Mennonite Church USA

Charlotte 2005 Delegate Assembly

Health Care Access Materials for Delegates

Prepared by the Healthcare Access Commission

April 19, 2005

The Atlanta 2003 Delegate Assembly authorized the Healthcare Access Initiative. Working on behalf of the Executive Board of Mennonite Church USA, the Anabaptist Center for Healthcare Ethics (ACHE) formed the Healthcare Access Commission to carry out that Initiative. These materials represent the Access Commission's progress report.

The Executive Board is recommending the following delegate actions in order to continue this project to its completion by the San Jose 2007 Delegate Assembly.

Resolved:

1. That we affirm the *Healthcare Access Statement* as the foundation for our theology and witness.

2. That we commit ourselves, and call on our members and institutions, to promote health and access to healthcare. We will begin by inviting each of our member congregations to utilize *Healing Healthcare: A Study and Action Guide on Healthcare Access in the United States* and to report the results of their study and work to the Healthcare Access Commission by no later than September 30, 2006.

3. That the Healthcare Access Commission continue its work through the next biennium with a primary focus on distributing information and developing tools to assist Mennonite Church USA congregations and their members, as well as area conferences and church-related healthcare institutions, in dealing with the growing challenges of healthcare costs and access as a community of faith.

Special instructions: The information and tools will grow out of a consideration of:

a. the special needs of congregations and institutions as documented by the studies conducted through 2005,
b. the stories that have been shared and collected across the church through surveys, focus group meetings and other means,
c. the variety of creative, innovative methods our congregations and institutions are currently engaged with, as reflected in their reports and suggestions (see #2 above.)

A summary of findings and recommendations will be included as a part of the Healthcare Access Commission’s final report on behalf of Mennonite Church USA for the 2007 delegate assembly.

Mennonite Church USA Healthcare Access Initiative

Project Purpose and Outcomes

April 19, 2005

Background

In response to the healthcare crisis of the early 1990's the leadership of our former Mennonite denominations developed statements calling for justice and stewardship in the healthcare system. When the federal government failed to adopt health care reforms and costs moderated temporarily, little attention was given at a church-wide level to acting on these earlier statements. Ten years later we are facing a larger crisis. We know that our church institutions, our pastors, and many church members are having difficult experiences with the healthcare system. In 2001 the Anabaptist Center for Healthcare Ethics (ACHE) conducted a number of focus groups throughout the church, along with an e-poll of 500 pastors. Participants confirmed that the most important medical ethics issue the church should deal with is healthcare cost and access. The Executive Board invited ACHE to develop a proposal for addressing this issue through a project for Mennonite Church USA. Delegates at Atlanta in July of 2003 approved the following actions:

1. *That Mennonite Church USA develop a new Resolution on Health Care in the United States, taking into account the current problems of access to health care along with the resolutions on record from the former General Conference Mennonite Church (1992) and the Mennonite Church (1993).*

   ***Special instructions**: The new resolution will be disseminated in draft format to Assembly Delegates of record by no later than July 2004, with the understanding that their feedback will be received and integrated into a final statement for delegate action at the 2005 Delegate Assembly.*

2. *That Mennonite Church USA authorize the Access Initiative, a project to demonstrate our commitment, as a community of faith, to universal access to health care by developing models that focus on helping congregations deal with problems of access to health care. These models will incorporate the following principles:*
   - *Access to health care for all persons (The starting point in this project will be Anabaptist congregations and the lives they touch.)*
   - *Emphasis on health promotion and prevention of illness*
   - *An emphasis on healing and caring rather than focusing only on curing*
   - *Recognition of our mortality and the limits required by stewardship of scarce resources*

   ***Special instructions**: The project team will explore the unique resources and talents of Mennonite health care professionals and provider organizations. They will collect, organize, and disseminate stories from providers and church members, work with key stakeholders, and begin engaging congregations interested in developing an access model in their communities. A progress report will be provided for delegates at the 2005 assembly.*

This written report constitutes a portion of the progress report referred to above. Delegates will receive additional information during the assembly.

Purpose

The Healthcare Access Commission was recruited and organized by ACHE in the fall of 2003. The primary objectives included carrying out the above two actions authorized by the Atlanta delegates. The 19-member group includes business professionals, church and lay leaders, educators, and healthcare providers.

Members of the Healthcare Access Commission	
Howard Brenneman	*Phyllis Miller*
James Gingerich	*Dan Nafziger*
Mary Graber	*Rolando Santiago*
Daniel Grimes	*Clare Schumm*
Timothy Jost	*Karl Sommers, Chair*
Joe Kotva	*Rick Stiffney*
James Krabill	*Sharon Waltner*
Allon Lefever	*Ron Yoder*
George Lehman	*Alan Yordy*
Marjorie Mendez	

The Commission adopted a guiding vision:

More equitable access to appropriate healthcare for all Mennonite Church USA members and our neighbors.

While this vision might sound grand, the Commission does not expect to work miracles. It does expect to help the church make incremental gains in promoting health and improving access to healthcare.

As a denomination, we have a tradition of praying for the special needs in our congregations which frequently relate to the health and well-being of members, their families and neighbors. A primary focus of the Commission's work is to provide congregations with practical tools that complement the spiritual and emotional support with which we are most familiar.

The Commission designed a project plan to carry out the above objectives. The tasks described below constitute the main components of this plan.

1. ***Healthcare Access Statement.*** Develop a Biblically grounded, compelling statement of conviction about access to healthcare and our responsibilities as church members in promoting health and access to healthcare.

   Status: Complete. See the statement that is included on the next two pages of this report, along with descriptive comments regarding its development and its role as a basis for action.

2. ***Story Gathering.*** Collect stories of how diverse people of faith are doing imaginative, "outside the box," healthcare access-related ministries. Collect stories of need that help us to better understand the issues of access faced by individuals, families, institutions, and employers.

   Status: This activity is ongoing. Nine stories of innovative work in addressing healthcare access have been documented. Some stories of need have been received; more have been requested. We expect to collect additional stories through analysis of the congregational survey.

3. ***Congregational Study.*** Complete a research project that assesses the problems of healthcare access in 65 randomly selected congregations that mirror the diversity of all churches in Mennonite Church USA.

   Status: Getting 65 randomly selected congregations to agree to allocate an hour to participate in this survey and discussion proved to be a challenge. Most of the 65 congregations that promised to participate have returned their completed survey forms. Analysis of the survey data is scheduled for May. Highlights will be available by mid-June.

4. ***Healthcare Provider Study.*** Develop a report on how our church-related healthcare provider ministries are impacted by the inadequacies of the current U.S. healthcare system.

   Status: A survey was conducted among 75 Mennonite Health Alliance provider institutions. An analysis of the data is being conducted. An overarching concern is the cost of providing uncompensated care.

5. ***Study/Action Guide.*** Fund an ACHE–produced study and action guide on healthcare access for use by congregations, Sunday school classes and small groups. This guide will include the biblical and historical foundations for our convictions about healthcare, our present healthcare challenges, and practical suggestions for how congregations can engage these issues.

   Status: A six–lesson study/action guide entitled *Healing Healthcare: A Study and Action Guide on Healthcare Access in the United States* has been written. Faith and Life Resources is currently designing the materials which will be printed by the end of June. Each delegate attending the Assembly will receive a complimentary copy for use in the sessions on healthcare, and to assist in advocating further use among members of their congregation.

6. ***Develop Recommendations.*** Facilitate a churchwide learning / action process resulting in improved support mechanisms for congregations, effective outreach ministries for our neighbors, and models to advocate for improving public policy.

   Status: This task will be completed in the next biennium. See delegate action #3.

Additional information will be available about the overall project – including new findings from the above referenced surveys – for delegates participating in this Assembly. The Commission is eager to stimulate discernment and collaboration to help the church live out its beliefs so that "God's healing and hope flow through us to the world."

Healthcare Access Statement

Mennonite Church USA

April 19, 2005

Our Theology

As followers of Jesus Christ we seek to provide love and care to all people. Our concern for the healthcare system is rooted in our desire to be disciples of Jesus. Our Savior and Lord intertwined preaching, teaching, and healing as reported in the earliest written Gospel (Mark 2:11-12; 7:24-30; 10:46-52). Jesus focused his mission on abundant life (John 10:10). Jesus healed the sick as a sign of God's reign (Matthew 9:35; Luke 7:18-23). Jesus challenged unjust societal structures (Matthew 23:23), and called for fundamental social change (Mark 11:15-19; Luke 4:16-21). Our concern grows from conviction that all persons have dignity and worth because they are created in God's image (Genesis 1:26-27; 9:6). Our concern blossoms from affirmation that life and health are God's gifts which we respond to in grateful stewardship (Psalm 107). Our concern is energized by realizing that God's love manifests itself in concern for our neighbor's well-being (Matthew 22:34-40; 1 John 3:17-18).

Throughout 20 centuries the Christian church has offered healthcare as part of a worldwide witness. Early Anabaptists incorporated Jesus' concern and care for the poor and the sick into confessions of faith. Citing scriptures such as "faith without works is dead" (James 2:20), Mennonites the world over have sought service opportunities and have made healing ministries pivotal in missions. In that tradition, Mennonite Church USA believes the church in mission "is called to be a channel of God's healing" which includes "the service of prayer and anointing with oil" (*Confession of Faith in a Mennonite Perspective* Article 10 1995). Mennonite Church USA members pledge to live in a way "that God's healing and hope flow through us to the world" (*Vision: Healing and Hope* 1995). Mutual aid, advances in mental health treatment emerging from Civilian Public Service, and compassionate healthcare for all are part of the Mennonite heritage. We now renew our commitment to this tradition of care.

We grieve that our present healthcare system suffers from complexity, greed, racism, fear of death, and lack of concern for the common good. Examples of this suffering include

- ✓ 45 million uninsured, over 70% of whom are among the working poor, who are sicker and die younger than those with health insurance; [1]
- ✓ the world's highest per capita healthcare expenditure coupled with comparatively poor outcomes in life expectancy, infant death rates, incidence of childhood asthma, and immunization rates;[2]
- ✓ the high incidence and cost of chronic diseases related to physical inactivity combined with a rapidly growing percentage of both children and adults who are either overweight or obese;[3]
- ✓ substandard care for persons of color, who are less likely to receive medical services than whites, even with comparable income and insurance;[4]
- ✓ runaway costs which erode employee healthcare benefits, undermine small business, and force more people into personal bankruptcy than nearly any other cause;[5]
- ✓ exclusion of the weakest and most vulnerable citizens from basic, non-emergency healthcare coverage, unlike all other developed nations;[6]
- ✓ decreasing access to appropriate assisted living and skilled nursing care for those on low and fixed incomes, including many who invested their lives in service through the church and now are told that Anabaptist-related providers are financially unable to accept them.[7]

Healthcare, in the biblical tradition of shalom, promotes and improves the physical and mental well-being of persons, families, and communities. While we applaud impressive advances in medical technology and treatment that have done much to cure disease and ease suffering, we contend that healthcare in the United States is unjustly distributed, broken, and unsustainable.

We admit our own guilt in this unjust situation. Due to both our financial interests and our desire to avoid inconvenience and suffering, we often failed in recent decades to make sacrifices to provide aid to those among us who need it most. We have not lived up to our potential in being good stewards of our health. We also failed to speak in a unified public voice calling for change.

God Creator, Redeemer, Sustainer is sovereign over all of life. We respond to God's love by service in all areas of life. So we must assist and prod ourselves, our congregations, our institutions, and our government to care for all people as together we work to promote health and relieve suffering in the name of Christ.

Our Witness

Because health is a gift from God and our bodies are temples of the Holy Spirit (1 Corinthians 6:19)**,** we seek to be better stewards of our health.[8] As Anabaptists we want our Christian beliefs to drive our behavior and actions in relation to our health. At the same time, because we are finite creatures and because we believe in the resurrection of the dead, we will accept limitations on medical intervention from the beginning through the end of life.

Because our life together in Christian community is a foretaste of the kingdom of God (John 13:34-35; Acts 2:37-47; 4:32-35; James 1:18-27) we commit ourselves to work toward adequate access to healthcare for all our brothers and sisters, including our pastors, in Mennonite Church USA.

Because health and healing are part of God's mission to redeem brokenness in the world, we will work with diligence as stewards of the gospel to provide better healthcare access for our neighbors.

Because the scriptural test of a just nation is how it treats its weakest members (Micah 6:8; Amos 5:24; Jeremiah 5:26-29)**,** we will be clear and consistent advocates to policy-makers on behalf of public health matters and access to healthcare for everyone. We join other faith-based communities in urging our government to establish policy for a system of healthcare in which everyone, everywhere in the United States has access to basic, affordable healthcare, and where the risks and expenses are shared by all.[9]

A call to prayer

As Mennonite Church USA 2005 Assembly delegates, we acknowledge that our deepest hopes and most prophetic acts for justice in healthcare will be in vain without God's Spirit leading us into new and unforeseen directions. Therefore, we humbly call on God in prayer to expand our vision and witness in this arena of healthcare access.

NOTES

[1] Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer", publication #7216, February 2005 (at: http://www.kff.org/uninsured/7216.cfm). 80% of the uninsured live in working families, and two-thirds of the uninsured live in families making less than 200% of the Federal Poverty level (less than $37,620 for a family of 4 in 2003.)

[2] National Center for Health Statistics, *Health, United States, 2004* tables 25, 26 and 115. This reference contains a wealth of data about the US healthcare system and is available at http://www.cdc.gov/nchs/data/hus/hus04.pdf. Also see the Organisation for Economic Co-operation and Development (OECD) at http://www.oecd.org/dataoecd/20/48/16502658.pdf and the American Lung Association at http://www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=261875.

[3] Chronic diseases include diabetes, heart disease, and various types of cancer. See, for example, *Health, United States, 2004* from footnote #2 pages 3-4, 34-37, table 69. See also World Health Organization (WHO) Fact Sheet at http://www.who.int/hpr/NPH/docs/gs_obesity.pdf

[4] Institute of Medicine, *Unequal Treatment, Confronting Racial and Ethnic Disparities in Health Care*, (Washington, DC: The National Academies Press, 2003).

[5] Trends and Indicators in the Changing Health Care Marketplace 2002 (Henry J. Kaiser Family Foundation May 2002).

[6] Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington, DC: National Academies Press, 2002).

[7] 2004 Provider Access Survey-MHS Alliance

[8] MMA's Guidelines for the Stewardship of Health at: http://www.mma-online.org/corporate/04_03_stewardship_health_guides.pdf

[9] See: http://www.uhcan.org/faith/faith_statements/intro.htm

From a Statement of Theology and Witness to Action

The purpose of this section is twofold:

1. To provide a context for understanding the healthcare access statement, and
2. To clarify expectations for the remainder of this project.

New Statement on Healthcare

Why prepare a new statement on healthcare?

1. The two earlier versions were developed prior to the formation of Mennonite Church USA. We should have just one statement that reflects the current beliefs of Mennonite Church USA.
2. The conditions have changed considerably since the earlier statements were written. A new statement should reflect our present context.

The Development Process

The Commission considered a number of revisions to the healthcare access statement over the last 15 months. Since this statement is for members of Mennonite Church USA, we wanted to convey a sense of urgency about addressing the growing needs facing the church. Initially, we also wanted to include some very specific suggestions about our responsibilities as a church and our call to government. A draft of a proposed statement was distributed to all congregations in August of 2004. It contained four pages of text organized around (1) the healthcare problems we face (2) our responsibilities as a church, and (3) our call to government action.

The Commission was very grateful for all the congregations and small groups that spent time reviewing the August 2004 draft and writing detailed responses to our questions. As shown in the chart, we received a total of 177 responses – some from individuals and some from groups. Responses came from 109 congregations in 20 of our 21 area conferences. A total of 78 (44% of the total responses) were either split in their vote or expressed some reservations.

Would you vote for the resolution as it now reads?		
Yes	95	54%
No	49	28%
Blank	33	18%
Total	**177**	

During the past five months, both the Commission and the Executive Board reviewed additional drafts of healthcare statements designed to increase the level of support based on the responses to the August draft. Efforts to include a wider scope of common ground regarding the role of the church in relation to government always resulted in rather fervent objections by some while at the same time being strongly affirmed by others. The breakthrough came at the Commission's March 9 meeting, when we agreed that:

1. *Our common ground is our theology. We should be clear about this in the statement.*
2. *Our disagreements reflect different understandings about how to translate our beliefs into policy.*

It is not productive for the church to debate statements based how healthcare systems work and could be reformed. We should remain focused on the principles of our theology. Consequently, we removed specific suggestions included in earlier statements. We agreed it is most important to help the church engage in a study/action process to discover the best way to witness to our theology in local settings. We will discover and record specific recommendations for addressing the healthcare challenges over the next biennium through our actions.

The Healthcare Access Statement – A Basis for Action

The statement begins with a clear, concise description of our beliefs. The first two paragraphs provide the rationale for why Mennonite Church USA should be actively at work to improve health and access to healthcare.

The current healthcare dilemmas are summarized, along with seven examples illustrating areas where there are special needs or a perceived lack of justice and/or stewardship in the healthcare system. We confess our track record on these matters in the past, and commit ourselves to new levels of faithfulness in these matters for the future.

We carry out our witness in four primary ways: (1) by being better stewards of our health, (2) by working to improve access to healthcare among our own members, (3) by working with persons having healthcare needs beyond our congregations, and (4) by being advocates for public policy changes that will improve justice and stewardship in the healthcare system for everyone.

There are many possible ways for Mennonite Church USA members and congregations to carry out our witness in these four areas. The Commission encourages members and their congregations during the next year to explore the various ways of witnessing that are compatible with their needs and interests. Some ideas for illustration are shown in the chart below:

OUR WITNESS	
Method	**Suggestions**
1. Seek to be better stewards of our health. *(Note: Guidelines for the stewardship of health are included at the end of this report. MMA will be helping the church implement these guidelines during the next biennium.)*	a. Become informed on issues of healing, personal well-being, healthcare ethics, and healthcare alternatives. b. Take personal responsibility for our lifestyle choices in regard to diet, exercise, stress management, and avoidance of substance abuse. c. Develop congregational programs that incorporate health promotion and healing as vital to church life. d. Engage the discerning faith community in decision-making that questions the use of expensive medical technologies in assisted reproduction (birth) and the artificial prolongation of life (death). e. Promote adoption and complete advance directives (living wills and proxies) as forms of service to our families, as expressions of Christian stewardship, and as testimonies to our trust in God's care. f. Exercise restraint in the use of expensive advanced medical technology when its use is of questionable long-term benefit.
2. Work to improve access among our members.	a. Ask congregations to make sure that all of their members have access to appropriate healthcare, being sensitive to the needs of the underinsured and uninsured. b. Commit ourselves to imaginative mutual aid among congregations, area conferences and various church institutions, making sacrifices necessary to meet the needs of fellow believers. c. Work with MMA to find alternatives or supplemental measures to commercial underwriting that embody the biblical ideals of mutual aid and compassion.
3. Work to improve access for our neighbors.	a. Commit money and time to create and support local pilot projects designed to provide better access, knowing we learn from both successes and failures. Projects might include free clinics, health education fairs, parish nursing, traveling dental vans, and community-based insurance alternatives. b. Support Mennonite employers and church agencies in finding ways to provide access to health insurance for employees and their dependents. c. Assist Mennonite healthcare providers and administrators in finding additional ways to provide care for the poor. d. Encourage and support Mennonite healthcare professionals to seek employment or volunteer in underserved areas.

OUR WITNESS	
Method	**Suggestions**
4. Advocate for public policy.	Be consistent advocates for healthcare as a basic need of all people, rather than a luxury reserved for the privileged. Listed below are some specific suggestions for public policy changes to bring this about: a. Support measures that move toward basic, affordable healthcare for all. b. Develop policy leading to long-term cost containment such as: (1) Increasing consumer cost awareness wherever possible and competition wherever appropriate; (2) Providing for collective negotiation and regulation of prices of government-permitted monopolies (drugs, medical devices, etc.); (3) Assuring quality outcomes while reducing administrative costs; (4) Constraining the rapidly increasing costs of malpractice insurance. c. Promote increased levels of community-wide collaboration among healthcare providers, health insurers, employers, government agencies, and consumers to improve the health of the community. d. Learn how other developed countries provide affordable access to basic healthcare for all, and apply relevant principles in the United States context. e. Place a high priority on preventive medicine and address public health issues including preventive physical exams, immunizations, proven screening tests, safe water and food, clean air, adequate nutrition, decent housing, sanitation, and economic opportunity.

A Renewed Call to Action

At this Assembly delegates will be asked first to approve the healthcare access statement described above. Secondly, delegates will be asked to affirm their commitment to promote health and access to healthcare over the next biennium as a part of our faith community learning/discernment process. This will be an opportunity for our members to work with some of the suggestions indicated in the above chart, and to share with the broader church what they have learned in their local settings. To do this effectively, we have prepared a study/action guide for use by congregations, Sunday school classes and small groups. Each registered delegate will receive a complimentary copy. Since this material will not be available prior to July, the remainder of this report provides a brief overview of this resource and how we might use it in our journey ahead.

Healing Healthcare: A Study and Action Guide on Healthcare Access in the United States

Description: A six lesson study/action guide on healthcare access. Developed by the Anabaptist Center for Healthcare Ethics and published by Faith and Life Resources.

Style: Written for group study among adults. Each chapter contains the following three elements: (1) a maximum 1,500 words of material for the teacher or group leader, (2) detailed suggestions on leading 60 minute group sessions, and (3) a two sided, reproducible handout sheet for the class that includes highlights, quotes, scripture references and conversation starters. The study/action guide is designed so that it is possible for a whole group to participate with only one copy for the group leader. Additional copies are needed only if group members desire additional information.

Authors/editing: Joe Kotva, Executive Director of ACHE, was the principal editor. The input for each lesson was written by the author noted in the outline below. Dale Shenk, Bible teacher at Bethany Christian Schools in Goshen, Indiana developed the leader support materials including the content of the reproducible handout sheets.

Content: A brief description of each lesson follows, along with the author's name.

1. **The Current U.S. Healthcare Situation** (Karl Shelly)
   a. The current healthcare crisis in statistics and stories.
   b. Connection to public health, preventive healthcare, and economics.

   Summary: The U.S. healthcare system suffers from runaway costs, millions of people without proper access to healthcare, and poor performance in key health outcomes.

2. **Biblical and Theological Convictions** (Willard Swartley)
   a. Biblical and theological underpinnings.

   Summary: The biblical ideals of shalom and justice, Jesus' healing ministry, and the example of the early church teaches us to work for healthcare that is accessible to all.

3. **Christian and Anabaptist Legacy in Healthcare** (John Roth)
   a. The broader Christian story.
   b. Our specific Anabaptist legacy.

   Summary: As Anabaptist Christians, we have a rich history of mutual aid, caring for the sick and the poor, and transformative work in mental healthcare.

4. **Improving Access Locally** (Phyllis Miller)
   a. Possible ways for individuals, congregations, conferences, employers, healthcare workers, and healthcare provider institutions to improve healthcare access for those around them.

   Summary: We can learn from what others are already doing as we meet the call to use our unique gifts to creatively address the local healthcare access needs of both fellow church members and our neighbors.

5. **The Policy Context** (Tim Jost)
   a. What are other countries doing?
   b. What are our public policy options?

   Summary: We can learn from how other developed countries coordinate healthcare, all of whom use public insurance programs to do better than the U.S. in controlling costs and providing access.

6. **What will we do? A call to action.** (Joe Kotva)
   a. An invitation to individuals and congregations to become involved in at least one of the following areas: preventive care, local access, public policy

   Summary: To become involved in promoting health and access to healthcare, we may participate in the following categories of activities:
   (1) Adjusting our expectations for what we demand from the healthcare system;
   (2) Making a renewed commitment to promote wellness and prevention;
   (3) Actively participating in local initiatives designed to help more people obtain access to healthcare; and
   (4) Becoming involved with elected public officials to advocate for improvements in public healthcare policy.

The Healthcare Access Commission encourages active participation from congregations and their members during this next biennium. Our study of these issues should be followed by reflections and actions. In order to learn from this churchwide experience, the Commission would like to hear a progress report from all who participate by no later than September 30, 2006. Delegates at the 2007 Assembly will learn more about our combined efforts and celebrate our churchwide progress.

Guidelines for the Stewardship of Health

Developed for Mennonite Mutual Aid by the Stewardship of Health Guidelines Committee

November 17, 2003

INTRODUCTION

As the stewardship agency of Mennonite Church USA, Mennonite Mutual Aid (MMA) promotes a holistic view of stewardship that goes beyond money management to include time, talent, health, and relationships. As part of this calling to help Anabaptists be more effective stewards of their health, this document attempts to identify the key principles for being a good steward of health that are consistent with our theology. These guidelines are intended to be freeing rather than binding, and to recognize the wide diversity in our understandings about health. MMA offers these guidelines for use by individuals, their families and the church to live out what it means to be a good steward of health. MMA will use these guidelines as a framework for developing and enhancing health-related products and services.

What is health? As Anabaptists, we believe that God calls us to follow the example and teachings of Jesus Christ. We do this as stewards of the Gospel by developing a personal relationship with God, by participating faithfully as members in the Church, and by joining in God's mission to heal and redeem the brokenness in the world. As Anabaptists we seek to have our Christian beliefs drive our behavior and actions in relation to our health. The following definitions reflect personal and community dimensions of health and the stewardship of health.

Health A state of optimal well-being taking into account all aspects of a person's life: physical, spiritual, emotional, intellectual, environmental, and social.[1]

Stewardship of Health Creating a nurturing environment to maximize our God-given potential of physical, spiritual, emotional, intellectual, environmental, and social well-being. Stewardship of health is a journey, motivated by our accountability to God and the church community, seeking a state of optimal well-being.

GUIDELINES

As Anabaptists, we believe that being good stewards of our health calls us to embrace the following guidelines:

1. Celebrate health as a gift from God.

God created humankind in his image and declared that it was very good.[2] Scripture reminds us of God's ever-present care and guidance as we live a life of faithfulness.[3] Jesus preached, healed, and taught God's way, showing in word and deed what God intends for all persons. Jesus said "I came that [you] may have life, and have it abundantly."[4] In this parable of Christ as the shepherd, believers receive and enjoy abundant life – life that is something more, something better, life with advantage – life without fear of death – *eternal life*.

Scripture reminds us that our body is a temple of the Holy Spirit.[5] As we live in harmony with the Spirit, our lives will display love, joy, peace, patience, kindness, goodness, faithfulness, gentleness and self-control.[6]

Being faithful to God means giving thanks for the gift of life and health, and being in tune with God's Spirit at work among us.[7] God's gift of health provides opportunities to develop a deeper, more active love for God by participating in the faith community, serving others, and being served by others. God desires and takes pleasure in our celebrating life.[8]

2. Respond to God's gift of health by living a balanced life.

As Anabaptists, we desire to live by principles that enable persons to be whole and in a state of well-being. Daily life choices influencing our well-being derive from our identity as followers of Christ. These choices are an integral part of our faith, just as prayer, reading the Bible, and attending worship services. We respond to God's love for us through the power of the Holy Spirit by making commitments that honor God. This means making choices that value all dimensions of life reflecting love for God, self, and others. It means striving for the right balance in all aspects of our lives: physical, spiritual, emotional, intellectual, environmental, and social.

God as creator calls us to value all dimensions of life. In the creation of the world, six days of work culminated in a day of rest and celebration. God blessed and set aside the Sabbath for the use and benefit of humankind.[9] We respond to God by cultivating an appropriate rhythm in our lives as we: work, play, eat, exercise, worship, pray, rest and serve others. We seek positive attitudes and enjoy humor[10] in relationships and in situations we cannot control. We strive to please God through our habits and lifestyle choices, not for personal benefit, but to live as faithful stewards of the Gospel throughout life's stages.[11]

3. Transform our faith communities to improve their stewardship of health.

In Scripture God gave his people guidelines to assure the well-being of the community. God promised freedom and health in the community in exchange for careful adherence to them. We believe faithful obedience to the Ten Commandments today would have a profound impact in transforming communities to live out a life of wholeness. Nurturing a relationship with God and caring relationships with others leads us to experience well-being in our lives.

The witness of Jesus provides three images for transforming our faith communities:[12]

Community	The church is a community of disciples called to carry out God's mission in the world.
Cross	Jesus' taking up the cross was an act of self giving love[13] that is reflected in the community by practicing mutual aid, thus bearing each other's burdens.[14]
New Creation	The church community embodies the power of the resurrection in the midst of a broken world.

In practical terms, these images motivate us to:

a. Develop discernment processes for church members to understand God's call and to be accountable to each other in carrying it out.

b. Strengthen the congregation as an interpersonal community of love, forgiveness, reconciliation, and healing.

c. Welcome and care for persons the world may consider unhealthy.[15]

d. Strive to make the institutions of our society contribute to the greater well-being of all.

e. Adopt earth-caring lifestyles to protect the condition of God's creation around us.

The purpose of these activities is to empower people in community to experience wholeness throughout their life journeys, and to help restore the world so that life in its fullness is possible for all members of the human family.[16]

4. Discern within the church community the faithful use of money and other resources to maintain health.

Health care expenditures in the United States ($5,035 for each American in 2001) are higher than in any other country in the world, yet over 40 million persons under age 65 do not have health insurance.[17] How much money and other resources are needed to maintain our health?

Chronic disease accounts for roughly 75% of health care costs each year. The focus in our health care system has not been on prevention of chronic disease, but on treatment of short-term, acute health problems. As a nation, we have emphasized expensive cures for disease rather than cost-effective prevention.[18]

To be responsible stewards in the use of resources to maintain health, we must become well informed and willing to modify our decisions and behaviors that are not in the best interests of the community. This means we must:

a. understand the health risks persons face based on their life stage, physical condition, and family history,
b. adopt personal habits and behaviors that incorporate preventive measures, and
c. evaluate the cost and benefits of available alternatives when purchasing health-related services.

We need discernment processes at work within the community of faith to help members deal with the difficult health care choices they face. Ultimately we must replace our irrational pursuit of curing with a new understanding of healing, which stresses the overall well-being of the person and community.[19]

To promote justice in our health care system,[20] we must recognize that financial resources are limited and that excessive spending on health care reduces our ability to meet other social needs in our broader communities (e.g. education, housing, and transportation.) Discernment processes assist individuals in knowing how to balance their personal health care needs with the needs of the entire community at a reasonable cost.

5. Recognize with confidence that death is a defeated enemy to be resisted but not ultimately to be feared.

Losses begin at birth and are a part of life's experience. These losses may be personal, such as in developing an illness or disability, or losses may be in relationships: divorce, children leaving home, or death of a loved one. Grieving is a normal, healthy response to a loss. Jesus wept as he grieved the loss of his friend Lazarus.[21]

Physical and emotional suffering and death have always been a part of the human experience because God's Kingdom has not yet been fulfilled. Through the power of the resurrection, death has been defeated. As Christians, nothing can separate us from the healing power of God's love, even though the result of losses and suffering may be physical death. We live with the promise of eternal life.

In dealing with losses, suffering and death, we choose to live, as much as possible, the way God would have us live. This may include:

a. Naming the loss and accepting responsibility for dealing with illness, disease, and brokenness and the suffering that comes with it.
b. Asking for guidance, prayer, and support from the community in coping with special needs and the difficult questions that come with illness and suffering.
c. Recognizing God as our companion in walking through our human efforts to restore health, as well as in the dying process.
d. Accepting death as the culmination of life's journey, anticipating transition into the fullness of God's new creation.

While death is a part of life, God promises us continuing life in his new creation.[22]

NOTES

Scripture quotes below are from the 1989 New Revised Standard Version of the Bible unless identified otherwise.

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[1] Most dictionary definitions include two variations as noted below from The American Heritage Dictionary of the English Language, Fourth Edition, 2000, Houghton Mifflin Company.

(a.) "A condition of optimal well-being" and (b.) "The overall condition of an organism at a given time."

We have chosen to define health in keeping with point (a.) This statement recognizes the definition of optimal health will vary widely, depending on a person's current state of health (or illness), age, physical limitations, etc.

Health has been defined in various ways over time. Ancient Greek physicians believed health to be a condition of perfect body equilibrium. Native Americans believed that being healthy was to be in harmony with nature. The Western world tried to understand health by examining its individual components rather than the interconnections of the various parts. This led physicians to focus primarily on disease and disability. In 1946 the World Health Organization defined health as: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Since that time, as holistic health concepts have been integrated into health promotion programs, wellness models frequently include emotional, spiritual, and environmental elements. (See Wolf Kirsten, *Health Promotion – an International Phenomenon*, National Center for Health Fitness, American University, 1997)

[2] Gen. 1:27, 31 "So God created humankind in his image, in the image of God he created them; male and female he created them..... God saw everything that he had made, and indeed, it was very good."

[3] Psalm 139:1-6 "O LORD, you have searched me and known me. You know when I sit down and when I rise up; you discern my thoughts from far away. You search out my path and my lying down, and are acquainted with all my ways. Even before a word is on my tongue, O LORD, you know it completely. You hem me in, behind and before, and lay your hand upon me. Such knowledge is too wonderful for me; it is so high that I cannot attain it."

[4] John 10:10 "The thief comes only to steal and kill and destroy. I came that they may have life, and have it abundantly."

[5] I Cor. 6:19 "...your body is a temple of the Holy Spirit within you, which you have from God,.."

[6] Gal. 5:22+ "But the fruit of the Spirit is love, joy, peace, patience, kindness, goodness, faithfulness, gentleness and self-control."

[7] Psalm 145:2 "Every day I will bless you, and praise your name forever and ever."

[8] II Cor. 5:17 "So if anyone is in Christ, there is a new creation: everything old has passed away; see, everything has become new!"

[9] Exodus 20:11 "For in six days the LORD made the heavens and the earth, the sea, and all that is in them, but he rested on the seventh day. Therefore the LORD blessed the Sabbath day and made it holy." (1984 New International Version)

[10] Proverbs 17:22 "A cheerful heart is a good medicine, but a downcast spirit dries up the bones."

[11] I Cor. 10:31 "So, whether you eat or drink, or whatever you do, do everything for the glory of God."

[12] Richard B. Hays, The Moral Vision of the New Testament, HarperCollins, 1996, pages 196–198.

[13] Mark 10:45 "For the Son of Man came not to be served but to serve, and to give his life a ransom for many."

[14] Gal. 6:2 "Bear one another's burdens, and in this way you will fulfill the law of Christ."

[15] Luke 14:21 "Go out at once into the streets and lanes of the town and bring in the poor, the crippled, the blind, and the lame."

[16] Howard Clinebell, Anchoring Your Well Being: Christian Wholeness in a Fractured World, Upper Room Books, 1997

[17] U.S. Department of Health and Human Services, *Health, United States, 2003 with Chartbook on Trends in the Health of Americans*, tables 112 and 151, DDHS publication No. 2003-1232.

[18] From Centers for Disease Control and Prevention (CDC), *The Power of Prevention*, 2003

- Five chronic diseases— heart disease, cancer, stroke, chronic obstructive pulmonary disease (e.g., asthma, bronchitis, emphysema), and diabetes—cause more than two-thirds of all deaths each year.
- Three modifiable health-damaging behaviors—tobacco use, lack of physical activity, and poor eating habits—are responsible for approximately 33% of all U.S. deaths each year.

[19] From the resolutions on health care passed by the Mennonite Church delegates in 1993, and the General Conference Mennonite Church delegates in 1992.

[20] Luke 4:18-19 "The Spirit of the Lord is upon me, because he has anointed me to bring good news to the poor. He has sent me to proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free, to proclaim the year of the Lord's favor."

[21] John 11:35 "Jesus began to weep."

[22] Romans 8:22-24 "We know that the whole creation has been groaning in labor pains until now; and not only the creation, but we ourselves, who have the first fruits of the Spirit, groan inwardly while we wait for adoption, the redemption of our bodies. For in hope we were saved."