.; b) education of the public.
2. System for Delivering Care — a) local clinics easily accessible.
3. Training — a) physicians to be made aware of all needs of people; b) paid for with public financial aid; c) with teaching funded for itself and not through research grants; d) and through continuing education.
4. Organization — a) requesting a definition of the responsibilities of regional and national government, encouraging the strengthening of the former; b) asking for incentives to attract quality health workers in underserved areas, and finally,
5. Financing — a) promoting prepayment plans; b) financing through a mandated trust fund.

Having made this statement, however, the church has not taken action in a concrete manner.

In subsequent years, health care — in the hands of the secular community — became increasingly inequitable and costly. It became a commodity and a business, increasingly unable to serve the needs of the most needy, and increasing its costs to such an extent that its annual costs have come to consume approximately 11% of our nation's gross national product (GNP).

The Christian Church (Disciples) spoke again in 1985 at the Des Moines Assembly, passing resolution #8536, "Concerning a Comprehensive Statement on Health Care Delivery". The resolution stated that the church "should have a current statement on the vital issue of comprehensive, quality health care as it affected the United States and Canada and the world at large" and instructed the General Minister and President:

- a) To appoint a task force to study this issue, prepare a report and make recommendations consistent with other church policies; and
- b) To identify funding sources needed to support the study; and
- c) To refer this issue to appropriate ecumenical bodies for possible joint participation in the study; and
- d) To have this study developed and presented to the General Assembly meeting in Louisville, Ky., October 16-21, 1987.

In accord with this resolution, the General Minister and President set up a Health Task Force to study the issues outlined, to prepare a statement, and to make recommendations. Its membership consists of 9 active Disciples of Christ members, most working as health professionals. This group of health professionals includes, in addition to physicians and nurses, a hospital chaplain and a local pastor. A staff person from the Presbyterian Church USA's Task Force on Health Costs/Policies has also been part of the life of the Task Force.

The Disciples of Christ Task Force has met four times, seeking to implement the Church's directive. In order to have a goal to work toward, it defined as a mission for itself and for the church "Reclaiming the Health and Healing Ministry of the Church."

At the first meeting of the Task Force, Dr. John Humbert, General Minister and President, noted that he saw the church as: 1) a health care provider; 2) an employer with employees, insurance programs and group purchasing practices; and 3) a witness and/or advocate concerned about costs and availability of health care for all. These set the initial parameters for the work of the committee.

## II. DEFINITIONS OF HEALTH AND HEALING

The Task Force on Health Care considered the definitions of "health" and "healing" at length. Certain inadequacies and limitations were self-evident, such as defining health merely in terms of physical well-being or viewing the healing from a mechanistic perspective as a "fixing" of the body. The answers to other questions, however, were less obvious. How inclusive and pervasive should our definition be? To say that "health" involves the well-being of the human person in all of his or her many and complex expressions is undoubtedly true. Do we then say that "health", and subsequently "healing" impinges upon the human person's physical, mental, emotional, psychological,

political, economic, cultural, spiritual and educational well-being? Can one be uneducated, or live under an oppressive political system, or be poor and still considered healthy? Or, if one were mentally and emotionally and spiritually strong, could he or she be described as "healthy" in the face of a terminal illness?

Our resolution of semantic dilemmas was to aim for definitions that were sufficiently broad to be seen as being wholistic, but that were also narrow enough to retain some specificity and hopefully some relevance.

Therefore, we do say that health and healing impinges upon the human person's physical, mental, political and spiritual make-up as well as his or her relationships with others, the environment and with God. Other aspects of human personhood, while arguably relevant, are omitted from the definitions for the sake of brevity and conciseness, but need not be omitted from the broader dialogue.

We further felt that an adequate definition of health and healing should pass certain criteria. First, the definitions must be theologically sound. They must be informed and shaped by Biblical record. Indeed, it is that record that reveals the complexity and paradox that is humankind. We are creature, made from the dust of the ground. Yet we are more than creature because we are fashioned in the likeness of the Creator who breathed into us the "breath of life" and caused us to become "living spirits". Thus we human persons are like the rest of the created order and derive a part of our identity from our "creatureliness". But we are also like God and have been given dominion over the created world. This shapes the other part of our identity and also creates the tension in which we live: More than animal, less than God; knowing freedom, but also knowing limitations; understanding the infinite, yet bound by our own finitude. That we must die, and know it, affects our use of technology to preserve life, for example. Our understanding of health and healing must take into account whence we have come as well as where we are headed, our potential as well as our liabilities, our capacity for God-like goodness and our tendency toward sin and selfishness.

Secondly, not only our definition of the words "health" and "healing", but our understanding of the concepts must be informed by the healing ministry of Jesus. The mere fact that nearly twenty percent of the Gospels are devoted to the healing stories should indicate the importance such activity — such essential being — held for our Lord and the early church. For Jesus, the healing mission was no less than a sign of the inbreaking of God's Kingdom upon human history. ("Go, tell John the things you have seen and heard: The lame walk....")

Certainly, one need look no further than these accounts to be convinced that health implies far more than physical well-being, or that healing goes beyond a mere restoration to the way things were. As the Good Physician, Jesus moved with ease from sick bodies — "Rise, Walk" — to sick minds — "Do you wish to be well?" — to sick souls — "Your sins are forgiven." His healing of the sick and afflicted frequently went beyond their expectations and was seldom a mere restoration to the way things were before the illness appeared. The healed individual is made whole in body, mind and spirit; relationships renewed; community is restored.

The individual is not merely "fixed or repaired", but renewed and made whole in all aspects of his or her life.

Our continued quest for insight into the nature of health and healing would be incomplete without a thorough study of the "healing stories" in Matthew, Mark, Luke and John.

It is also important that health not merely be defined in negative terms. It is not enough to say, "Health is the absence of disease, or pain, or disability". Health is a dynamic, creative, integrating force in human life that is ill served when we simply say what it is not. Even in our attitude toward preventive, there is often a negative connotation. We diet and exercise and take flu shots "to keep from getting sick". So long as our chief motivation is avoidance, we still miss the blessings of robust "health". Not being sick is probably a good starting point for understanding health, but it should only be a point of departure for a long, long journey.

A final criterion for an adequate definition of health is that health should not be seen as an end in itself. The history of God's people has been the history of their struggle with idolatry, of making means into ends, of worshipping the creature instead of creator. Much of the '80's emphasis on wellness and fitness is laudable, but the line between healthy interest in fitness and idolatry is a thin one for many people. 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".

With this introduction and these criteria, we humbly offer the following definitions of "Health and

Healing". We do so, not to etch them in stone, but to suggest a starting point for a dialogue. As our understanding of these dynamic concepts grow and change, so will these definitions.

Health is a dynamic state of physical, mental, political and spiritual well-being in which individuals live in harmony with one another, with the natural environment and with God. (Shalom) Healing is the process of restoring physical, mental, social and spiritual well-being, while facilitating harmony among individuals, the natural environment and with God.

### III. INTERIM FINDINGS OF TASK FORCE

The Disciple Task Force on Health Care, during its course of four meetings, thus far has discovered much about our denominations's potential action on this complex issue. The following paragraphs will point out some specific issues, problems, and concerns that the Task Force feels would be good information to present in some format to the wider Disciple community.

- A. The Task Force communicated with the General Units requesting information concerning the basic issues of health care services as related to the ongoing programs which they presently operate. It is gratifying to report that the General Units are involved in many of the issues of health care today.

The Division of Overseas Ministries is involved in health-related ministries all over the world, particularly through the Christian Medical Commission of the World Council of Churches. The Division also employs a number of persons who are involved in overseas ministry for whom they provide psychological and medical examinations. In terms of world missions, the DOM is engaged in forms of ministry that equip persons to understand and foster conditions supporting health, justice, and peace.

The National Benevolent Association has a complete report for the General Assembly concerning its services in the area of health care. The National Benevolent Association is of course one of the direct providers of health care through its intermediate and skilled levels of care in residential, personal care, or independent-living NBA related units. The Church Finance Council is involved in promoting the stewardship of one's own body and health in the area of its work.

The Division of Homeland Ministries is currently involved in three particular health programs which concern the training and prenatal care for welfare mothers, health care for the resettling refugees, and health and safety at work for the farm workers. In addition to that, DHM through the Department of Christian Education provides information on current health issues such as drunk driving and AIDS.

The Christian Board of Publication sees itself as bearing responsibility in the area of witness or advocate for health care services as it uses its publications such as "The Disciple" to disseminate the information concerning health care and health care services as well as the CBP publication of curriculums, camp and conference material, and general publications dealing with health care.

The Board of Church Extension has the opportunity to assist congregations in planning their facilities providing counseling for the use of space in a way that promotes good general health for the congregation, frequently drawing the attention of congregations to issues of architectural barriers to a healthy environment which plague many church facilities.

The Division of Higher Education is involved in two basic forms of activity in health care: 1) to work in medical education with professionals trained by medical school faculty and 2) to provide instruction related to health, human values, and biomedical ethical issues within the broader academic community. The health and human values program established by United Ministries in Education (UME) has its initial focus on medical education and its curriculum. Studies of biomedical ethics in the training of health care professionals are an integral part of medical education and draw more closely together those persons in medical schools with concerned campus ministers.

- B. In an effort to study the health care habits and attitudes of members of the Disciples congregations, a health care survey was sent to approximately 3,000 persons who were voting representatives at the Des Moines General Assembly. Sixteen hundred responses were received, creating a study that is a fair representation of our communion and is statistically significant. The Task Force reviewed this survey at its last meeting and compared it to a like survey conducted by the Presbyterian Church (USA). A comprehensive report of this interesting survey will be presented October 17, Saturday, at the 1987 General Assembly, Louisville, at an afternoon

interest group. However, a brief summary of the findings as prepared by the Office of Research includes the following information:

The survey was mailed to 2,925 persons who had been voting representatives at the Des Moines General Assembly. It was not sent to persons with mailing addresses outside the United States, nor to persons under 24. 1,656 responses have been tabulated. (Another 51 responses have been received. About 15 of them were flawed so they could not be included. The rest arrived too late to be included.)

The selection of the sample introduces several biases which need to be kept in mind while reading the results. 1) Iowa residents are somewhat overrepresented. 2) Clergy persons are heavily overrepresented. Clergy persons make up nearly 29% of the sample; less than 1% of the total participating membership. 3) The sample is probably slightly healthier and wealthier than the total Disciples population. 4) The age distribution is somewhat skewed. The Gallup Report, May, 1985, estimates the membership of the Christian Church is: 32% under 30; 29% 30 to 49; 19% 50 to 64; and 20% 65 and over. Our respondents are: under 30, 3%; 30 to 49, 32%; age 50 to 64, 41%; 65 and over, 21%.

The number of people responding to the survey (58.36%) suggests health and health care are a strong concern to many people. (The only thing we did to encourage people to respond was pay the return postage.)

In the fall of 1986 Disciples were generally happy and healthy. 39.6% said they were "very happy" (only 5% said they were "not too happy"). 38.5% reported "excellent" health while only 0.4% said their health was "poor".

Being overweight was the most frequently reported health-related condition (44.7% said "yes"). Arthritis (23.9%) and high blood pressure (18.0%) were second and third in frequency.

Concern for their health has caused a large number of Disciples to change their diet (63%). 45% have started to exercise regularly. 35% spend more time in prayer and meditation.

Asked about their satisfaction with various aspects of the health care system, more Disciples were "satisfied" or "very satisfied" with the care given by their physician than with the care given by their pastor; more with their hospital than with their congregation.

Nearly 97% agree spiritual health is supportive of physical health and more than 95% agree that maintaining health is a Christian responsibility.

Asked to indicate the extent of stress they experience on a scale of 1 to 5 (1-a great deal of stress; 5-no stress) Disciples responded: 1) on the job, 2-3, 44.9%; in personal/family life, 3-4, 68.2%; in relationship with friends, 68.9%.

The Task Force is evaluating and studying existing health-related programs presently in place in local congregations and communities across our country. Often a local church input into this type of venture is ecumenical in nature, but we have found some health programs conducted by local Disciples congregations. Specific programs will be illustrated at the interest group session at the Assembly so that interested congregations can "learn how to do it" in attempting to expand its local outreach ministry.

Yet to be achieved by the Task Force are the following:

1. the in-depth study of national and global health care delivery issues,
2. the exploration of means of providing health care to the medically indigent in the United States,
3. the in-depth studies of bioethical issues which face congregations and individuals in the world today,
4. the technical assistance to local congregations and regions who are seeking to establish programs and disseminate information concerning health care.

#### IV. RECOMMENDATIONS

The process of our gathering information in the areas of health, of educating ourselves concerning the specific issues of today, and of recognizing the theological basis of involvement of the church in health and healing has propelled the Task Force toward making the following recommendations concerning future continuing relationships in this broad arena of human experience. It is evident to us that the three roles previously discussed — that of the church as a provider of services, as an employer and as a witness or advocate for health care services — offer opportunities for involve-

ment to the congregational, regional and general manifestations of the Disciples of Christ. The Task Force therefore makes the following recommendations:

A. The Congregation

1. As Provider

The Task Force recommends the Congregation assist the church in reclaiming its role in health and healing by surveying current health care services in its community, assessing the needs that are not being met satisfactorily for all community citizens, and organizing itself ecumenically if possible to "fill in the gaps" in services. The Congregation may wish to become a focal point for education about and dissemination of information concerning current issues such as AIDS, nutrition, conditions of aging, etc. The congregation may also choose to become a direct provider of services within its own buildings such as pre-natal clinics, blood pressure monitoring, mental health counseling, etc.

2. As Employer

The Task Force recommends the local congregation become a model employer in the community, overseeing the provision of adequate health care coverage for its full and part-time employees. Current studies indicate that frequently parttime employees in many organizations do not experience the complete coverage that is offered to fulltime persons.

3. As Witness/Advocate

The enhancement of ecumenical relationships in each community can stimulate the growth of awareness and the increase in knowledge of health care issues; therefore, the Task Force recommends the congregation join with its ecumenical partners to promote an emphasis on health and healing in the community. Such joint endeavors may offer the financial and moral support to address "gaps" in health care services.

B. The Regional Church

1. As Provider

The Task Force recommends the Regional manifestation assist the church in reclaiming its role in health and healing by supporting the congregations with the provision of direct services at the local level. The production of health care information, the technical assistance needed to provide services to specific populations such as the elderly, AIDS victims and families, the lower socio-economic population, as well as the formation of a Regional Health Care Committee to coordinate regional services, are activities which may be provided at the Regional level to strengthen the efforts of the local congregation.

2. As Employer

The Task Force recommends the Region become a model employer, assuring full health care benefits to all employees — both full and part-time — and that it further encourage the congregations to provide equitable coverage for all employees.

3. As Witness/Advocate

The enhancement of ecumenical relationships at the Regional level for the purpose of a more comprehensive, penetrating awareness of health care issues is a recommendation of the Task Force for the church at this level. The Region has an opportunity to join with others in advocating for an increase in health care services to specific groups. The interpretation of national policies with regard to the Medicaid/Medicare coverage deserves the broader scope of Regional awareness and action. Inherent in becoming an advocate for health care issues is the direct promotion of more healthful practices in the Region such as attention to health habits and attitudes of church members, consideration of healthy environment requirements in newly constructed or remodeled church buildings in the Region, and concern for the education of church leaders on the issue of bioethical issues - to name a few.

C. The General Church

1. As Provider

The Task Force recommends the General Church lead its members in reclaiming the role of the church in health and healing by continuing to support - spiritually, financially, and publicly - the existing programs of its General Units. The response of the General Units to the provision of health care services should be expanded as requests are received by the

congregation and regional level of the church to "fill in the gaps" formed by a lack of sufficient services presently. It is the hope of the Task Force that the General units will in each of their areas of concern and responsibility establish pilot programs requested by local congregations as well as support ongoing programs seeking General unit assistance.

## 2. As Employer

The Task Force recommends the General church study its own health care coverage and seek to become a model employer through the practice of providing equitable health care coverage for its full and part-time employees. The Task Force further recommends that the General units through the Pension Fund and its other insuring agents explore the possibility of decreased rates for health care coverage through the participation of preventive health measures such as no smoking, reduced alcoholic consumption or non-alcoholic lifestyle, regular seat belt usage, etc.

## 3. As Witness/Advocate

The Task Force recommends the General church sponsor a seminar for church leaders of all three manifestations that would offer an opportunity for increased awareness of health care practices and issues that will elicit responsiveness to the reclaiming of the church's role in health and healing. Further, the Task Force requests the General church assist in the enhancement of ecumenical relationships as we advocate and seek support for social issues in health and health care particularly as they affect the poor and the medically indigent. An informed and informing General church may address legislative attempts to resolve national concerns such as the extension of private insurance to provide comprehensive coverage for more persons and for more frequently occurring conditions and diseases as well as the expansion of Medicaid/Medicare benefits to the uninsured and the under-insured.

It is the assumption of the Task Force that the General church will continue to provide witness to the role of the church in health and healing by its strong advocacy of the right of every person to health care services in order that all experience the wholeness of life.

### The Task Force On Health Care

Mary Lee Loving, Chairperson, Southwest  
Karen Burniston, Indiana  
Barbara DeHaven, Upper Midwest  
Frank Griswold, West Virginia  
Donald T. Lucey, North Carolina  
William H. Lee, Virginia  
Andrew Nichols, Arizona  
Eda Rivera, Northeast  
Larry W. Whinnery, Indiana  
Thomas Mainor, Presbyterian Church, USA, Pennsylvania