EMORY | ROLLINS SCHOOL OF PUBLIC HEALTH | Interfaith Health Program
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| Title | Playing To Our Strengths: Religious Hospitals and Community Health Status |
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| Date | October 27, 1994 |
| Location | National Interfaith Healthcare Leadership Conference |
| Background | Dr. Gunderson presented this paper in which he described the distinctive contribution of religious hospitals and laid out the ways in which the resources of those could be expanded beyond the boundaries of healthcare service delivery to address key social factors impacting public health. Drawing on the research of Dr. William Foege, Dr. Gunderson laid out the *Five Gaps Strategy*, which provided a framework for the efforts of the Interfaith Health Program to identify religious organizations at a community level and to understand their distinctive assets. That framework has informed IHP's programmatic and research efforts in many ways to the present day. |

Introduction

The chance to speak to you is both a privilege and a challenge. The privilege is self-evident: you represent many years of experience guiding some of the most prestigious health institutions in The United States. The challenge may be different than you expect. I want to engage you as colleagues working in hospital settings, but I am not primarily interested in accepting those as the proper boundaries of our discussion. I appreciate the cumulative wisdom, prayer, science and sacrifice that your institutions represent. But I am challenged to look beyond what now exists and ask what mature faith and good science demands of tomorrow. I engage health issues and as part of them, hospitals, from the perspective a community activist having worked for years around the hunger problem building soup kitchens, food banks and homeless shelters. My frame of reference is also heavily informed by public health science. As Director of the Interfaith Health Program of The Carter Center I share the public health strategy that underlies most of The Carter Center's health work. The Center, under the leadership of President Carter and Dr. Bill Foege, operates a number of health initiatives broadly united by a focus on preventing or eradicating disease and confronting other health risks, such as civil conflict or war, before they have the chance to kill and disable people. We run technical programs

seeking ways to track kids under two years of age in the U.S. so that they can be immunized on time. We have helped to coordinate the activities of UNICEF, WHO and key foundations to raise immunization rates world-wide. Under the leadership of Mrs. Carter, we have worked on mental health policy exploring strategies of early detection, prevention and reduction of the stigma suffered by those with mental illness and their families. The Atlanta Project is an aggressive and comprehensive effort to mobilize a vast range of political, corporate and human resources to attack the web of poverty in urban Atlanta. You get my point: we are mostly oriented toward public health threats and community responses.

My particular program, the Interfaith Health Program, has a mandate to mobilize faith groups toward their full potential as agents of healing and wholeness. This is hardly a new idea-- each of you represent an institution born of this idea, in most cases a century or more ago. But the religious community is still an under-achieving force in health, especially when you recognize health threats as inclusive of violence, substance abuse and other behavior-linked, choice-triggered risk factors.

In approaching this discussion I am making two assumptions about religious hospitals that would be naive, if they were not deliberate. - First, I assume that religious hospitals are not merely referred to as such in honor of the theological commitments of the people who have their initial capital but also because of the accountability of current decision-makers to religious beliefs. - Second, I assume that religious hospitals are willing to be more than specialized peripheral agencies in society, perhaps even catalysts for the larger struggles of society to build a healthy and just society.

We make the same assumptions of other forms of ministry, most of which are also in a time of strategic formation and choice. We witnessed this in the last year as we traveled to 14 cities to meet with community leaders in health organizations and faith groups. In most of these meetings representatives of local religious hospitals participated. The meetings usually included a sampling of interfaith ministries, denominational efforts, people from the health department and, usually, the Mayor's office. We detect the stirrings of a genuine movement with the power to affect the health status of millions of people. I am here today because that movement-- born of God and expressed in hundreds of institutional commitments and many thousands of personal choices--needs you, your institutions, your resources, people, your knowledge. Your struggle is not unique or isolated from the larger struggle of religious people. When I was asked to speak to you on the subject of playing to your strengths, I immediately thought, not of your structures and capital assets, but the enormous strength you have because you are free to do the right thing, to ask the right questions, to choose life. That's the main strength to which I will be appealing today. Let me offer you the framework we have developed to help leaders such as yourself identify your strengths, remember your commitments and find the way forward.

*The Five Gap Strategy*

The Interfaith Health Program is tantalized by two numbers:

- At least 60%--many researchers would say up to 90%-- of the years of life lost before age 65 result from factors that are preventable. At least 2/3rd of suffering is premature and preventable!
- At least 150 million U.S. citizens participate in some faith group--a church, synagogue or mosque which we also know share a high priority on healthy living, wise choices, alleviating and preventing suffering.

Why do we continue to endure the disease, injury, disability that you see every day in your clinics, ER's and on your floors? As we at Interfaith Health thought this through we developed a focus on five strategic gaps. Let me warn you that I am using the word gap in a different way than you might guess. It is most commonly used in the sense of something that is missing. But more interestingly, the gap can also be used in the way it is in mountains: the way through, the safe passage a leader seeks to get his people to the good land on the other side. It is this second usage that I will primarily use this morning.

This is a strategy for finding a strategy, and nothing could be more important in a time of information deluge. There was a time when information was power; when the one with the best data carried the day, set the agenda. Today the power rests with the right question, the well-grounded goal that can serve as an intelligent, faithful filter through the waves of info-babble that pull you like a prevailing wind. The 5-Gap Strategy is intended to help you get the questions right. This morning I'll be aggressive in suggesting some of the sources of the answers, too, but I do so knowing that you will have to do most of that work in your own community in order to get the answers right.

Gap One: Applying knowledge we already have. There is a vast and growing body of knowledge that has yet to pass into common practice. You know this in your own specialized field of expertise. Ask any researcher to list accepted knowledge that has yet to be applied in most hospitals. You will get a quick, and probably long answer. This is especially true if you ask scientists a field or two removed from your primary focus. For instance, although a research cardiologist could probably point to a number of things you are doing that lag behind the best science, that list would be much shorter than if you asked a sociologist what their science knows about community engagement that you do not appear to be applying. This is not for the faint of heart. Where is your knowledge gap? Let me suggest that for most hospitals, the gap is in the appropriation of public health science and socioeconomics. Let me present three specific scientific frames that point to leadership gaps that should be taken seriously as you seek to play to your strengths.

1. What are the actual causes of death and disability in your community? You probably have, or could have, a print out this afternoon on what people die from in your hospital. By tomorrow, you could get data on your local health department's jurisdiction. But would you know the causes death and injury in your community?

This is a surprisingly difficult question to answer because human beings are complicated animals experiencing multiple risk factors linked to more than one disease-specific outcome. Heart disease, for instance, has well-documented links to a number of risk factors. Youth suicide or homicide cannot be traced to a single risk factor. Even motor vehicle injuries are multi-factorial. Science, just like the hospital, is organized around disease-specific knowledge. Unfortunately, human life is not organized or lived that way.

We are beginning to penetrate behind the misleading data about the medical causes of death to think clearly about the actual causes of death and disability. Dr. William Foege, the Fellow for Health Policy of The Carter Center and former head of the CDC recently published an article in the Journal of the American Medical Association with Dr. Michael McGinnis, the Deputy Assistant Secretary for Health. Their work extends and updates findings of a 1986 study by The Carter Center, Closing the Gaps. Foege and McGinnis identified what science understands as the major underlying causes of death in the United States currently. (The conclusions are summarized in the appendix of this document and I commend the full article to you.) Their answers are unsurprising, but deeply troubling to hospital leaders who recognize that their institutions have focused almost exclusively on medical pathologies.

The big surprise is that there is no surprise in this data. But is this science integrated into the process of setting priorities nationally or in your hospital? Foege and McGinnis note: "The most important implications of this assessment... are found in the way the nation allocates its social resources... In 1993, health care costs in the United States are expected to reach $900 billion, an average of more than $14,000 annually for each family of four... The preponderance of this expenditure will be devoted to treatment of conditions ultimately recorded on death certificates as the nation's leading killers. Only a small fraction will go to the control of many of the factors that the Table indicates imposed a substantial public health burden.... "

If the nation is to achieve its full potential for better health, public policy must focus directly and actively on those factors that represent the determinants of death and disability. This science can be like a bucket of cold water for hospital planners... But most hospitals are not too worried for hospitals are organized to serve individual sick people and what seems to link these disease and injury risks is the central role of individual choice. Want health? Don't smoke. Don't eat unhealthy things. Exercise. Don't drink much. Watch out for infections. Stay away from environmental problems. Stay away from guns. Be chaste or use a condom. Wear a seat belt. Don't do drugs. See your doctor for regular check-ups. Bingo! There goes half of the causes of premature death! All because people made better individual choices. Now, if we can figure out how to bill for it, even the hospitals will be happy. Of course, you have figured it out.

Any hospital with a marketing department has all sorts of programs on wellness, exercise, smoking cessation, substance abuse counselling, mental health services,

diet design and weight-loss. Which of you is not a smoke-free workplace? Which does not encourage your employees to participate in heart-runs, walk-a-thons and stress-reduction programs? You can buy spandex as easily as you can flowers in most hospitals today. I don't mean to imply that hospitals have fulfilled even this individualistic agenda. Much programming in this area is fringe activity. Only a few months ago the Catholic Health Association surveyed the community benefit programs of 429 religious hospitals. Ninety-seven percent sponsored health education programs, 77% sponsored stop-smoking clinics and 62% offered weight reduction programs. But only 1/3 trained pastoral care-givers. Only 16% sponsored community forums where citizens could discuss their healthcare needs.

The great weakness with the individualized wellness approach is the failure to seriously engage the obvious fact that disease and injury falls predictably along lines of groups, not just individuals.

2. Why are some groups of people less healthy? Foege and McGinnis do not fully explore the socioeconomic critique of health science, although they point the way. They suggest that roughly 7% of deaths--about 150,000 annually-- are linked in a complex way to poverty. Many health thinkers are looking carefully at the social roots of disease and injury. One surprising one is Aaron Antonovsky, a sociologist of health whose research has been directed to the question, "What keeps people well" rather than the traditional question, "Why do people get sick?" Less than a year ago he spoke to an international conference on The Anatomy of Well-Being, held in Israel. He identified serious scientific and moral shortcomings of the individualized "wellness" movement. The wellness movement is based on exactly the same root understanding that Foege and McGinnis document: we have great control of our individual health outcomes. Much of the wellness movement also emphasizes emotional and spiritual factors, which can only be inferred from the above data. This movement suggests that we choose our destiny, our health, our stress level, our cholesterol count, our heart rate, our body fat ratio, our flexibility. The prime determinants of our wellness are found inside our own individual skin. This is not a new idea at all, of course, but the absolute core American myth of the sufficient and independent individual. Antonovsky subjects this view to a rigorous critique. He points out that the emphasis on finding health within is most popular with those most comfortable with the status quo.

This is true enough to be dangerous. We are so historically conditioned by the American myth that we fail to look beyond it for other factors. This is almost forgivable, somewhat charming, failure of self-understanding in an individual. It is absolutely unforgivable lapse of health science and moral perspective when the individualist myth is endorsed by such a key health center as a hospital administration. One's personal health can be seen as the accumulation of individual life choices regarding various health risks. However, an individual is shaped in a social context, that health risks reflect group choices, at the very least peer-influenced choices. How pleasantly we explore the terrain of individual choice. How awkward we become as we enter the forest of social choices. Antonovsky points to

five key stages of coherence--which he almost equates with health-- beyond simple individualism that have great relevance for a health organization. Four of them are especially relevant:

1. Linkage vs. isolation. People are social and can only be healthy in active relationship to others. Exclusion or isolation is a prime health risk for the physically or emotionally disabled, the cognitively handicapped, the homeless, the isolated elderly, and the stigmatized. They do not exist because they are not valued and they know it. Their health depends on relationship, not just care; conversation, not just instruction.
2. Information vs. noise. A healthy environment gives us clear messages and the messages must contain content that has some degree of freedom choice. It is clinically unhealthy to receive incoherent messages which demand or instruct without any chance to reject, adapt or respond. This is a central problem of minority groups, immigrant or illegal workers, lower-class persons, illiterates or those in any sense deviate, in many cases women.
3. Availability of resources. Antonovsky points out the obvious: even if one is to make sense of the paradoxes of life and formulate a healthy, coherent strategy for living, the plan depends on the resources to put it into action. "It is the environment, of one's past and one's present, that determines the degree of freedom available to the actor in the course of carrying out a plan."
4. Responsiveness vs. rejection. A healthy environment is responsive and attentive. The issue is not only the environment's baseline attentiveness, but the actor's power to compel it to listen and respond. Antonovsky argues that the failure to be able to compel a hearing is itself a second level of failure and that the insensitivity is itself a risk of health because it further devalues and fragments the identity of already hurting people.

Antonovsky argues that the wellness movement is inherently crippled as much as what he calls "techno-biomedicine" (what happens in most hospitals) because it perpetuates a limited understanding of health that does not adequately describe reality. "It raises a serious moral issue of therapy--any school or technique of therapy--for it ignores heart of the matter. True, the amelioration of personal suffering is a worthy goal, but without going to the heart of the matter, the world in which one lives, a greater price must be paid."

At the December 1993 meeting Theodore Pincus responded to Antonosky's paper and underlined the link between socioeconomic status and health, which is most reliably reflected in educational status. Pincus noted that: It is now recognized that the most common diseases, including arthritis, hypertension, back pain, psychiatric disease, peptic ulcer disease, heart attack, diabetes, renal disease, chronic bronchitis and emphysema, epilepsy and stroke, occur two to three times more commonly in people who have fewer than 12 years of education (25% of the U.S. population) than in people with more than 12 years. These disparities in disease prevalence according to formal education remain significant when adjusted for age, gender, race and smoking. The only exception to these trends among relatively common

diseases are cancer, allergies, asthma, thyroid disease and multiple sclerosis. He notes that if any other factor were found to be so directly linked to health status, it would likely be incorporated into standard medical care. Unfortunately, Pincus notes that we spend far more resources on changing an individual's cholesterol level than on his socioeconomic level.

This is not just a failure of moral courage, but a collapse of good science. Pincus noted that almost any published clinical study requires the inclusion of age and duration of disease of the patients, but information concerning patient socioeconomic status is included in less than 5% of clinical studies in medical literature. What is the implication of this science for hospital administration? Follow good science to the root causes of disease and injury in your community and you will find more than just a long list of sick individuals: you will find yourself in a community struggling with social incoherence.

3. Is there an ethical cost-benefit calculus reflecting health goals? In 1993 for the first time an institution devoted to the language of economics and finance examined the costs and benefits of investing in health and, more importantly for you, how to set relative priorities on what to invest in. It is as if your local Chamber of Commerce did a careful study of the actual burden of health. The World Bank economists have created a tool for cost- benefit analysis that should be allowed to shed its light on hospital practice in Birmingham just as clearly as it has in Bangladesh. The key, if somewhat crude, tool is the Disability Adjusted Life Year (DALY) which measures the relative "burden of disease" created by different causes of disability and death. Taking 65 years as the "normal" lifespan it suggests that a death from cancer at age forty-five would costs 20 DALY's while someone afflicted with blindness at the same age incurring a loss of 50% function would cost 10 DALY's.

Their economic calculus values acquired productive skills so that a child of five is valued less than an educated young man of twenty-five. Most faith groups would not share the assumption, but it is convenient of the economists to make it so explicit. I should note that removing this bias skews the emphasis even more toward health risks affecting children and youth, which is exactly the opposite of where hospitals are oriented. The DALY is merely interesting until one lays it as a screen on competing expenditures in the highly limited health care budgets of developing countries. Basic public health preventative interventions scream to the top of the list while highly technical curative procedures drop like hot stones. War and violence cause far more DALY's than HIV, even in Africa. Conflict resolution and peacemaking become high priority health initiatives. Would it be any different in Phoenix or Columbus? How would it weigh your capital and staff budget?

I have laid out three complementary scientific tools that are now commonly accepted, but largely unapplied in most U.S. hospitals: -We have examined the actual causes of death and disability. -We have strengthened the analysis by penetrating this data to find the linking theme of socioeconomic factors. -And we have found a way to look at the relative impact different programmatic initiatives might have on

suffering. These scientific tools develop teeth when they are adapted or implemented on the communities you are committed to serving. National data is certainly better than none all, and much better than being pushed only by marketing and politics. The real impact will come when you do your own examination of actual causes of death and disability in your county; run your own analysis as to how socioeconomic status affects health around your hospital and how the DALY tool would lay as a screen over your own hospital budget when it is based on local data.

Gap Two: The gap between what we say we believe and what we actually do. We have met with a striking diversity of community leaders working in many institutional settings from many faith traditions. We are not very interested in seeking new theological synthesis. Rather, we are interested in closing the gap between what each of us has already committed to and what we actually do. The strategic leadership gap is not so much envisioning, but remembering. Remember what is behind you or beneath you in the basic commitments that precede you, your buildings, your technologies. There have probably never been institutions in the history of the church that had more explicit goals, written in unmistakably clear American English than do your hospitals. These may be, what Johann Metz calls "dangerous memories," inconvenient and troubling and certainly uneconomic. But you certainly do not need new theology or philosophy in order to have a clear ethical framework.

Sister Mary Marie Ashton, who many of you know as a professional colleague, was the CEO of Fairview Hospital in Minneapolis when it was the largest hospital in the city. She also served as the State Health Director for eight years before returning to guide the Sisters of Carondolet through the painful, but liberating, decision to sell the hospital and find a new mission expressed through nine free community clinics scattered around the city in underserved neighborhoods. I asked her how the Sisters were able to undertake such a dramatically different path. She says they came to the point where they remembered why they came to Minnesota in the first place. "When we remembered who we were, we knew where to go."

I urge you to be bold in reappropriating religious language, to bring it into creative tension with the best of health science and the most urgent of public issues. From the Centers of Disease Control to the police, secular agencies are reaching out to people of faith seeking to engage the power of spirituality in the most critical problems. As we meet here today the American Public Health Association is meeting in Washington. The incoming President, Caswell Evans from Los Angeles, convened his presidential forum on the challenge of faith and health. David Satcher, head of the CDC has spoken time and again about the crucial role of faith communities in the crises of violence and substance abuse. Dr. Lee Brown, the Director of the Office of Drug Control Policy, recently testified before Congress saying, "The Church has a paramount role to play in delivering moral and spiritual values to our communities, and in providing guidance to America's youth. The intervention and active involvement of leaders and members alike can provide a positive turning point for many drug users who want to find a new way to live." Methodist Bishop Felton May

tells of going into the drug- racked neighborhoods of East Washington DC and being told by residents and clergy alike, "don't come in here with your programs and big ideas. This is serious and, if you are not a spiritual man, you have no chance."

Today's good science is raising health questions that only good, mature, tough-minded faith can answer. If your hospital is merely one more polished secular service agency you have no power beyond increasingly bureaucratic technique. You certainly have no power to save, little chance of healing the terrible wounds of our day. The specific sentences and phrases of your founding statements are important only to the extent that they encourage you to re-engage the living God of today. For the power of God is not evidenced in what happened once long ago, but in the power to compel now, to frame commitments for the future. If you remember who you are, you will know what you must become.

Gap Three: Applying what already works somewhere else. The heart of gap three is the instinct is to adapt, rather than building from scratch. But let me be quick to signal two caveats in the process of doing this related to hospitals and their communities:

1. What is worth replicating can be a highly subjective process, especially if you look beyond directly comparative organizations for models of best practice. In this presentation, I am leaning on other presenters, as well as you, to share explicit hospital-based models of excellence. CHA and Interhealth have award processes that hold up the very best of hospital practice. So I felt free to bring into creative tension models that you might not think of as being relevant. But in doing so, I do not want to be understood as downplaying the importance of excellence in the hundreds of core functions inside the walls of the best hospitals. I am primarily bringing this excellence into creative tension with what is going on outside.
2. Many of the models I cite are difficult or impossible to turn into reimbursable opportunities. Their only recommendation is that they help people be healthier in a highly cost effective way. That doesn't help you if you are trapped in a competitive corporate culture emulating profitable secular institutions unbound by religious or moral constrictions toward the underserved. Financial stewardship is a heavy responsibility. But the focus of this presentation looks at cost effectiveness in a way that may well threaten traditional institutional structures.

So what are some current models that might have the power to modify management choices or, even, to change strategic direction? Replace the Hospital Let me begin with the most threatening suggestion, because it is where I began this entire encounter with hospital strategies in the first place: Let's look at what hospitals can learn from the philanthropic foundations such as Robert Wood Johnson that have health as a focus. I have been with hundreds of leaders of health ministries based in, or relating to religious groups in the last couple years. Many of them talk and act as if the religious community has few resources with which to work. For instance,

despite the obvious benefit and mission impact, most parish nurses are still volunteers, sort of the status of church librarian. The reason: no money. This is continually pointed to as a barrier to new or expanded health activities from congregations to health systems.

It doesn't take long to look around the religious landscape to realize that this is either disingenuous or ignorant. The fact is that 86% of all charitable giving flows through the local church. By comparison, only 8% is given by foundations. But more to our point, the religious community controls or owns over 700 hospitals, perhaps 29% of the acute care beds in the United States. Granted, there are a variety of control structures and joint venture relationships that buffer most hospitals from direct intervention by religious organizations. But as strong leadership by Cardinal Bernadine has shown in Chicago, many of these institutions are at least potentially accountable to religious structures. Hospitals are not independent; they have a history and a family and a memory. They share in larger hope. But more than share, they were born to serve a larger hope. Christian institutions trace their larger hope to a cross which at least underlines that survival is not the ultimate goal for the Christian or Christian institution.

On its 20th anniversary, Terrance Keenan reflected on what the Robert Wood Johnson Foundation had learned. He points to an evocative list of critical freedoms. Listen to them in contrast to our constant jabber about the constraints of the competitive environment surrounding religious hospitals:

- Independence in selecting their goals.
- Freedom to invest in innovation.
- Freedom to fail. Keenan explains, "This, perhaps, is the greatest of all freedoms in seeking to devise new approaches to social problems."
- Time to anticipate the future.
- Unequaled flexibility and speed.
- The freedom to persist. Since they answer to no outside constituency, foundations have the luxury of staying the course. They are not subject to the whims of political change, popular taste or intellectual fashion. They can 'hang in' on a tough and intractable issue—keeping it on the public agenda until there is sufficient professional or political will to deal with it.
- The power to pioneer new fields of knowledge.
- The freedom to develop new institutions or institutional systems for confronting major needs.
- The ability to convene.

This is easy for Robert Wood Johnson to say, of course. After all, they have the capacity to invest upwards of $100 million a year. Keenan argues that local foundations with relatively modest assets ($5-10 million) can utilize the same freedoms with the same relative local impact. To understand the importance of the potential of small foundations built on the sale of hospitals you must understand that the dominant trend in philanthropy is matching funds and collaborative funding. If you sold your hospital for a net $40 million that might generate between

$3-$4 million a year in unencumbered funding available for health ministry, it would be likely to leverage similar matching funding from national foundations, if you did your programming creatively. This combined amount could be relied on to leverage another match from local congregations for health ministries of demonstrable community impact. Thus your $4 million would actually leverage between $12-$16 million in program expenditures. This is a very large amount of money when targeted locally, especially when invested using the powerful freedoms Keenan notes above.

Those of you accustomed to budgeting for MRI machines and cardiac surgeons may have lost touch with what $12 million can buy in terms of community-based health workers and activities. For beginners, few communities need a great deal of capital expenditures: the buildings are typically underutilized. Health workers range up to, not down to, RN- trained personnel. Many relevant programs utilize community organizing skills that are shockingly inexpensive to recruit. My point is simple, $12 million buys a great deal more in community health than it does inside the walls of the hospital, especially when you are free to persist and answerable only to your most mature faith and honest health science.

Imagine if the founders of your hospital were to walk into town today with the money equal to the net assets of your organization. Remember their founding premise. If survival is not the mission, what is God calling us to today? Would they seek some vehicle to enable consistent application of preventive social health science? Probably so. Would they open a hospital as the most useful institutional support for such science? Probably not. We know of hospitals and systems that have converted their stainless steel and concrete into foundations that demonstrate what can be done. The Kansas Health Foundation was born in this way. The Jewish Healthcare Foundation of Pittsburgh is a very recent example. The Vesper Society in Oakland rests on a corpus of two hospitals. Lutheran Hospital in St. Louis is another recent model. Most people seem to think that consolidation of hospitals will proceed no less quickly in the next 10 years than in those past. If we look to southern California as something of a model of what will happen elsewhere we can expect that at least half of the 700-some religious hospitals will change hands whether this is good news or a source of sorrow for their boards.

In light of the science I stressed in gap one, consolidation is not a bad thing at all. It is primarily driven by the fact that services can be provided more inexpensively. However, managed care tends to sacrifice those things that are unlikely to be reimbursed for several reasons including the fact that the people concerned are uninsured, the services are long range or indirect: the kind of things most prominently mentioned in most of your founding statements. I do not suggest that in every case religious hospitals should abandon their service areas. I would personally seek out a religious hospital for my children or myself and would regret the loss of them in all cities. But I do want to offer those who cannot survive in this environment another way-- I would say a preferable way-- to serve their God-given

mission of promoting health and wholeness and defending the interests of the marginal people God loves.

John McKnight tells of examining the major reasons for admission to his local Chicago emergency room. The examination of the ER resulted when his local community organization won access to the hospital, but failed to notice any improvement in the health of the neighborhood. It turned out that the top seven ER admissions were automobile accidents, interpersonal violence, other accidents, bronchial ailments, alcoholism, drug-related problems and dog bites. McKnight points out "the medicalization of health had led them to believe that hospitals were appropriately addressing their health problems, but they discovered instead that the hospitals were dealing with many problems for which hospitals are always too late and which required treatment of another sort." One might ask why a group of community amateurs had to be the ones that did such basic data analysis. But then again, has anyone examined your admissions data recently?

The key is that currently the largest portion of potential health assets in control of religious groups are invested in curative hospitals. Some of these assets, perhaps most of them, should be brought more closely in line with the most strategic health target. The most profound critique of hospitals is that they are the wrong tool for the time. At the current time and, perhaps, for some years forward, religious hospitals have the choice of transferring their assets into liquid form and then through the vehicle of a foundation, into support for the plethora of community health structures that are highly adapted to preventive health science and highly unlikely to be paid for any other way. The reality is that in most cases there are existing community organizations capable of expanding to fill many of the organizations needs implied in the community health strategies. The hospital must find a way to strengthen what exists and need not usually start from scratch. The tool most fitted for the transfer of resources is the philanthropic foundation.
My point is that these foundations can be an effective institutional alternative to the hospital structure for achieving health goals in your community. It is not the only model, of course. Let us look at some other ways that hospitals can play to their strengths on behalf of the community.

Extend the Institution
There are many ways that a strong hospital can be a base of health for the entire community. The key is to change the image from being a place that you bring people when they are sick to a place from which expertise, understanding and compassion flow into the surrounding communities. How different the focus is: outflowing healing instead of place of incoming wounded.

- Church Health Center, Memphis:
  The Church Health Center (CHC) is about as good as you can do a freestanding clinic for the working poor. Dr. Scott Morris has served 15,000 people with efficiency, medical competence and compassion that simply establishes the benchmark. This is no mere Band-Aid-and-pill ministry. It has dentists, exercise

classes, nutritionists, pastoral counsellors and a fabulous referral network of unreimbursed specialists. This is wrapped in a rich moral integrity that is a force to be reckoned with in Memphis. Of course, there are other clinics that also offer free or radically sliding-scale services in many communities throughout the country and most are expanding their ministries as more and more people fall outside the reach of commercialized health payment systems. What is special about CHC is that they are beginning to struggle with exactly what I am encouraging you to do. The Center has strong relationships with 120+ churches in Memphis that provide dollars, doctors, volunteers and resources. But the healing activity has all happened at the Center. The Center can only take care of about 10% of the underserved people in the Memphis region. What if the Center were seen as the resource and the congregations as the primary healing centers? What could the Center do to mobilize and equip the congregations of Memphis to be islands of wholeness and healing that would radically extend the capacities of the whole body of Christ in the city? CHC is pushing beyond the service model toward prevention. Would more healing result? Of course. Would it be more expensive? No. What would it mean to CHC? Who knows? At the apex of excellence CHC is engaging questions that will pull it far beyond its demonstrated knowledge into new waters. That's what I'm impressed by.

- Parish Nurse/Congregational Health Minister:

Most of us are familiar with the concept of what has been called the parish nurse. There are now some 3,000 congregations with some variation on this theme, which we regard as one of the key growing edges of the broad movement of faith and health. We are still in the primitive stages of this phenomenon. I expect congregational health ministers to grow exponentially in the coming years driven by good science and good faith to become as common as organists and youth directors. The disciples of Jesus were not trained as musicians or youth directors. They were trained and commissioned as agents of healing and sent to communities. The closest we have to this model today is the congregational health minister. I am not so interested in parish programs that focus exclusively on keeping the congregation healthy, although that is not a bad thing at all. But it is like building a church basketball gym and then only letting members play. The point is for healing to flow out of the congregation onto the neighborhoods and the health ministries should be especially known for this. This is a primitive movement with limited vision about the full consequences of bringing health back into the congregation. There are some 300,000 houses of worship. What if one in five had a trained health promoter mobilizing the congregation for health ministries in the surrounding neighborhoods?

- Interfaith Health Atlanta:

I want to extend this congregational health challenge a bit further, which is where the best sciences teases us to move. The Carter Center Interfaith Health Program, led my colleague, Dr. Tom Droege, is working with two clusters of congregations in severely underserved parts of Atlanta. We have assigned a part-time health coordinator to each cluster of 10-12 congregations of widely varied

faith traditions. The faith groups have identified congregational health promoters in each congregation which we have trained in basic health promotion, disease prevention strategies. These are laypeople, mostly without formal health training but clearly identified as natural accepted helpers in their congregations. We have built in evaluation from the inception of our work and will be able to track much of the outcome of this strategy. In our case operations are covered by a little funding from the Pew Charities Foundation. The training is provided through the Emory School of Nursing that hired someone with particular cultural skills. But we have done nothing that a smart hospital couldn't do. This movement toward the congregations is not merely "cheap health," but good science. It is not just a good symbol, but tough-minded application of mature faith. The more we learn about the connections between health, wholeness and spirituality, the more we are driven to a renewed appreciation for what can happen in a healthy congregation. The more we learn about the patterns and predictors of disease and injury, the more we appreciate the congregation as a place where the family, neighborhood and community must and can be built. Any of us who has ever served on a church committee must tremble at the challenge, for it is nearly miraculous that we can agree on the stationary, much less become a place of healing and wholeness for the community! Like many institutions in our society, the congregation is weak, and somewhat depressed about its own capacity. If health does not make sense at the congregation, however, it does not make sense. The standard congregation does not come to an understanding of faith and health magically, any more than the children learn the Scriptures by magic. It happens as a result of responsible leaders acting through creative programs to teach and encourage. It takes money, time and prayer to make it happen.

- Breath of Life Heart Body and Spirit:

In this same context, I want to acknowledge the breakthrough work being done by Donna Willis in Baltimore, Newark and Huntsville that is even more radical than our own. Donna has worked out of the best of health science, but also as someone brought up in the Seventh Day Adventist tradition of health and personal responsibility. Donna has developed a strategy based on identifying strong neighborhood-level leaders and training them to do basic disease screening and health promotion activities. One of the core skills is identifying what health services are available locally and how one can access them in real life situations. This extends work done with 200 congregations in Baltimore for some time by Dr. David Levine out of Johns Hopkins which has documented impact on hypertension. It turns out that health promotion skills are far more teachable than you might expect.

- Cafe 458:

A great number of creative, smart and tough-minded ministries have grown out of what began as the movement against hunger. Many have engaged people who were hungry and found that they had far more problems than could be answered by food. People with empty stomachs also lack most other survival resources

and are caught in a web of defeat, despair and brokenness that is nearly intractable. But many who have engaged the hungry have stayed engaged with both heart and mind wide open to God's healing spirit. One of the most remarkable, but replicable, models of this process has borne fruit as the Cafe 458 in Atlanta. This began as a free cafe where hungry people could be served just as they might in another restaurant, instead of in the industrial style of the large downtown soup kitchen. The cafe setting was designed to encourage conversational interaction among the clients and volunteers. Not surprisingly, the managers learned an enormous amount in a hurry about the real needs and lives of the guests. The primary fact was the ubiquitous struggle with different addictions, in some cases multiple ones. In response to the need, but in keeping with the small scale strategy of the Cafe, the managers collaborated with a local Baptist church to convert a homeless shelter into a place for long-term stay for clients participating in a new rehabilitation ministry housed across the street from the Cafe. The ministry shows early signs of successful rehabilitation in terms of the addictions, but also of other transitional complications, such as housing and job placement. The key is the small, intimate scale and constant personal interaction among guests and volunteers. We are publishing a small book on this project in January that I'll be glad to send to you. But I stress that the good news of this project is bad news for those seeking large scale answers to broad social problems such as substance abuse and homelessness. Healing happens one by one. This is a difficult model to lay over against the larger scale hospital. It cuts to the heart of the problem with medicalized protocols and reminds us of the tremendous power of eye-to- eye personal relationship.

- Christian Community Development Association:

It is easy to despair for the presence of strong witnessing faith communities in the cities. The big, mainline congregations heard the call to greener pastures far from the urban core, leaving many neighborhoods without a name brand religious presence except for the hospitals. It turns out that God did not leave just because the Southern Baptists, Lutherans, Presbyterians and Catholics did. A striking example to which religious hospitals simply must be accountable is found in the network of 200 some churches loosely affiliated in the Christian Community Development Association. Don't go near them if you only want a few nice ideas to add to your neighborhood marketing plan. These folks are serious. Most of the churches identify closely with the evangelical vocabulary, but do so in such a radically biblical way that they shatter the stereotype. The churches are usually interracial, filled with people from all classes and take saving souls and healing broken bodies and neighborhoods with equal seriousness. Nearly every congregation has some kind of free medical clinic and health outreach. Most disconcerting of all, they don't talk about anything they don't do. The "Moses" of CCDA is John Perkins, a prophet and incisive critic of do-good religious groups. Writing after decades of work on the frontiers of community development, he cites the characteristics of authentic churches. Perkins sets health ministry within the natural life of the authentic church and refuses to split it out as a

specialized function. However, Perkins is clearly speaking to kind of sacrificial, engaged spirituality that is probably imbedded in your founding charter.

- Shalom Zone:

The United Methodist Church has launched a similar strategy as CCDA through their "Shalom Zone" initiative. This was born through the personal learning process of Bishop Felton May when he tried to confront the terrible web of drugs, violence, brokenness and despair in southeast DC. The Shalom Zone was launched nationally in response to the riots in Los Angeles. Based on explicit theological commitments, the Shalom Zone confronts the linked problems of urban brokenness by defining a specific geographical location "in which congregations could play a pivotal role in developing economic prosperity, eliminating racism, coordinating community resources, empowering community leaders and residents to plan their community's future and proclaiming the Gospel." It does not envision a new layer of specialized agencies, but focuses on strengthening the local congregations to play the powerful catalytic role.

- Industrial Areas Foundation:

As we traveled around the country meeting with health leaders, we often found ourselves admiring the work of an organization that has some things to teach people interested in large-scale community change. The Industrial Areas Foundation is a Chicago-based group with an explicit strategy that builds on the cross-cultural, interracial and interfaith strength of congregations. The specific goal is to find political objectives of high priority to a significant cross-section of congregations and to focus that positive energy into effective political action. The basic activity is house-to-house interviews with members of the congregations to find potentially unifying themes and concerns. When the linking agendas are found, they are tested in community meetings that are very inclusive (and sometimes loud) events. Eventually, the elected leaders and those that want to be elected find the organization to be an especially strong, focused and intelligent force to be reckoned with. The organization creates a local entity: BUILD (Baltimore), Pica County Interfaith (Tucson), ABLE (Atlanta), TNT (Nashville) and so on. Often the linking theme that mobilizes the community is related to the schools, but sometimes it is health. The model expects confrontation in absolutely classic American style political action. It is non-partisan, issue-oriented, grassroots politics. I look to IAF as a health model because it has developed a simple methodology for listening to the community that takes the faith community more seriously than do most Bishops. It offers you a model for engaging your own religious congregations in an effort to find a vision capable of resonating across race and class. Can you imagine a community united across religion, race, and class willing to work hard and smart to force the critical breakthrough decisions for a healthy community? Can you imagine such a process achieving its goals without you? What part is hard to imagine: the passion of people, the willingness to engage real decisions in politics, your willingness to push the community decision-makers toward health decisions?

- The Carter Center Sentinel Event:

At The Carter Center one of the key health risks that we struggled with is youth firearm death. Injuries, including automobiles and firearms, are responsible for a larger number of lost years of potential life before age 65 in the U.S. than any other risk factor. In at least seven states firearms now claim more young lives than automobiles. The trend lines indicate that this will be true almost everywhere in a few years. Slightly more than half of firearm deaths are suicides; 46% are homicide and about 4% unintentional. This is not only a tragedy for the parents and the families. The fear of firearm violence is dominating life after dark in the United States, dominating recreation and shopping patterns, real estate choices and the routes we choose to get to work and back. It is surely affecting your ability to draw patients. Speaking of patients, it is useful to note that 86% of firearm-related admissions to emergency rooms are not insured. As we explored the fearful prospect of increasing children's deaths, we convened a meeting of national experts on guns and children. I have copies of our report, Not Even One, for everyone here, so I will not go into our conclusions in depth. The basic tool forward is the open, compassionate mind that values each and every child. We came to understand that the key to ending youth firearm death was to look closely at each and every death with the expectation that we could learn what the responsible community could do to prevent the next one. We know it will take 10 years to turn things toward sanity, but we are designing a protocol which would use interdisciplinary teams to undertake a public health investigation of each and every death. This is a simple series of questions to be answered by a team of 6-8 people including someone with links to the school, to a local faith group, to the public health agency, probably the police, maybe an age-peer or two and--why not--the local hospital. The primary goal is to empower the community to find clear-eyed paths forward. If, as we hope, the teams will operate all over the United States, it is likely that national policy choices will also emerge. This strategy is a learning strategy based on humility of the experts and respect for those with different perspectives. Like the IAF model, it understands that when people find their own answers, they are far more likely to be implemented. In this strategy, the vast expertise and rich experience of the religious hospitals are valuable not so much for what you already know, but for what you could learn. You are highly unlikely to find the answer, or even understand the event by yourself. Of course, the learning strategy is applicable to many other health issues than guns and kids. You could use this kind of strategy to find the way forward on youth pregnancy, TB and all sorts of health issues.

- Media Advocacy as a health tool:

Almost every religious hospital offers educational programs without charge to the community. More than half spend some time in public advocacy, usually defined by traditional lobbying at city and state levels on behalf of government funding or policy related to health. Most hospitals are skilled in the use of electronic media for marketing their reimbursable services. I want to urge you to re-imagine these traditional emphases (education, advocacy and media) combined in the service of health promotion and disease prevention. Two

leaders in this area are Larry Wallack of the School of Public Health at Berkeley and Mike Pertschuk of the Advocacy Institute. Wallack describes media advocacy as the process of using the media strategically to apply pressure for changes in policy to promote public health goals. "It provides a framework for moving the public health discussion from a primary focus on the health behaviors of individuals to behaviors of policymakers and corporate executives whose decisions structure environment in which individual health decisions are made." Media advocacy has been most effectively engaged in the struggle with the number one killer in America--tobacco and more specifically, the tobacco industry. Media advocates frame the health issue in a way that allows appropriate response. You can see a furious bare-knuckled struggle in the press now between the tobacco industry and health advocates over the frame around second-hand smoke. "It's a matter of individual rights," says Philip Morris, "A second prohibition!" The issue would simply never have had to be fought if it were not for a network of several hundred health advocates like Larry Wallack coordinated by the Advocacy Institute via electronic Internet. The battle using full-page ads in major newspaper is merely round 300 of a long term struggle. The advocacy equivalent to the battle of Lexington was when Philip Morris tried to co-opt the Bill of Rights by sponsoring a tour of the original document around the country a few years ago. The advocates, at first befuddled on how to derail such a pure American symbol, helped each other analyze the openings for framing the media's understanding of tobacco as a health risk as a terrible wrong. Working online on the Internet the advocates developed a "bill of wrongs" and a 30-foot statue of Nicotina which held up a daily count of how many people had died from Marlboro cigarettes since the Philip Morris tour had been going. The tour was discontinued quietly six months early.

Where are the hospitals in this struggle? Besides treating cancer patients and holding smoking cessation clinics, are you using all your tools to confront the tobacco death machine locally? What if you linked with health advocates locally to frame smoking in a way that the local press could understand? You are doing it already to promote your hospital for political and funding purposes. Why not use the tools to make a direct impact on health by confronting the causes of death and injury in your community? If not tobacco, why not the gun industry or alcohol industry or drug industry? We began this section by looking at congregational health ministers and have moved into more and more social models of health activity. All of these can be based in a hospital but all extend the institution in somewhat awkward ways, pulling the resources into the community.

Gap Four: Working in isolation.

What we have discovered in our research is that institutional isolation is itself a primary health risk in most communities. As we went from city to city we knew that people of different faiths often work without learning from or collaborating with each other. This is true from soup kitchens to hospitals. But it is also true that people of the same faith traditions, but different ethnic groups are isolated, too. And

people of all faiths tend to work in ignorance of their colleagues in secular settings or in different disciplines. I want to indicate three strategic directions you could move, as a leader in a religious hospital, across the isolation gap.

*1. Public Health Partners:* I am continually intrigued by the potential convergence of thinking among the public health community and the religious health community. On the face of it, the public health structure is primarily governmental and secular. And on the face of it, religious health people are mainly into institutional medical strategies. As I have looked for who has the science necessary to undergird a coherent and effective national movement, it is largely public health thinkers. This, of course, is strongly reflected in my Gap One presentation earlier. What is even more interesting, is that the learning edge of Public Health thinking is exactly where I am urging you to look: at the behavioral and social roots of most of our health risks. Both public health and hospitals are far more comfortable with microbes and infections. But just as you are being pulled into the community, public health is being pulled beyond needles and pills into the realm of behavior and social factors. Dr. Jocelyn Elders makes this explicit: Two powerful forces have come together in the first stages of a union that could change (the focus on cure versus prevention), the interfaith community and the public health community. Together they--together we- -can ignite a revolution that changes national attitudes about health care and preventative medicine. In the United States, we pride ourselves on the doctrine of separation of church and state. But we need an integration of church and state in the arena of public service.

Like yourselves, public health strategy is rooted in a world view that sees health as part of justice, not as something available to the highest bidder. It seeks fair and universal access to health assets. Although it has traditionally avoided religious vocabulary, it has always reflected an underlying strategy rooted in social justice and equality. As public health science has increasingly confronted behavior and social action, it has also increasingly reached out to the religious community. Sometimes this is a naive expectation that "people might listen to preachers." Of course, they do not. And sometimes it is a strategy coveting congregational facilities as cheap service sites. But at root, the move toward the religious community is driven by good science and good sense.

Health thinkers like Ronald Labonte are struggling to reformulate the task of health around the concept of community empowerment, wading into the difficult problems of how professional experts can give power to somebody else. He speaks about the need for the underserved to get respectful, professional service from organizations such a hospitals. But he goes beyond to explore deeper linkages. I cite him, not because he has all the answers for you, but because he represents the kind of learning partner that is profoundly useful to you as you are pulled toward the same questions.

I would urge you to look to the public health community as partners with analytical tools suited to the task of finding your way to serve communities, and not just

individual clients. Public health science can help you frame a strategy for employing, not just your health assets, but the much larger pool of health resources laying untapped and unchallenged in the congregations. For instance, as public health science frames the health issue of adolescent violence, you can see why early intervention in broken families is so important. The question is not just how you can help, but how can you bring your community's pastors and lay leaders into action. The Carter Center's protocol for investigating youth homicide will rest heavily on public health agencies and the faith community. Why can't religious hospitals take the lead on the religious side?

Public health practitioners are increasingly focused on health promotion in a way that fits the religious world view like a glove. Hospitals have traditionally reacted to disease far more than they promoted health. Your reactive, cure- oriented science is not much help on the positive side of things. Public health is also on the learning edge, trying to understand not just how we prevent every individual injury and disease, but how we promote wholeness and healthy communities. These are questions that are simply not being asked seriously by many people today. These are exactly the questions you should be asking and, more importantly, helping to answer.

In every city we visited we found it easy to include hospital personnel and public health agencies in serious, substantive planning about how the faith community could play a role in advancing the health status of the entire community. From David Satcher, the head of the CDC to Caswell Evans, President of the American Public Health Association, the public health profession is turning toward the religious community with an appreciative and open mind. These are partners worth your time. I remind you of my earlier assumption that hospitals must be more than specialized marginal agencies in society. Your great power is your mandate and your freedom to ask the right question and to ask it in a way that can lead the entire religious community to respond. Who else will lead the churches and the mosques and the synagogues? The public health community is your natural partner in this kind of task.

*2. Interfaith partnerships:* I have stressed the need to reach out to your public health colleagues. But you must also take leadership in reaching out to your brothers and sisters within the religious community. The essence of gap four is realizing that the most strategic action is building bridges of learning and collaboration with your likely partners in health and faith. Traditional interfaith dialogues tend to be fairly abstract and harmless. Interfaith dialogues framing health are far from abstract. In cities all over the U.S. we have convened a bizarre assortment of faith groups with absolutely consistent experience of energy, creativity and collaboration. In most cases the interfaith group has continued to meet, often with the health commissioner, sometimes with a religious hospital providing leadership. This takes time and staff and some planning or the conversation simply devolves into another committee. But your hospital can be the anchor of a community-wide interfaith

coalition for health that can be a significant asset for implementing the various strategies I have outlined earlier.

One important function of an interfaith coalition is that it is almost by definition inter-racial, too. In most cities in the U.S. today racial polarization and intolerance is a significant health risk in that it impedes community-wide policy making and planning. Scratch the surface of community-wide failure to immunize children or respond to youth violence or provide crisis counselling or adequate primary care and you will find racial division. Unfortunately, in most communities we visited even the pastors meet in separate places. Health can mobilize and sustain activity across all racial lines, especially if the faith community is the organizing framework. Why leave it to the health commissioner or the Mayor to lead the religious community toward health. Why shouldn't the major health institutions serving the religious community take leadership here? The responsibility for leading collaboration falls to the strongest partner in the conversation. In most communities that is likely to mean you.

Gap Five: Matching current deeds with future needs.
We know that we will not fulfill God's intentions of wholeness and health for the world within any of our lifetimes. It is a task we will pass on to our children and theirs after them. We also know that actions we are taking today will affect the life chances of generations to come in ways we are only now beginning to comprehend. The clumsy abuse of resources, the careless abuse of fragile biological networks, the voracious consumption of material things for frivolous purposes is diminishing the prospects for millions of people in coming generations. I say this to make two points. First, as we take urgent steps today to seize the opportunities for health, we must do so with an eye to the long term implications of our strategies and choices. Second, we must make our personal and corporate choices in honest accountability to our own highly privileged status. We in this room are among those to whom vast amounts has been given in trust. This is not some abstraction, but an empirical fact of life--and death. Our choices will affect the lives of children and families for many years to come. Will they experience the fulfillment of God's intentions for health and wholeness? One determinant of that is our wise and faithful choosing in the next few years.

The fifth gap leads our minds down the path hundreds of years and urges us to feel family bonds with people we will never know. What will be the role of religious health organizations 200 years from now? Who can imagine? But we can ask whether religious health organizations 10 years from now will have moved in a direction that makes us more hopeful or more fearful about the longer path. What will we look like in 10 years? Surely "we" will be more interdisciplinary and interfaith than is customary today. The boundaries between public health, hospital, clinic, community organizing, advocacy and congregational ministry will be less distinctive and less problematic.

Many of our organizational structures will have evolved along more integrated lines. In some cases this will reflect a higher level of collaboration of separate organizations, in other cases actual merger of functions. This will depend on local realities of funding, culture and personality. Many existing hospital organizations will no longer exist at all, but will have evolved into other structures for health ministry. Some of the assets will be the wellspring of many community health initiatives. In some cases the religious hospital will have evolved into the active hub of comprehensive health interventions and services linking people of faith from many disciplines and settings into a coherent and competent force for health.

And surely, in 10 years we will continue to prod each other further onto the learning edge of health ministry. We will still be finding our way further into the mystery of how such an odd assemblage of limited human beings can serve as the very hands of God caring for a broken world. Let me dare to say that the turmoil of our time--the frustrated struggle we are experiencing--is not the final dying throes. No, God is not done with us, yet--not with the hospitals or with any of our ministries. The great gift of my time with the Interfaith Health program has been to travel and see hundreds of examples of this on the streets, in the hospitals, clinics and congregations. And surely I have seen only a tiny portion of the abundance of God's handiwork in health.

Bill Foege tells of his breakthrough when he realized that the saying "some things have to be seen to be believed" is exactly wrong. In fact, you have to believe in order to see what you are looking at. We now see clearly that God has not left us alone to find our way by ourselves. God has given us each other and, yes, I believe that God is evident in our midst as we work together. We do not need to seek in fear. Our deepest desire to be part of God's redeeming work in the broken world will surely be honored.

Appendix

Actual Causes of Death in the United States.
The following discussion is based on the article by Dr. William Foege and Dr. Michael McGinnis in the Journal of the American Medical Association, November 10, 1993.

Tobacco: The overwhelmingly largest cause of death is tobacco, accounting for 400,000 deaths a year. Although we perform nearly 5,000 tobacco funerals a day there is never a tobacco death certificate written. But how do they die? Between 11% and 30% of cancer is tobacco linked, 17%-30% of cardiovascular deaths, 30% of lung disease deaths, 24% of pneumonia and influenza deaths, 10% of infant deaths. Diet and sedentary activity Diet and sedentary activity patterns account for 14% of deaths, just under 1/3 million per year. This is quite tricky because diet links to so many other risks. However, we know that 22%-30% of cardiovascular deaths find their cause here, as do 30% of diabetes deaths, between 20% and 60% of fatal cancers. If you take the upper and lower boundaries of these diseases you have a

range between 309,000 and 582,000 deaths per year. Taking the lowest accounts for 14% of deaths.

Alcohol: Misuse of alcohol can be held accountable for 100,000 or 5% of deaths a year but this misstates on the low the side the full impact on the health of communities. Alcohol contributes to 60%-90% of cirrhosis deaths, 40%-50% of vehicle fatalities, 16%-67% of home injuries, drownings, fire and job injuries and 3%-5% of cancer deaths. The Closing the Gaps study identified between 5% and 15% of all years of life lost before age 65 as lost to alcohol. Examining 1987 data, the CDC concluded that alcohol is responsible for 105,095 deaths which is the commonly-cited number in the literature today.

Infectious agents: Infectious agents, not counting HIV, which shows up later, currently account for 90,000 deaths a year. This factor would have been dramatically different at the time of the founding of your institutions which usually predated the growth of preventative public health measures and widespread immunizations. Tuberculosis, which was the second leading cause of death in 1900, for instance, accounted for 1,810 deaths 90 years later. As you know, microbial agents, especially in tuberculosis and HIV are now resurgent and likely to increase as factors of death in the 90's.

Toxic Agents: Toxic agents are among the most difficult, or controversial, to identify with estimated deaths linked ranging from 57,000 to 108,000 in 1990. Toxic agents pose threats as occupational hazards, environmental pollutants, food and water contaminants and as ingredients in commercial products. Cancer deaths attributable to synthetic chemicals range upward from 30,000 including 9,000 from asbestos along. This area includes large non-fatal effects that can be very damaging, such as those that result from childhood exposure to lead and large-scale environmental changes whose impact we are only now attempting to track and understand. Firearms caused more than 36,000 deaths in 1990, 51% of which were suicides The risk of death by homicide experienced by an African American male is now one in 20, surpassing all other risk factors by a large margin--forty-one percent of deaths between 15-19. This is a rate of risk at least 80 times larger than any other industrialized nation. Caucasian risk of homicide is also 800% higher than any other nation. If trend lines continue, within a few years firearm death will surpass auto fatalities in every state in the union.

Sexual Behavior: Unprotected sexual intercourse accounted for approximately 30,000 deaths in 1990, which includes approximately 5,000 from excess infant mortality rates among those whose pregnancies were unintended, 4,000 from cervical cancer and 1,600 from hepatitis B. HIV accounts for 21,000 of the deaths.

Illicit Drug Use: Approximately 3 million Americans have serious drug problems resulting in 20,000 deaths. Vital statistics reports indicates 9,000 deaths directly attributable to drugs which does not include those clearly, but indirectly linked such as accidents, homicides, infections from HIV and hepatitis. The linkage between HIV

and intravenous drug use alone is likely to increase this factor as a cause of death in coming years.

Motor Vehicles: Beside those already accounted for in alcohol or drug use, approximately 25,000 deaths result from motor vehicles. This factor accounts for nearly 40% of deaths among those aged 15-24, although it is going down as firearm deaths are going up.

Other factors: Lack of access to primary care is associated with increased risk of death from many causes, although the exact impact is difficult to quantify. The Carter Project estimated that lack of access to standard primary care, screening and preventative interventions accounted for 7% of premature deaths and 15% of potential years of life lost before age 65 in 1980, mainly due to infant deaths. Poverty is closely linked to lack of access, especially in the United States (and Third World countries), but its impact goes far beyond access.