KEVIN TANKERSLEY PHOTO

Congregational Health Ministry Survey Report

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The ancient Hebrew prophet Jeremiah asks, "Is there no balm in Gilead?" For the faith families of the three Abrahamic traditions, health – physical, mental and spiritual – has historically been closely linked with deeply held religious beliefs. Within the United States much of what we know as the complex fabric of health care has its origins in the religious communities. Today the landscape is still dotted with voluntary hospitals whose titles reflect their origins; Augustana Hospital, Presbyterian St. Luke's, Jewish Hospital. Many Christians are highly conscious of the central role of healing within the ministry of Jesus. Indeed, there are some 42 accounts of Jesus providing healing contained within the Gospel – a larger number of accounts than those of Jesus preaching or teaching. With all its religious pluralism the United States provides a unique laboratory for the study of health care and religious practice. The expression of faith through the provision of health services is not limited to specialized church-related health institutions but is an intrinsic part of the witness and mission of tens of thousands of local congregations as well. The Congregational Health Survey conducted by the National Council of Churches USA in 2006-07, represents a modest attempt to understand more fully the nature of congregational involvement in the provision of health education, provision of direct health services and advocacy activities related to health care policies. This report summarizes the results of that study and suggests some implications from its findings, which may be of interest to pastors, denominational leaders, health care advocates and the public at large concerned with the state of health care policies in the United States today.

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WHY STUDY THE CONGREGATIONS HEALTH MINISTRIES? WHY NOW?

The National Council of the Churches of Christ, USA, is the nation's preeminent ecumenical agency comprised of 35 member churches with a constituent membership exceeding 44 million believers. The diverse member churches come together in the NCC where they explore the nature of Christian unity and when possible share in a common witness to the world. Throughout its long history the NCC has been a venue for the member churches to work together on a wide variety of issues related to health and health care policy. In recent years the NCC and its member churches have shared with the American public a growing concern for the issues of the cost and equity of access to quality health care for all Americans.

During the last four years the NCC has participated in a broad coalition of others in supporting Cover the Uninsured Week which promotes awareness of the more than 47 million uninsured Americans. Moreover, within the national dialogue, which has increasingly addressed concerns about the American health care system, various observers have suggested an expanded role for the "faith-based" sector in meeting the health care needs of our society. The member churches of the NCC are organized locally in more than 105,000 local congregations. It is through such local congregations that "faith-based" initiatives take place at the community level in meeting the needs of underserved, and privileged, populations.

While much discussion takes place concerning the provision of such services, little is actually known about the extent and nature of such health ministries, as they are typically called, on a national scale. Some previous research has been conducted by, for example, the African Methodist Episcopal Church, and the Presbyterian Church USA, but such studies are designed to render denominational perspectives often shaped, understandably, around denominational priorities. No previous research has sought to ask the same questions across denominational boundaries with a specific focus on activities of health education, direct service provision and public policy advocacy.

The NCC initiated the Congregational Health Survey motivated by the confluence of these factors: apparently increasing local response to unmet health needs, a growing need among member churches to form a self-consciousness network of churches providing such programs, and a sense that in a renewed national debate concerning health care policy, the national churches would be guided in their exercise of moral authority in that debate by the lived experiences taking place daily in their respective congregations.

"Health ministry" is understood as compassionate care activities related to health needs conducted as part of a church's overall mission.

WHAT CONGREGATIONS WERE INCLUDED IN THE STUDY?

The Congregational Health Ministry Survey consisted of 15 questions, including identifier and demographic questions, and questions pertaining to congregations' involvement in an array of health activities over "the past 12 months." "Health ministry" is understood as compassionate care activities related to health needs conducted as a part of a church's overall mission. A listing of health activities was presented in areas of education, provision, voluntarism, events and advocacy. Open-ended questions permitted reporting of alternative or specific health-related activities. The six-page survey was mailed in stages to an available sample of 88,400 congregations between December, 2006 and April, 2007. For the sake of convenience and cost, respondents were given the opportunity to respond over the Internet, and 2,519 responses were received online. The sample predominantly consisted of congregations from the member communions of the National Council of Churches USA, but other church groups were specifically included to assure a greater diversity of congregations.

Limits of time and money made it impractical

to include all congregations of all NCC member churches within the sample to be surveyed. At the local level, many such initiatives are often co-operatively sponsored by two or more congregations. For this reason the survey was also sent to 231 local and regional ecumenical and/or interfaith agencies (state councils or conferences of churches, etc.). A small number of mosques were included in the sample (20).

Finally, as is common practice in such religiously based surveys, local clergy "passed along" the survey to neighboring churches which sponsor health care programs when their own congregations do not offer such programs. As a result of this practice, congregations of traditions outside of NCC membership responded and are included in the analysis. While this sample does not provide a representative sample of all churches, it does encompass a significantly large, wide and diverse segment of the congregational universe.

WHO RESPONDED TO THE SURVEY?

By the close of the data collection phase of the project 6,037 usable surveys (7%) had been returned electronically, via fax, or by return mail. Analysis of the denominational affiliations of the respondents is reported in Table 1. While the largest number of responses was provided by the larger mainline protestant denominations, notably United Methodists and Presbyterians, the total sample is drawn primarily from 11 national church bodies, ecumenical agencies, as well as from the Muslim community. Some large denominational bodies, for example, the Episcopal Church provided only a sample of their congregations rather than a full listing of congregations to be surveyed.

Racial composition of the respondents was overwhelmingly identified as Caucasian (90%). African American congregations represented 16% of the surveyed sample and 4.7% (282 individual cases) of respondents. Asian/Pacific Islander congregations 0.7% (41 cases) and Hispanic respondent congregations represented 1% (60 cases) and multicultural congregations 2.2% or (132 cases). These latter four groups were likewise under-represented in the overall sample due to unavailability of adequate mailing lists. Additional means will need to be pursued in order to gain a fuller picture of the health care ministries within minority communities. Data from a survey conducted by the African Methodist Episcopal Church may provide a broader perspective on that particular African American community, but were unavailable at the time of this report. More than 98% of the responding congregations use English as the predominant language in their worship services.

Congregational size was thought to be an important consideration in a congregation's capacity to initiate and sustain health care ministries given the labor-intensive nature of the tasks to be undertaken. It was not surprising therefore to discover that responding congregations represented congregations that are, on the average, larger than all US congregations as reported in the highly respected National Con-

Table 1 – Number of responses, by denomination

Denomination Name	*Number of Returned Surveys*
The United Methodist Church*	2516
Presbyterian Church (USA)*	1240
Evangelical Lutheran Church in America*	956
United Church of Christ*	743
Episcopal Church*	172
Missing, Ambiguous, or Unknown Group	164
American Baptist Churches in the USA*	43
Progressive National Baptist Convention, Inc.*	39
Church of God (Anderson, IN)	38
The Church of God in Christ	37
Others**	217

Note for Table 1: Congregations reporting more than one affiliation are reflected separately under each group.
* Denotes a Member Communion of the National Council of Churches USA
** For a full listing of other congregations responding, go to www.health-ministries.org.

gregations Study. Table 2 illustrates a comparison of respondent congregations compared to all congregations based on membership. The larger size of respondent congregations relative to all congregations was confirmed in a comparison based on average non-holiday attendance as illustrated in Table 3.

Table 2

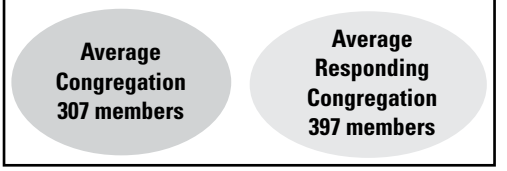

Table 3

More than one quarter of all the responding congregations are located in suburban settings with an additional 20% reporting their community type as "rural non-farming. Rural farming and small city communities accounted for 15% each in terms of the community type reported by responding congregations. Ten percent reported their location as within a small town with only 9% reporting their location in the inner city.

The surveys were completed in 74.5% of the cases by the pastor of the congregation, 8.4% of the surveys were completed by lay persons and in a similar number of cases (7.4%) by a staff person other than the pastor. States with the largest representation in the sample were Pennsylvania (552), Ohio (385), New York (315), Illinois (265) and California (251).

WHAT CAN WE LEARN FROM THIS SURVEY?

The Congregational Health Ministry Survey constitutes a pioneering study in the field of health activities and congregations. The results of this study:

1) Document the very large amount of congregational activity addressing health issues; 2) Portray the range and distribution of the health-related activities in congregations; and 3) Suggest the characteristics of congregations that are most involved in the provision of health services.

The 6,307 congregations who responded to the survey and their collective 2.5 million members, have responded to the needs of their communities though programs of education, direct services and advocacy. While this initial survey leaves undocumented much of the congregational landscape of the United States it does provide an important basis upon which future studies might build. Used within appropriate constraints the findings of this study do much to advance our knowledge of congregational responses to health care needs within their communities and their capacity to address those needs.

WHAT PATTERNS OF HEALTH CARE MINISTRIES WERE REPORTED?

Only 6.4% of the respondents reported that their congregations offered no programs of any kind in health care ministries. It should be noted that this figure is probably lower in all churches as some recipients of this survey may have chosen not to complete it since, in their perception the survey was "not for them" because they provide no such services. The sample of the 6,037 responding congregations report a staggering total of 78,907 programs of health ministries or an average of 13.07 health-related activities per congregation.

The three program areas which served as the foci of this survey were:

1) health education

2) direct provision of health services, and

3) advocacy of public policies related to health care.

In order to isolate these three types of health care ministries from more typical

Table 4 – Program Frequencies

Program Frequency	*%*	*Total*
Volunteer Services	87	18,754
Direct Service	70	13,033
Health Education	65	24,072
Health Events	57	17,988
Advocacy	35	5,052

volunteer services routinely offered by congregations and from one time "health events" which are not necessarily sustained programs, separate responses were also recorded for volunteer services and health events. Table 4 reports the frequency of report in each of the five areas of programming.

Table 5 – Respondents Reporting Health Education Activities

Prevention	28%	Dementia	12%
Older Adults	28%	Drugs	12%
Explain Programs	24%	Organ Donation	12%
Members' Health	24%	State of Regional Health	11%
Exercise	24%	Diabetes	11%
End of Life	23%	Obesity	10%
Spiritual/Alternative	21%	Teenagers	10%
Nutrition	21%	Child	10%
High Blood Pressure	20%	Uninsured	9%
Additions	20%	Needed Resources	8%
Handicap Accessibility	17%	AIDS	8%
Alcohol	16%	Smoking	7%
Mental Health	15%	State Child Health Insurance Program	4%
Government Policies	14%	Family Planning	3%

Within the congregations, provision of volunteer services routinely takes place independent of other health care ministries. These volunteer services are often hallmarks of the sense of community established by congregations as they reach out to each other as members of a given congregation. Fully 87% of the congregations reported their participation in such activities as visitation to the sick, provision of meals and transportation to medical appointments and assistance with health related paperwork. Even congregations that have not established health care ministries are apt to provide such services.

Health-related events, such as use of the church facilities for blood donor drives or health fairs, are by definition limited-time events rather than on-going programs and therefore require less structure, staffing and budget to accomplish. The impetus for health events, such as a blood drive, may originate outside of the congregation. Indeed congregations may simply permit the use of their facilities for such events that are actually planned, initiated and conducted by community health agencies. These events organized by outside organizations might provide hearing and vision screening, or flu shots, for example. Such health events may be "portal" events for congregations, introducing members of the church to problems they may not have been aware of in their community, pointing to new and interesting programming possibilities, and suggesting new or broader ministries to their membership and/or communities. Such events may serve to sensitize congregations to largely unspoken health concerns that are not adequately addressed by existing systems. As these needs become better understood within the congregation a decision may be made to develop an ongoing response through some form of sustained program. Fifty-seven percent of the respondents reported hosting health events within their congregations.

HEALTH EDUCATION

More than 65% of the respondents report offering health education programs within their community. With a median of four programs per congregation more than 24,000 health education programs were offered by the sample as a whole. Table 5 lists the kinds and frequency of the content of these educational programs.

Congregations that run at least one education program are likely to run several. While 35% of the congregations in the sample run no education programs, of those that do, more than 80% run multiple education programs. More than 30% of all congregations in the sample ran five or more education programs.

These data were analyzed to better understand which congregational characteristics (e.g. race composition, location, size, etc.) best predict the operation of education programs. Holding all other factors constant, African American congregations as well as suburban and urban downtown congregations ran disproportionately more education programs than other congregations in the sample. The best predictor of the operation of numerous health education programs was average attendance; clearly, larger congregations run more programs than smaller congregations.

For every additional 250 people in attendance, one more educational program was run. No significant findings with regard to denomination or region were found.

DIRECT SERVICE

Surprisingly, more congregations in the sample engage in the provision of direct health services (70%), than provide educational health programs (65%). Direct services are understood to mean provision of medical care provided directly to individuals, usually by someone specifically trained to do so. However, a lower total number of direct service programs (13,033) are offered than total educational programs (24,072). This is probably explained by the greater need for organization, financial resources and personnel required to sustain direct service programs. Only a quarter of congregations provide three or more direct service programs. The array and frequency of direct service programs offered is reported in Table 6. Health screenings were by far the most common form of direct service provision with 27% of all congregations providing some form of screening. Thirty-seven percent of congregations provided at least one service exclusively to their own congregation, while 31% of congregations provide at least one service exclusively to the community. More than 50% of congregations provide direct service to both. This table illustrates that, with the exception of the services of a parish nurse, all direct services are more frequently offered to both congregation and community than as a service to congregational members.

Table 6 – Direct Services

Counseling (Referrals)	32%
12-Step Program	32%
Screening	27%
Emergency Medical Funding	25%
Exercise	23%
Counseling (mental health)	22%
Clinic	20%
Counseling (provide service)	20%
Support Group	20%
Parish Nurse	18%
Referrals	16%
Daycare Health	8%
Health Minister	5%

A statistical analysis was performed to better understand which congregational characteristics best predict direct health care service provision. Once again, larger congregations (higher average attendance) predicted provision of greater numbers of direct service programs. Controlling for all other factors, suburban and urban downtown congregations provided significantly more direct service programs. Rural congregations offered fewer such programs. In the case of rural communities, the existence of both larger congregations and direct service provision may be in inverse relation to need. Neither denominational affiliation nor the predominant race of the congregation had a significant effect.

WHO RECEIVES THE DIRECT SERVICES?

The survey explored the balance between the provision of direct service to "congregation only" or to the community. An attempt was made to assess the congregational characteristics that best predict a "congregation only" orientation. Again, larger congregations were less likely to emphasize "congregation only" services. Downtown urban congregations were also significantly less likely to emphasize "congregation only" services as they were to offer programs for the wider community. Rural congregations had more direct services for the "congregation only" as opposed to services provided to the wider community. No significant effects of race, denomination or region were observed.

Table 7 displays the pattern by which congregations offer a variety of direct services to congregation members exclusively or to community members at large. The most significant finding is that services offered to both the broader community as well as congregation members is the most common practice of congregations offering direct services. The only exceptions to this pattern is with regard to the services of the parish nurse (and in the few cases in which a health minister, his/her services tend to be restricted to congregation members). This restriction is likely due to the practicability of limiting the work load of parish nurses and/or health ministers.

Taken as a whole, the patterns of service to congregation and community underscores the extent to which congregational involvement in health services is viewed by congregations as a ministry within the broader community rather than an intramural benefit of church membership.

Table 7 – Who is Served?

CLINIC	20%
For Congregation	4%
For Community	6%
For Both	12%
REFERRALS	16%
For Congregation	4%
For Community	4%
For Both	8%
SCREENING	27%
For Congregation	7%
For Community	5%
For Both	16%
SUPPORT GROUP	20%
For Congregation	4%
For Community	5%
For Both	12%
EXERCISE	23%
For Congregation	7%
For Community	4%
For Both	13%
12-STEP PROGRAM	32%
For Congregation	2%
For Community	13%
For Both	18%
HEALTH MINISTER	5%
For Congregation	2%
For Community	0%
For Both	2%
DAYCARE HEALTH	8%
For Congregation	1%
For Community	2%
For Both	3%
COUNSELING	22%
For Congregation	7%
For Community	2%
For Both	11%
COUNSELING (provide service)	20%
For Congregation	7%
For Community	2%
For Both	11%
COUNSELING (referrals)	32%
For Congregation	12%
For Community	3%
For Both	17%
PARISH NURSE	18%
For Congregation	10%
For Community	1%
For Both	6%
EMERGENCY MEDICAL FUNDING	25%
For Congregation	8%
For Community	5%
For Both	12%

ADVOCACY

As might have been expected, public policy advocacy was a far less common practice, although among the congregations who practice health care advocacy, there is a wide array of approaches to this activity. Advocacy can be understood as efforts to inform and/or urge action on health policies and practices on a systemic level, usually involving public officials. The variety and frequency of these advocacy activities is shown in Table 16. About a quarter of all congregations engaged in any form of advocacy. Of these, 60% of congregations (15% of all congregations) participated in two or more forms of advocacy. When hearing sermons on advocacy issues is included, fully 35% of congregations have one or more advocacy practices.

A health advocacy scale was produced incorporating all advocacy activities except "hearing a health advocacy sermon." Controlling for other characteristics, larger congregations, African American congregations, as well as suburban and downtown congregations were significantly more likely to engage in advocacy. White and rural congregations engaged in significantly less advocacy. Similarly some denominational differences in response were observed.

Incorporation of whether or not the congregation heard sermons on health advocacy issues went hand in hand with an additional 17% of increase in congregational advocacy by itself. Furthermore, it eliminated the predictive significance of being an African American or suburban congregation. That is, African American congregations, or suburban congregations, are simply more likely to have heard sermons on advocacy, which we observed occurs together more often than expected with more advocacy activities. African American churches without a pastor who advocates are no more likely than Hispanic or Asian congregations to engage in advocacy. White congregations, even allowing for the effect of advocacy sermons, engaged in less advocacy. Larger congregations and downtown congregations engaged in significantly more advocacy activities, controlling for the role of sermons.

In general regional patterns were not observable with the exception of California. At the time of the survey California was engaged in a statewide reform effort with regard to health care coverage. This timing may account for the finding that the California churches in the sample engaged in advocacy substantially more than the sample as a whole. This performance was 11% above the mean in the sample as a whole.

WHY DO SOME CONGREGATIONS ENGAGE IN HEALTH CARE MINISTRIES AND OTHERS DO NOT?

As has been suggested by several of the findings above, size of congregation has been shown to be a significant factor in predicting congregational engagement in education, direct service or advocacy activities related to health care. But size alone is not sufficient to predict broad and multifaceted embrace of health care as a field of ministry activity. Our reflection on both the statistical analysis and the substantial anecdotal information that was received with the returned surveys suggests a more complex confluence of factors. These factors, taken together might be described as capacity, leadership and opportunity.

Capacity often comes with size especially as relates to organizational coherence, financial

and human resources and a congregational orientation toward active programming in addition to the worship activities of the congregation. Capacity is also measured in terms of the stature of the congregation within the community and whether it is looked to within the community as a source of community service and programming in relation to issues such as child care, feeding programs or homeless shelter. Congregational literature often emphasizes the "200 mark" of membership above which programming becomes not only expected but critical to institutional membership. While there are considerable and notable exceptions to this rule of thumb, these data corroborate this tendency especially in provision of direct services beyond the congregational membership. Finally, capacity may be understood in terms of congregational self-perception of having skills and or services sufficient to address needs within the complex world of health care. Even small congregations with members willing and able to assist others in completing complex insurance forms or schedule transportation to a series of medical treatments, is in possession of considerable capacity.

Leadership appears to be a critical element in congregational provision of education, direct service and policy advocacy activities. The study strongly suggests the importance of pastoral leadership in enabling congregational participation in policy advocacy. With regard to health education and direct service provision as well as advocacy activities, a number of other sources of leadership were noted in the anecdotal material. Parish nurses, and far less commonly, health ministers too, provide crucial leadership in forming and maintaining health initiatives within congregations. A surprising number of other sources of leadership for congregations in their pursuit of health care activities were identified. Denominational staff or coordinators specifically focused on health ministries were commonly recognized as resources. While there is by no means such a role identified in each denomination, in those instances in which there are such persons, local congregations look to them for assistance and leadership. That leadership comes in both print and electronic materials, conferences and especially in identification of experience-based or "best practice" models. Leadership is also sometimes available from local ecumenical agencies focused on health care and operates across denominational lines often in relation to local or state councils of churches. Finally, leadership comes from key lay persons within the congregation with specialized health care knowledge. Numerous comments within returned surveys highlighted the leadership roles of retired doctors, nurses, medical technicians and social workers initiating and staffing various programs of education and direct service. The role of key lay leaders in making health ministry happen in congregations, how laypersons interact with the pastor, how voluntary involvement translates into programming, are undoubtedly fruitful areas for further research.

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Opportunity might express a final critical element in relation to congregational provision of health care programs of education, direct service and advocacy. This matter of opportunity is related to leadership but is also closely related to awareness of health needs in the specific community surrounding the congregation. Opportunity seems to present itself through a variety of means judging from the anecdotal responses from the sample. Health events initiated by a municipal office or neighboring hospital may serve to quicken a congregation's awareness of the need for greater education about diabetes or hypertension, for example. Cover the Uninsured Week has been instrumental in calling the attention of congregations to the needs of those – within both congregation and community – who skip medical appointments or fail to have prescriptions filled when they lack insurance coverage. Sponsoring or serving as volunteers at homeless shelters often awakens congregational awareness of chronic physical and mental health needs among that

population. This awareness, in fact, becomes opportunity for service as congregational members seek to find ways to address unmet needs. It is not uncommon for congregations to discover holes in the fabric of the health care system and seek to address such needs directly through preventative education, medical services or advocacy.

Within congregational life then, capacity, leadership and opportunity, it seems form a kind of "fire triangle" which best explains the combustion that results in congregational initiation of health care ministries of education, direct service and advocacy. The form which that initiative takes is unique to the community and to the congregation. The patterns of activity that were reported in this sample are highly differentiated and conform to few norms. Health ministries are undertaken by congregations alone, with other congregations or in partnership with secular organizations in relation to a dizzying array of health issues and needs. Some are directed primarily to meet the needs of congregational members and others are offered without cost to any in need. Some are complex and expensive operations, which require extensive financial support garnered often from sources outside the congregation. Other programs are operated entirely within the modest budgets of the church. While no questions on the survey addressed the longevity of congregationally based health care programs, anecdotal information suggests that such programs are expanding in size and moreover, that the number of congregations finding health care services as a part of their own sense of mission is growing.

WHAT ARE THE IMPLICATIONS OF THIS STUDY?

The rich fabric of congregational involvement in health education, direct service and public policy advocacy hold numerous implications for institutions related to congregational ministry and/or to health care. Our purpose in reporting these data fully as represented in the tables is to enable these groups to examine the data and draw their own conclusions.

The National Council of Churches and its member communions recognize in the findings of the study considerable confirmation that local faith based organizations can and do play an important role within the complex picture of health care in America. The study confirms, as well, the reality that congregations look to national denominational and ecumenical structures for a variety of institutional supports related to these ministries. National denominations and ecumenical agencies will likely wish to review and strengthen their respective relationships with congregational health ministries in a number of ways which may include:

- Creation and/or maintenance of networks of congregations engaged in health ministries.
- Establish or strengthen national staff structures which relate to health-engaged congregations.
- Development of electronic communications and print and electronic resource materials.
- Consider incentives to congregations to explore involvement in health care ministries through time limited "health events."
- Sponsor conferences, perhaps ecumenically, to advance training, provide resources and to nurture these ministries.
- Prepare and disseminate sermon resources related to the health care system and policy reform.
- As health care public policy debates arise in the national agenda, denominations working together, will want to draw from the lived experiences of local congregations in providing testimony regarding the unmet health care needs of the communities they serve.
- Denominations will likely wish to reason together about the ways to celebrate, augment and extend to more congregations the kinds of health care efforts reported in this study.
- National church agencies will surely want to learn more about congregations that did not respond and what prevents them from engagements in health care ministries within their communities.
- A related inquiry may address the question of what types of local planning and coordination bodies (committee, deacons, pastor alone, etc.) best address the kinds of decision-making that results in effective health programming.
- Acting together denominational agencies will want to learn more about the kinds and types of organizations which partner with congrega-

tions on the local level and, as may be appropriate, explore the nature of the relationship at the national level between such organizations.

- Local and state health departments may see within the findings of this study potential for working in partnership with local congregations to reach underserved populations.
- Congregations themselves may draw some satisfaction from the multifaceted health ministries highlighted by this study and may adapt or expand their own practices.
- Policy advocates should be heartened to discover the willingness and capacity of local congregations for advocacy activities and may want to ask how this capacity can be maximized within state and national public policy debates.
- Researchers might well find in this study a rough mapping of the terrain of health care among diverse congregations and seek to further explore matters such as how the programs began and how they are maintained, as well as the number of persons served and approximations of the aggregated financial value of such programs within the national health care economy. High priority should be given to the development and application of research which might effectively explore minority and marginalized communities where health disparities are acute. Too, they may wish to inquire as to the training, recordkeeping and substance of the advocacy activities in congregations.

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In the present national moment it is likely that adequate health care policies will only be established through a thorough and well-framed national debate. Communities of faith bring with them not only years of experience in meeting health needs locally but a commitment to the common good. The findings of this modest study might well make a contribution in heightening awareness, providing evidence of the kinds of needs that have not been met under current policies and especially in identifying thousands of congregations and tens of thousands of volunteers who daily step forward in acts of kindness to secure a better future for others. To the degree this study has provided them with a voice in this important societal debate, we are grateful.

A Note of Thanks

It is self-evident that any study of the sort represented by the Congregational Health Ministry Survey Report is the effort of many persons. At the conclusion of our work therefore, we find ourselves indebted to many.

Our most profound thanks is owed to those thousands of pastors, parish nurses, lay persons and volunteers whose efforts to provide health services we have sought to chronicle in this report. We appreciate their time and effort in completing and returning the survey in the midst of their daily activities. Similarly, we are appreciative of the various individuals and offices within national church bodies for their assistance in obtaining the mailing lists which made the survey possible.

At several junctures we were assisted by colleagues with expertise in sociological research who offered wise counsel, and in some cases, assistance with data analysis. We are particularly indebted to Dr. Mark Chaves, Duke University and Andrew M. Lindner and Mathew C. Marlay, Pennsylvania State University.

The Robert Wood Johnson Foundation provided support for this research and our colleagues there likewise offered thoughtful reflections as we developed the survey. We particularly thank Elaine Cassidy for her guidance in the survey design and analysis and David Morse and Elaine Arkin for their help in disseminating these results. We are grateful for this support.

Despite the many contributions of the individuals and institutions named above, this report reflects solely the views and perspectives of the National Council of Churches USA. Likewise, any errors which have stubbornly lingered remain our responsibility.

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