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A Faith-Based Prescription for the Surgeon General: Challenges and Recommendations

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Abstract This article summarizes how the Office of the Surgeon General can leverage faith-based resources to fulfill its mission and that of the Surgeon General of the United States. Such resources, personal and institutional, have been utilized historically in health promotion and disease prevention efforts and are a valuable ally for public health, an alliance that continues under the Obama Administration. This paper outlines the history and mission of the Office; details the recent history of federal faith-based initiatives; and advocates an expanded alliance between the faith-based and public health sectors sensitive to legal and professional boundaries.

Keywords Public Health Service · Religion · Health promotion · Community medicine

Introduction

In June, 2011, the White House sponsored a conference in New Orleans for faith and community leaders from across the Gulf Coast region. Keynoted by the Surgeon General of the United States (SGUS) and the Executive Director of the White House Office of Faith-Based and Neighborhood Partnerships (OFBNP), the conference was a part of a series of meetings entitled, "Connecting Communities for the Common Good." These meetings are being held throughout the country, at the time of this writing, and are introducing the work of respective federal agencies with the intention of engaging a "conversation on how all levels of government can partner with nonprofit organizations" to address social needs. The New Orleans event focused in part on provision of adequate healthcare services and promotion of healthy communities (DHHS 2011d).

At first glance, this may seem to be a most unlikely partnership between representatives of two divergent federal domains: one scientific and devoted to public health, the other

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devoted to faith-based initiatives in domestic policy. Is there any precedent for such efforts? Is there a legitimate strategic value for public health here? What are the pitfalls of such rapprochement, institutional or legal, among science, religion, and public policy? These constituencies do not exactly have a rosy history of working together. Is there actually good reason for optimism about the potential of such efforts, based on the statutory duties of the SGUS and on the success of federal faith-based initiatives over the past three administrations? This paper will explore these issues, in three sections: first, an overview of the history and mission of the work of the SGUS; second, a summary of recent federal faith-based policies and programming; and third, an outline of recommendations to strengthen and expand present efforts.

History and Mission of the OSG and SGUS

The Office of the Surgeon General (OSG) originated in the U.S. Marine Hospital Service (USMHS) that dates to 1798 (see Koop and Ginzburg 1989). In 1870, the Service was repurposed and, the next year, the position of Supervising Surgeon was created as its chief medical officer. The USMHS later evolved into the U.S. Public Health Service (USPHS), with the Surgeon General as director, until being absorbed into the old Department of Health, Education, and Welfare during the Eisenhower Administration. The Surgeon General has since emerged as a public figure, the national leader in promoting efforts to protect and improve the health of the U.S. population.

By statute, the SGUS is chief administrator of the OSG and Commanding Officer (CO), or operational commander, of the Commissioned Corps of the United States Public Health Service (PHSCC). The SGUS is a three-star flag officer with command over one of the seven federal uniformed services. The Commissioned Corps uses naval equivalent ranks, whereby the SGUS holds the rank of VADM, or Vice Admiral, and its officers are deployable assets. The OSG supports the mission of the SGUS, which is several folds: protecting the public's health, providing public health policy analysis and advice to the Executive Branch, leading national public health initiatives, and issuing professional practice standards and research priorities.

The SGUS is thus not, *de jure*, the nation's head doctor, chief medical advisor to the President, the country's top biomedical policymaker, the architect of healthcare reform, the nation's number one patient advocate, nor merely a ceremonial position, an attribution heard from those who wish to abolish the position. The SGUS is sometimes referred to as the country's top health educator, and while not quite accurate—no SGUS has been trained or credentialed in health education—the OSG serves as a bully pulpit for health-promoting messages. To wit, high-profile public campaigns to raise awareness about smoking in the 1960s, childhood immunization in the 1970s, AIDS in the 1980s, health disparities in the 1990s, and childhood obesity at present, as well as efforts aimed at control of communicable diseases during the formative years of the PHSCC (see Chase 2003). There is also a *de facto* policy-advisory role to the Executive Branch, but this is not a primary duty of the SGUS, nor does it explicitly emphasize medical or healthcare policies, but rather public health policy. There are also miscellaneous statutory duties related to serving on advisory boards of various federal agencies.

More accurately, the SGUS is a service-wide CO equivalent to the Chief of Naval Operations, the Army and Air Force Chiefs of Staff, and the Marine Corps Commandant, except that, as with the respective COs of the nation's fifth armed force (the Coast Guard Commandant) and the other noncombatant service (the NOAA Corps Director), he or she does not serve as a member of the Joint Chiefs of Staff (JCS) nor, as with these latter two

services, does the OSG mission fall under the mission of the Joint Staff. The Coast Guard Commandant now reports to the Secretary of Homeland Security, the NOAA Corps Director reports to the Secretary of Commerce, and the SGUS reports to the Assistant Secretary for Health (ASH), who holds the protocol rank of a four-star flag officer (ADM or Admiral) in the PHSCC. The ASH, in turn, is chief administrator of the USPHS and reports to the Secretary of Health and Human Services (SHHS). The OSG is one of over a dozen offices, councils, and agencies under the aegis of the USPHS Office of Public Health and Science (OPHS). Besides operational command over the PHSCC, the SGUS also sponsors the Medical Reserve Corps (MRC).

These barebones descriptives of the OSG and SGUS may be familiar to some of the readership of *Journal of Religion and Health*. The nuances of the organization and functioning of the OSG and SGUS are more complex (see Wright 1994). Indeed, while use of OSG as an acronym for the Office is standard issue, both SGUS and USSG are used for the Surgeon General, the latter more frequently. Yet the official title is Surgeon General of the United States (akin to the Surgeon Generals of the Army, Navy, and Air Force), so SGUS is more consistent with the title and thus makes more sense and will be used here. But absence of consensus over this issue alone—not a mission-critical one, obviously—underscores the fuzziness regarding the position in many people's eyes, even occupants of the office of President. The most celebrated post-War SGUS, Dr. C. Everett Koop, lamented that "no one ever tells you what the job description is of Surgeon General" (Mullan 2004, p. 181).

SGUS nominees often have no background in public health. In one notable instance, during the first term of the Reagan Administration, the nominee, Dr. Koop, was actually age-ineligible to serve in the PHSCC. It took an act of Congress to amend a statute enabling him to be inducted into the Corps and to serve as SGUS (see Glastris 1987). In the current administration, the initial nominee was a cable TV commentator, who subsequently reconsidered and withdrew his name and was replaced by a more qualified nominee. In both instances, the contested nominees were surgeons. Perhaps these Presidents' advisors were under the mistaken impression that the title Surgeon General requires a nominee to be a physician board-certified with a specialty in surgery. Nothing statutory, in fact, requires the SGUS to be a physician (just a member or eligible member of the PHSCC Regular Corps), although recent legislation was introduced (unsuccessfully) to make this a requirement (H.R. 3447, 110th Congress) (U.S. House of Representatives 2007). Graduate training in public health would be ideal, and in fact, "specialized training or significant experience in public health programs" is required in the U.S. Code (42 U.S.C. 205) (U.S. House of Representatives Office of the Law Revision Counsel 2010), but this does not seem to be a consideration when SGUS candidates are nominated by the President or sit for confirmation hearings before the Senate.

A more significant issue in the current fiscal environment—and current public health environment—is that the need for public health resources has never been greater. The chronic under-preparedness of the U.S. public health system and gaping holes in its infrastructure, notably regarding availability of physical and human resources, state-federal linkages, and coordination of efforts among states, have been identified and commented upon extensively both for professional and lay audiences (Garrett 2000; Mullan 2002).

Besides chronic infrastructure issues, the health of the U.S. population is also beset with myriad acute threats, both potential and ongoing: bioterrorism, natural disasters, emerging infections and looming pandemics, antibiotic resistance, environmental breakdown, accelerating epidemics of teenage obesity and diabetes, underserved and underinsured populations. The resources required to address these issues are prodigious, as are the costs. The public health establishment must identify a means to leverage existing resources that,

to date, have not been formally integrated into coordinated efforts. These include private- and volunteer-sector resources that may not be on the radar of the USPHS or OSG because they do not function principally or explicitly to fulfill a public health mission.

Among the most underutilized resource that could be better mobilized by the OSG to further its mission is the often contentious domain of faith-based organizations. The intersection of public health and the faith-based sector has a history that goes back over a century to the beginnings of the public health field. Leveraging faith-based resources could provide the OSG and SGUS with a valuable ally in efforts to promote health and prevent disease in the U.S. population.

Faith-Based Resources: Promise and Controversy

The potential of faith-based resources for human services delivery has long been recognized. Religious congregations, institutions, and organizations have played significant roles in meeting needs especially in underserved and disadvantaged communities, such as among ethnic minorities, the aged, recent immigrants, and the medically challenged or at risk. The faith-based sector has played a prominent role in education, social services (e.g., job training, income assistance, home care), rehabilitation of offenders, environmental advocacy, community development, and notably, public health. A substantial literature details congregational- and denominational-based efforts at health promotion and disease promotion, across myriad religions and faith traditions and especially in minority communities, dating to the 1970s (Levin 1984). This work, for the most part, has been located within, funded by, administered by, conducted by, and accountable to private-sector entities, primarily foundations and faith-based institutions themselves. A recent example of note was the Faith In Action program for interfaith coalitions of volunteer caregivers that was operated by the Robert Wood Johnson Foundation from 1983 to 2008 (Jellinek 2001).

To facilitate these efforts, President Clinton signed into law (P.L. 104-193), as a part of the 1996 welfare reform legislation, the first federal provision for "charitable choice." This is described by the Congressional Research Service as "a set of provisions in law intended to allow religious organizations to provide federally funded services from specifically named programs on the same basis as any other nongovernmental provider…. [and] does not contain special funding for faith-based organizations and it applies only to programs designated by Congress" (Burke 2001, p. 1). These efforts by the Clinton Administration had additional specifications: the intention is to "allow states to contract with religious organizations… under any covered program on the same basis as any other nongovernmental provider" (p. 4), such organizations are eligible "so long as the program is implemented consistent with the Establishment Clause of the first amendment to the Constitution" (p. 8), religious organizations "shall not discriminate against a person in giving assistance under any covered program on the basis of religion, a religious belief, or refusal to actively participate in a religious practice" (p. 17), no funding "may be spent for sectarian worship, instruction, or proselytization" (p. 18), and "[n]othing in the charitable choice provisions of P.L. 104-193 is to be construed to preempt a provision of a state constitution or law that prohibits or restricts spending of state funds in or by religious organizations" (p. 12). These guidelines were further extended and specified through subsequent legislation signed by President Clinton (P.L. 105-285, P.L. 106-310, P.L. 106-554).

Legislation signed by President Bush in 2001 (H.R. 7, 107th Congress) elaborated the parameters of the Clinton Administration's charitable choice provisions. The purpose of

the provisions, simply, was to "provide assistance to needy individuals and families in the most effective and efficient manner" (Burke 2001, p. 4), and therefore "the government shall consider religious organizations on the same basis as other nongovernmental organizations" (p. 7) without altering "the duty of a religious organization to comply with federal laws prohibiting discrimination" (p. 12). Upon taking office, President Bush also signed two Executive Orders (E.O. 13198 and E.O. 13199) that established a White House Office of Faith-Based and Community Initiatives (OFBCI) and enumerated their responsibilities in relation to other federal agencies.

The OFBCI was created as a mechanism to give structure to the Clinton charitable choice provisions. The Office had a primarily policy and educational role and, significantly, contained no provisions to fund any program. The functions of the Office were carefully specified, including developing a policy agenda, coordinating public education and encouraging voluntarism and demonstration projects, encouraging charitable giving, serving as a clearinghouse for ideas and a source of technical assistance to state and local governments, showcasing and publicizing innovative grassroots and civic initiatives, and helping potential recipients cut through bureaucratic red tape (Bush 2001b). An Executive-Department-level Center for Faith-Based and Community Initiatives was established within several cabinet-level agencies, including the Department of Health and Human Services (DHHS) (Bush 2001a). These Centers were charged with identifying barriers to participation by faith-based organizations in delivery of social services, proposing development of innovative pilot and demonstration projects, and coordinating outreach efforts to disseminate information. Again, no funding was provided to any program nor was any provision made to budget for or fund any program. To underscore this message, a subsequent Executive Order (E.O. 13279) reiterated the purpose of the Office as ensuring that "all eligible organizations, including faith-based and other community organizations, are able to compete on an equal footing for Federal financial assistance used to support social service programs" (Bush 2002, p. 77142) and then restated the Constitutional issues contained in the equal-protection provisions of the legislations signed by President Clinton.

Under the Obama Administration, this initiative has been modestly repurposed (Daly 2009). Upon taking office, President Obama signed an Executive Order (E.O. 13498) renaming the OFBCI as the Office of Faith-Based and Neighborhood Partnerships (OFBNP), establishing a President's Advisory Council, and making a few amendments to E.O. 13199 while reiterating the specific purpose of the Office (Obama 2009). The Order states, "The Federal Government can preserve these fundamental commitments [guaranteeing the equal protection of the laws and the free exercise of religion and forbidding the establishment of religion] while empowering faith-based and neighborhood organizations to deliver vital services in our communities" (p. 6533). The only designation of federal funds specified in the Order directs DHHS to provide requisite administrative support to the Advisory Council.

Through the OFBNP, the Obama administration operates the 11 agency-level Centers established in the previous administration. One of these is the DHHS Center for Faith-Based and Neighborhood Partnerships (CFBNP), also known as the Partnership Center. The Center makes clear that, as under the old OFBCI model, "there is no 'faith-based funding'" (DHHS 2011a). Rather, the Center exists to "enable community and faith-based organizations to partner with the government through both nonfiduciary and fiduciary partnerships to achieve the goals of HHS." These include poverty reduction, reducing unintended pregnancies and improving maternal and child health, and promoting healthy families. Under the Bush and Obama Administrations, notable faith-based initiatives in public health have included substance abuse and recovery programs, global HIV/AIDS

relief, expansion of community-based health centers, programs to combat homelessness, natural disaster preparedness, domestic nutrition assistance and international famine and hunger relief, veterans' health, and malaria prevention (White House Office of Faith-Based and Community Initiatives 2008b). Many of the efforts initiated during the Bush Administration are continuing under President Obama.

As readers may recall, at the outset of the Bush Administration the faith-based initiative was a controversial source of contention among competing political constituencies. Legal and political red flags were raised, primarily due to images elicited by the word "faith" moreso than by the substance of the legislation or Executive Orders that established the initiative. Past history (pre-dating the OFBCI) of conflicts between competing religious and political ideologies, such as related to sex education (see Freedman-Doan et al. 2011), did not inspire confidence that these issues would be negotiated carefully. As noted, however, the various pieces of legislation and presidential Orders throughout the last three administrations explicitly address important legal and Constitutional concerns raised about the scope and application of charitable choice to the delivery of government social services.

For sure, "faith-based" remains a heavily emotion-laden phrase meaning different things to different people. To some, it implies an ultra-conservative force for social control, even a weapon to transform our republic into a theocracy. To others, it signifies a font and locus of efforts to improve lives, motivated by the social justice and communitarian orientations of the historic faith traditions, the same worldview that underlies the public health ethic. "Faith-based" can evoke stereotyped images of fundamentalist extremists bombing family planning clinics or carrying out *jihad* against innocent civilians, or, at the other polarity, Dr. Martin Luther King, Jr., and Rabbi Abraham J. Heschel and other activist change agents marching for civil rights and progressive causes, evangelicals supporting global health and environmental initiatives in the developing world, the long history of social justice work in the Roman Catholic Church, and efforts of myriad mainline religious groups—Christian, Jewish, Muslim, Hindu, Buddhist—to feed the hungry, build housing for the homeless, dig wells, construct free clinics, and establish immunization programs. The theology that informs one's faith can be that of fundamentalism or of liberation, or most typically of something in between. "Faith-based" is not the property of any one sectarian stream of institutional religion, wholly owned to the exclusion of other constituencies, despite what partisans would assert.

As described, some version of a faith-based agenda has existed for the last three presidential administrations, two of which have been led by Democrats. Characterization of the faith-based initiative during the Bush Administration as being driven by the religious right was simply not accurate. Some of the same organizations and individuals on record as opposed to the OFBCI are now involved in an advisory role for the OFBNP. Liberal and reform-oriented groups such as the Americans United for Separation of Church and State, the National Council of Churches, the Religious Action Center of Reform Judaism, the United States Conference of Catholic Bishops, and Evangelicals for Social Action are fully on board with the current version of the initiative and have had significant input into formulating its mission, functions, and specific aims (White House Office of Faith-Based and Neighborhood Partnerships 2010).

Ironically, and this point is often forgotten, much of the institutional leadership of the religious right was stridently opposed to the initiative, and teamed with activist liberals and progressives to attempt to kill it. One may recall the unusual tag team of Dr. Pat Robertson and Norman Lear working together to scuttle the initiative right out of the gate. The religious right was especially opposed to the form the initiative took in the first term of

President Bush, due in part to its refusal both to limit access for Eastern or non-Christian faiths and to create a most-favored status for ultra-conservative Christians. The secular left was opposed to the initiative, on principal, as an attempt by the religious right to gain access to public funding. As noted, the reality was quite the opposite; the religious right attempted to derail the initiative. Further, the initiative was initially directed by Dr. John DiIulio, an Ivy League professor, Roman Catholic, and lifelong Democrat, and overseen by Dr. Stephen Goldsmith, former mayor of Indianapolis, special advisor to the President, chairman of the board of directors of the Corporation for National and Community Service (first appointed by President Clinton), which administers federal volunteer social service programs, and Jewish. Needless to say, neither of these gentleman—a Democrat and a Jew—was a representative or agent of the Christian right.

If this narrative seems surprising or counterintuitive, it only underscores two significant realities: (a) the large amount of disinformation and negative spin engineered by political opponents of the Bush Administration that circulated at the time and (b) the serious missteps of the White House in rolling out the initiative and its persistent clumsiness in efforting to right the ship. These factors combined into a perfect storm that damaged the OFBCI's reputation in the public eye. The director eventually left, lamenting the initiative's politicization (DiIulio 2007). Subsequently, the initiative righted itself and went on to operate successfully under able hands for the next several years, although in greater obscurity and eliciting less pushback. That the Obama Administration retained the initiative, with some refocusing, suggests its acceptance as an effective vehicle for constructive social change by both sides of the political aisle.

A Role for Faith-Based Resources in the OSG

Over a century of population-based health research, policymaking, and intervention attests to a health impact of personal faith (for good or bad) as well as a demonstrated value of communal faith-based resources for effecting health-related change (DeHaven et al. 2004; Johnson 2002; Krause 2008). Much of this effort has been led by religious organizations and faith-based institutions, across faith traditions (see Numbers and Amundsen 1986; Sullivan 1989). The roots of these institutional partnerships, or efforts at co-existence, date back centuries, and reflect the longstanding and central role of religious bodies in organizing charitable activities such as the founding and sponsoring of hospitals and healthcare systems (see Levin and Koenig, 2005). Even before that, religious institutions served as loci for organized and ritualized efforts to care for constituent members and to attempt to heal their illnesses, a role taken on by the earliest churches (Kelsey 1995), by the religions of pre-Christian antiquity (Amundsen and Ferngren 1982), and by esoteric traditions throughout the world (Levin 2008). It could be asserted, without exaggeration, that religious institutions and the faith-based sector, generally, more so than any other domain, are most responsible for the establishment of institutionalized healthcare throughout history and, still, into the present day. The myriad clinics, hospitals, and medical care systems with the words Baptist, Methodist, Lutheran, Presbyterian, Catholic, Jewish, or Adventist in their names attest to that fact.

More recently, religious congregations have sponsored primary-care initiatives, such as screening programs and free clinics; faith-based agencies have provided public health services and implemented community health education interventions; denominations have issued policy statements supporting healthcare reform; and a large body of epidemiologic and health services studies has identified religious correlates and determinants of rates of

morbidity, mortality, mental health and well-being, and healthcare utilization (Levin et al. 1996). This work has focused on historically underserved populations and communities at a disadvantage in accessing medical care or public health services. Faith-based initiatives directed to rural African-American communities in the South, for example, have functioned successfully for decades, mobilizing denomination-wide efforts at risk reduction and elimination of health disparities (Holmes 2004), such as through congregational health promotion programs (Baruth et al. 2008). Charitable choice has been identified as a significant ally for enhancing the "civic tradition of church-based activism" among urban African Americans (Harris 2001, p. 148).

In an era of healthcare reform, with an already overburdened and underdeveloped public health infrastructure facing new demands, a major challenge for public health agencies is to develop new resources to meet their respective missions. This challenge is also an opportunity. For the OSG, the opportunity is to leverage connections to the private volunteer sector, especially faith-based organizations, in order to marshal support for statutory duties of the Office and the SGUS. Such relationships are not without precedent.

During the Bush Administration, private and federal efforts sought creative solutions to community health needs, especially for quality primary healthcare. Federal efforts involved the U.S. Agency for International Development, DHHS, and the Department of Veterans Affairs, and focused on HIV/AIDS, malaria, maternal and child health, child survival, overweight and obesity prevention, and expansion of the nation's community health centers, among targeted outcomes (White House Office of Faith-Based and Community Initiatives 2008a). Under the Obama Administration, the DHHS CFBNP issued a report documenting faith-based and public health sector partnerships in H1N1 influenza (Center for Faith-Based and Neighborhood Partnerships 2009). The administration is also expanding the President's Emergency Plan for AIDS Relief (PEPFAR) program, developed by the Bush Administration as a public–private partnership, mostly with local faith-based and community groups, to combat the HIV/AIDS epidemic in sub-Saharan Africa (Dybul 2009). Under the current administration, PEPFAR oversees U.S. global efforts at prevention, treatment, and research throughout DHHS agencies, including the Centers for Disease Control and Prevention, the National Institutes of Health, the Health Resources and Services Administration, the Food and Drug Administration, and the Substance Abuse and Mental Health Services Administration (DHHS 2011c). This work exemplifies the Obama Administration's recognition of the benefit of partnerships with faith-based organizations for addressing urgent global health needs. Just since the beginning of 2011, domestic faith-based public health efforts sponsored by the administration also include initiatives to encourage breastfeeding, to foster careers in healthcare, to assist the public in obtaining insurance coverage, to address Hispanic health needs, to promote fathering and mentoring, to advocate for exercise and healthy lifestyles, and to boost primary prevention through building local capacity (DHHS 2011b).

A significant barrier to advancing a faith-based or faith-friendly policy within the OSG may be the historic tendency of Presidents to nominate medical doctors without a public health background to be SGUS. Physicians, by dint of their training, may be less familiar with the history of faith-based contributions to public health; indeed, there may be little understanding of the identity, role, and functions of the public health sector itself. Ideally, the SGUS would be a public health professional, such as an epidemiologist or health educator or expert in health services or health policy, but that is an argument for another day. Faith-based issues aside, someone trained in the theory and methods of population health, which physicians typically are not unless boarded in preventive medicine, may be more amenable to building on existing faith-health linkages and collaborations. Future

SGUSs with public health training may be more familiar with the research literature on nonmedical determinants of population health, health behavior, and health services use, including faith-related resources, whether they themselves choose to be personally involved in the practice of religion, which is immaterial in this context. They also may be more familiar with ongoing programmatic efforts by faith-based and community institutions and organizations to help meet national public health goals.

Another barrier may be concern over church-state separation issues that, as noted, were clarified through legislation and Executive Orders in the past three administrations, as well as in a comprehensive Final Rule issued by DHHS (Thompson 2004). Religious liberty, freedom from religious coercion, and nonuse of public funds for religious functions are serious concerns and have been addressed and resolved to the consensus satisfaction of legal and policy experts. The presence of influential individuals such as Barry W. Lynn, Executive Director of Americans United for Separation of Church and State, serving in an advisory role to the OFBNP shows the current administration's intention to face this issue. According to a recent DHHS report, so long as faith-based efforts stick to providing "secular goods and services," then a collaborative role for the OSG, or other federal social services agencies, is permissible (Lupu and Tuttle 2008, p. 270), a proposition supported by the Supreme Court (Esbeck 1997).

An additional barrier, that can be surmounted, involves command-level independence of the SGUS in policy-related agenda-setting and strategic decision-making. As in all military and civilian bureaucracies, there is a chain of command, in this instance up through the ASH, the Principal Deputy Assistant Secretary for Health (P-DASH), the SHHS, and the President. The SGUS thus has limited statutory authority to formulate agendas and to strategize and is not immune from being hindered by "partisan political agendas" (Carmona 2007, p. 34), as noted by one former Surgeon General. Still, the SGUS has considerable "tactical" authority to engineer and captain creative solutions to meet the OSG's mission and, indeed, to help flesh out that mission. Recently proposed legislation (H.R. 3447, 110th Congress) sought to amend the Public Health Service Act "to ensure the independence of the Surgeon General from political interference" (U.S. House of Representatives 2007, p. 1), which ideally would have supported the SGUS in moving forward with more creative collaborations for protecting the nation's health.

An example of creative thinking to address public health challenges is the recent call by a former SGUS, Dr. David Satcher, to increase our national investment in prevention at three distinct levels of intervention: downstream (focusing on individual behavior), midstream (focusing on communities and institutions), and upstream (focusing on policymaking) (Satcher 2006). Such a multifaceted approach holds the best promise of success in solving both acute public health crises and more chronic deficiencies in preparedness and response to longer-standing population health risks. Promising areas of faith-health collaboration can be identified for the OSG and the SGUS across all of these levels. The following suggestions do not define new functions for the Office, but support statutory or traditional functions of the OSG by leveraging faith-based resources for purposes of fulfilling its stated mission.

1. The most high-profile public function of the SGUS, moreso than operational command of the PHSCC, is as the nation's leading public health advocate. A recent Institute of Medicine (IOM) report recommends a "more prominent and powerful role" (Schaeffer et al. 2009, p. 9) for the SGUS in public health advocacy and education in order to fulfill the OSG's responsibility for "providing scientifically valid information about health risks to the American public" (p. 7). Collaboration with congregations, denominations, and professional clergy organizations of all faiths can be a valuable

means of *informing the public, raising risk awareness, and changing behavior*. Pastoral involvement in health education at each of the levels of prevention, especially in minority communities, has been ongoing for decades (Levin 1986). Pulpit clergy have functioned as agents of health-related social and behavioral change, targeting personal preventive behavior and mobilizing collective action to reduce population- and community-wide risks. The OSG can partner with faith-based professional and congregational organizations to develop educational modules for use in congregations and communities, supporting clergy and communal service professionals as resources for health information, advice, and referrals and further developing churches, synagogues, mosques, and temples as loci for community health education programs, including training of lay health advisors. This has been a successful model for health education and health-behavior change programs since the 1970s (Hatch and Lovelace 1980; Levin in press) and has been utilized by local health departments throughout the country (Barnes and Curtis 2009; Zahner and Corrado 2004), but has not been adopted as a formal means of extending the mission of the OSG.

2. The same partnerships can be developed for *identifying public health needs and eliminating health disparities in underserved populations*, such as new immigrant communities. Faith-based organizations, foundations, and academic institutions can collaborate on health and healthcare censuses for needs assessment, program planning, and resource allocation. Such relationships can extend the OSG's educational role from providing information to the public to being a trusted source or conduit of health information for the federal government and the states. The IOM report calls on the OSG to develop an annual State of the Nation's Health report for the SHHS, to be presented to Congress and the public. In many underserved communities, especially those "off the grid" for reasons related to lack of access to healthcare or government services, extreme poverty, or immigrant status, religious congregations may be the most established institutions and the only viable avenue into the community. Congregations provide existing channels of communication with members, a strongly developed culture of volunteerism, and centrally located and available physical resources such as meeting space (Nordtredt and Chapman 2011). Without collaborating with faith-based community leaders, such as pastors and communal services professionals, it may be impossible in some communities to conduct valid population surveys or needs assessments or to develop meaningful responses to identified needs.
3. For over 40 years, congregations have been loci for *delivering preventive healthcare*—screening (e.g., hypertension, diabetes), immunizations, perinatal care, geriatric primary care, community mental health—especially in low-income and minority communities, in both rural areas and the inner city (Falck and Steele 1994; Olson et al. 1988; Westberg 1984; Wu and Hatch 1989). These programs succeed by drawing on institutionalized social support structures and functions within congregations (Eng et al. 1985), building on the historic role of the congregation as a "therapeutic community" especially in underserved communities (Gilkes 1980), and exemplifying that "[c]ost effective programs can be developed which take advantage of volunteer effort and existing community resources" (Falck and Steele 1994, p. 389). These relationships can be valuable not just for ongoing efforts but for disaster relief, triaging of large numbers of acute medical cases, first-response efforts in disease outbreaks, and addressing other public emergencies which will overburden existing public health resources unless institutional and human extenders can be identified and mobilized. The MRC, which is under sponsorship of the OSG, would be wise to formalize channels for accessing congregational resources within its existing network of nearly 1,000 regional, state, and

local units (Skupien 2011). These resources can then receive ongoing standardized education and training and be better prepared to recruit new volunteers, better integrated into existing chains of command, and better equipped to respond quickly and effectively when emergency response is required.

4. Religious denominations have been at the forefront of the national discussion on healthcare policy. Major policy statements have been issued by Christian and Jewish groups (e.g., United Methodists, Roman Catholics, National Baptists, Reform and Conservative Jews), and through these efforts, the faith-based community was a major player in crafting legislation on the table during the recent healthcare reform debate. These efforts are consonant with the historically prophetic role of religion as an agent of change—calling out individuals, institutions, and governments from their complacency and sin. A key role for the SGUS is as a public health policy advocate, both in an advisory role to the President and to federal agencies and as an opinion leader for the American public. Denominational policymaking arms can be valuable allies to the SGUS, both as sources of ethical guidance and a means to tap the pulse of the faith-based sector on issues of concern and as a community of experts whose support can be mobilized for *strengthening the national resolve to bolster the public health infrastructure* and develop and meet national public health goals and objectives.
5. Effective public health preparedness, surveillance, and disease prevention—like communicable pathogens themselves—recognize no national boundaries and thus, to quote Dr. Koop, "[O]ur country has a great deal to offer other countries with respect to public health" (Koop 1989, p. 13), plus a moral obligation to do so. Accordingly, the DHHS Office of Global Health Affairs (OGHA) is charged with promoting the health of the world's population through global strategies and partnerships, including bilateral and multilateral engagements with nongovernmental organizations (NGOs), such as the World Health Organization, and U.S. missions overseas, via the health attaché program (Fischer et al. 2009). There is a role here for the OSG in *meeting the nation's global health responsibilities*, specifically through managing collaboration with international faith-based relief organizations located in the U.S. and involved in domestic relief efforts and through partnering with other federal agencies charged with addressing public health challenges with global impact. This is consistent with recent deployments of the PHSCC as a "global emergency preparedness and response asset," such as in highly publicized tsunami and hurricane reliefs efforts (Galson 2009). To this end, the SGUS can work closely with the directors of the OPHS and OGHA to coordinate the efforts of faith-based organizations already part of its existing network of resources. The SGUS is a public figure with a network of connections throughout the U.S., through the PHSCC, the MRC, its relations with state and local health departments, and its other partners. The OSG can mobilize public opinion, volunteerism, and commitment of federal resources to address public health crises (e.g., natural and manmade environmental disasters, emerging infections, pandemic disease, war and genocide, bioterrorism) that, regardless of where they originate, equally impact on people here and abroad. The globally connected membership of the American Public Health Association's Caucus on Public Health and the Faith Community would be a valuable professional and academic resource for such efforts.

Keeping in mind the immediacy of public health needs, the federal government can use all the resources that it can muster. The issue of coordination of resources—tangible and human—looms especially large. By this we mean coordination of efforts within and among states, and between states and the USPHS and other federal agencies. Considerable

improvement was made during the last administration. The post-9/11 anthrax crisis sparked organized efforts to address substantial gaps in public health infrastructure and preparedness, not just for early response to future public health crises such as pandemic influenza (DHHS 2005) but for meeting ongoing mission-critical goals. But coordination of efforts is still lacking, and inequities persist from state to state. Limited resources remain a problem. The best laid plans are impotent without sufficient resources to carry them out.

Accordingly, DHHS and constituent agencies, especially those within the USPHS, including the OSG, would be well served to begin planning how to draw on faith-based resources in fulfillment of their mission and operational goals and objectives. The faith-based sector is a large and valuable resource with a history of collaboration with healthcare providers and state and local public health agencies. Moreover, this sector "may be well positioned to provide such services more efficiently and effectively than can some federally administered programs and agencies" (Campbell et al. 2007, p. 215). The untapped potential of such partnerships was presciently noted by Dr. Caswell E. Evans, Jr., former president of the American Public Health Association, who affirmed that "the linkage between the faith community and public health is a bridge across which public health messages can be delivered while servicing mutual and basic goals" (Evans 1995, p. 2). Moreover, he continued, "The health and faith partnership is one example of how we can practice public health creatively using existing relationships to advantage" (p. 2).

Partnerships between the faith-based and public health sectors are integral to rebuilding our nation's public health infrastructure and elevating and maintaining our preparedness against public health threats. According to Dr. Satcher, "Engaging faith congregations" in the work of federal public agencies, even the venerable Centers for Disease Control and Prevention, "is not new" (Satcher 1999, p. 2). Faith-based organizations can serve a vital function in support of the OSG's mission to protect the public's health through providing leadership and guidance for public health programming, policymaking, and research. The SGUS can mobilize faith-based resources, as needed, to fulfill each of these functions. Again, quoting Dr. Satcher, "Through partnerships with faith organizations and the use of health promotion and disease prevention sciences, we can form a mighty alliance to build strong, healthy, and productive communities" (p. 3). This is a policy that can be embraced by both major political parties and by the current and future administrations.

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