



CHRISTIANS for
SOCIAL ACTION

FAITH, JUSTICE, AND THE FIGHT FOR HEALTH

A CHRISTIAN RESPONSE TO AMERICA'S HEALTH CARE CRISIS

A FOUR-PART SERIES + REFLECTION GUIDE

ARTICLES AUTHORED BY DR. MARK DEHAVEN WITH DR. DANIEL GUTIERREZ

INTRODUCTION

Health care is not only a medical issue — it's a justice issue. It shapes who gets to live with stability, who carries preventable suffering, and who is forced into impossible choices between care and survival.

In this four-part series, Dr. Mark J. DeHaven invites us to see the U.S. health crisis through the lens of Christian faith, moral clarity, and neighbor-love. From the social conditions that produce illness, to the injustices baked into a profit-driven “sick care” system, to the growing mental health epidemic and the church’s calling to respond, this series asks a simple question with enormous weight:

What does it mean to love our neighbor when our neighbors are being crushed by preventable illness, untreated suffering, and medical debt?

We created this guide to help you move through the series slowly — whether you’re reading alone, reflecting with friends, or using it in a church, classroom, or small group. Each part includes takeaways and reflection questions to help you pause and listen:

- What is the Spirit bringing into focus?
- What feels familiar — and what unsettles you?
- What would faithful action look like in your community?

Our hope is that this resource helps you move beyond outrage toward imagination — and beyond compassion toward repair.

KEY THEMES

1. HEALTH IS SHAPED BY SOCIAL CONDITIONS, NOT JUST PERSONAL CHOICES.

Where we live, what we earn, and what we endure are often stronger predictors of health than medical care alone.

2. THE U.S. HEALTH CARE SYSTEM IS A MORAL PROBLEM, NOT ONLY A POLICY PROBLEM.

When access depends on wealth and profit, suffering becomes a feature — not a bug.

3. PREVENTABLE ILLNESS REVEALS PREVENTABLE INJUSTICE.

High rates of chronic disease, early death, and medical bankruptcy are not inevitable — they reflect systems and decisions.

4. MENTAL HEALTH IS PART OF NEIGHBOR-LOVE.

Isolation, stigma, underfunded systems, and untreated trauma create a crisis that Christians are called to meet with compassion and competence.

5. FAITH CALLS US TO PROTECT THE VULNERABLE.

Scripture consistently links righteousness to the defense of the poor, the sick, and those denied dignity.

6. THE CHURCH IS UNIQUELY POSITIONED TO BUILD COMMUNITIES OF CARE.

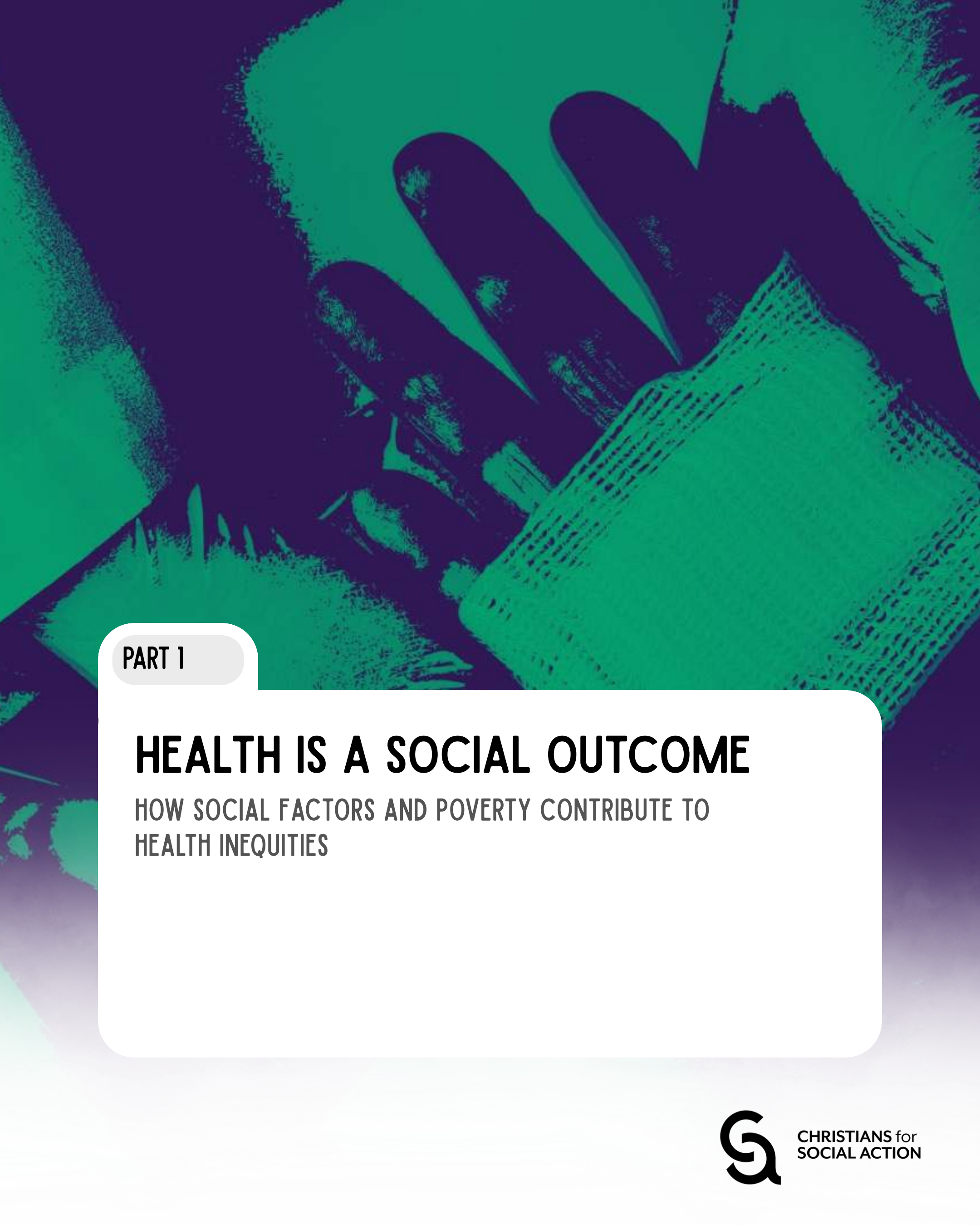
Congregations can reduce stigma, strengthen social connection, partner with local services, and create practical pathways to health.

7. ADVOCACY IS AN ACT OF DISCIPLESHIP IN PUBLIC.

Loving our neighbor includes speaking up when policies and systems harm our neighbors.

8. HOPE IS NOT DENIAL — IT'S REPAIR.

Christian hope shows up as presence, truth-telling, and sustained action where people are weary.



PART 1

HEALTH IS A SOCIAL OUTCOME

HOW SOCIAL FACTORS AND POVERTY CONTRIBUTE TO
HEALTH INEQUITIES



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In Part 1, Dr. DeHaven explains why social and economic conditions drive health outcomes far more than doctors or prescriptions. He explores the devastating impact of poverty, chronic stress, and neighborhood inequity on people's bodies and lives, making a powerful case for why Christians must advocate for health justice.

Recently enacted and proposed cuts to Medicaid, the National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC) are deeply troubling and could have devastating consequences for the health of all Americans, especially the poor and vulnerable. These actions threaten to undo much of the slow but steady progress made over the past 50 years toward eliminating health disparities and promoting health equity.

Medicaid provides coverage to more than 80 million low-income people in the United States, including almost 40 million children. It also provides care and resources for low-income pregnant women, people with disabilities, and elderly individuals.

Cuts to the NIH and CDC threaten decades of research and public health programs that have significantly improved outcomes for people on the margins of society.

The United States already lags behind other developed nations in key health indicators — infant and maternal mortality, chronic disease rates, and access to care.

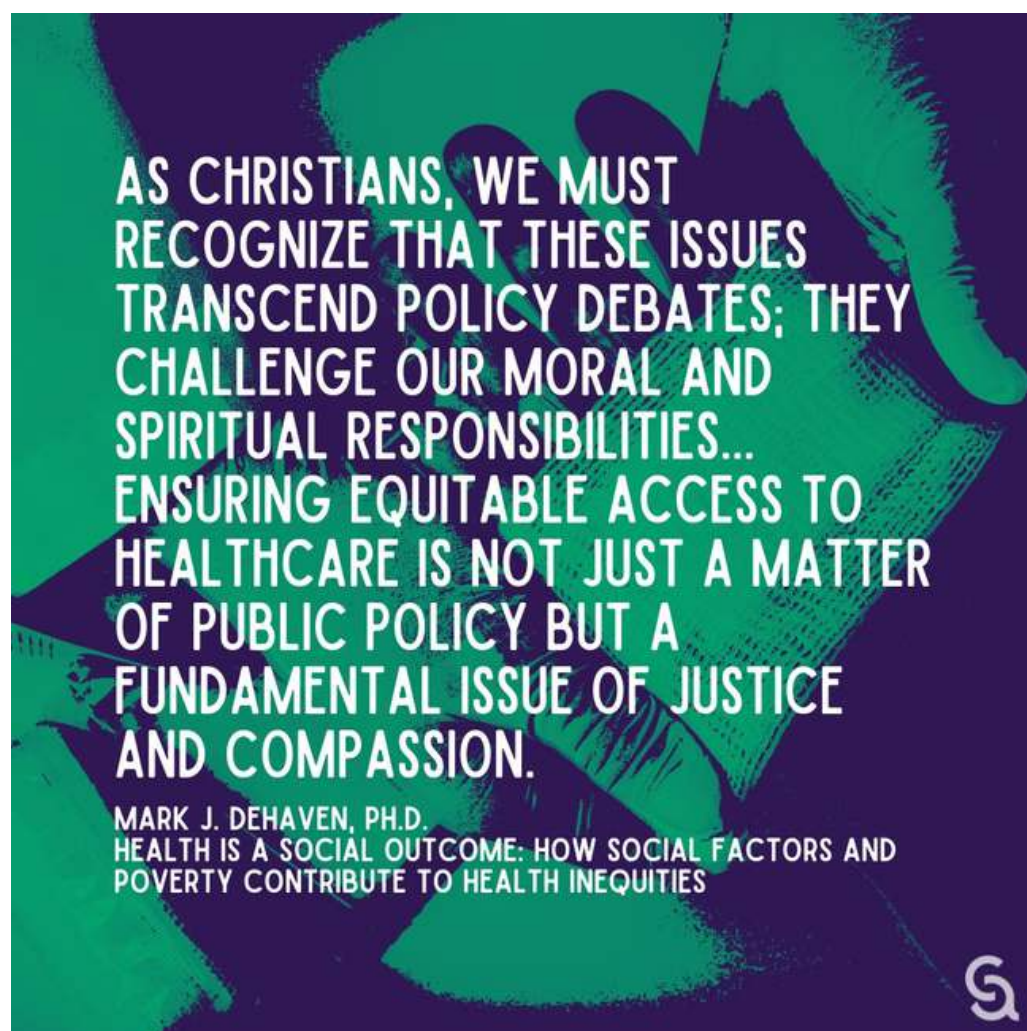
The U.S. has the highest number of preventable deaths among wealthy nations, despite spending more per capita on health care than any other country.

Systemic inequities that jeopardize the health of the poor help explain why the U.S. ranks 34th globally in life expectancy. Further reductions in health care access will not only harm millions of people today but will also deepen the long-term burden of disease in our society.

As Christians, we must recognize that these issues transcend policy debates; they challenge our moral and spiritual responsibilities. Throughout Scripture, we are commanded to care for the poor, the sick, and the marginalized (Prov. 31:8-9, Matt. 25:40). Ensuring equitable access to health care is not just a matter of public policy but a fundamental issue of justice and compassion.

THE SOCIAL DETERMINANTS OF HEALTH

Unlike most other developed nations, the U.S. has never fully embraced what the World Health Organization (WHO) considers essential for a healthy population — Universal Health Care (UHC) and Primary Health Care (PHC). UHC ensures that all people, regardless of income, have access to medical services without financial hardship. PHC integrates health care with social services, recognizing that factors such as housing, education, and employment impact health outcomes. (1,2)



The importance of addressing health within a social and economic framework was recognized as early as the 19th century.

The German physician and social reformer Dr. Rudolph Virchow argued that disease is largely caused by poverty, unemployment, malnutrition, and lack of access to medical care. He famously described medical practitioners as the “natural attorneys for the poor” since they directly witness the effects of inequality on health. (3)

Over the past 50 years, the U.S. has made slow but meaningful progress in recognizing the connection between social conditions and health outcomes, particularly in marginalized communities.

The establishment of Medicaid and Medicare in 1965 marked a significant step forward. More recently, community health initiatives have combined clinical medicine, public health, and social services to create more comprehensive health care models. (4,5,6)

However, health care alone is not enough. Research shows that medical care accounts for only about 20% of health outcomes, while social and economic factors account for 40%, health behaviors for 30%, and the environment for 10% (7,8). Similarly, health disparities are deeply tied to social determinants such as housing quality, food security, job opportunities, and neighborhood safety.

THE IMPACT OF CHRONIC STRESS AND POVERTY

The consequences of inequality extend far beyond access to medical care. Chronic stress from poverty and instability increases the risk of mental health disorders such as depression, while also contributing to weakened immune function and chronic diseases like cancer, heart disease, and diabetes. An individual's zip code is often a more reliable predictor of health outcomes than their genetic code.

The Affordable Care Act (ACA), passed in 2010, expanded Medicaid coverage, providing more than 41 states and the District of Columbia with additional resources to address social determinants of health (SDOH) — including transitional housing, rental assistance, and nutrition services.

However, these advances are now at risk. If Medicaid is cut and public health programs are dismantled, the burden will fall disproportionately on the most vulnerable members of society. (9,10,11,12,13)

A CALL TO ACTION FOR CHRISTIANS

In a 1966 speech to the Medical Committee on Human Rights, Dr. Martin Luther King Jr. declared, “Of all the forms of inequality, injustice in health care is the most shocking and inhuman,” because it often results in physical death. While some progress has been made since then, the poor remain systematically deprived of equal access to a healthy life and are at increased risk of preventable disease, disability, and premature death.

Christians cannot remain silent in the face of policies that will worsen suffering for millions. Limiting Medicaid and reducing the reach of the NIH and CDC contradicts the Christian virtues of mercy and compassion and undermines our biblical call to love our neighbors as ourselves (Mark 12:31). As people of faith, we must advocate for policies that uphold human dignity, protect the vulnerable, and promote health justice for all.

Here are some ways you can take action:

- Educate your church community about the moral and social impact of health care inequities.
- Advocate for policies that protect and expand Medicaid and public health funding.
- Support local organizations working to address the social determinants of health in marginalized communities.
- Engage in community health initiatives that provide holistic care to vulnerable populations.

FAITH IN ACTION: TRANSFORMING COMMUNITIES THROUGH VISION AND PARTNERSHIP

Let me conclude with an example. Early in my career, I joined the board of a non-profit linked to a small inner-city African American church.

The pastor had a vision for building affordable housing, while I, as a professor of community medicine, saw an opportunity to improve community health. When I asked about funding, he smiled and said,

“MARK, WHEN THE LORD GIVES YOU A VISION, HE PROVIDES THE PROVISION.”

With no initial funds, we spent four years raising nearly \$16 million to build a 150-unit low-income housing complex — the first new construction in the area in 70 years. It included a fitness center, a teaching kitchen, community health offices, and garden beds.

This effort sparked a 20-year partnership with the pastor, leading to a coalition of 30+ African American congregations funded by the NIH and CDC.

Together, we improved treatment for chronic diseases, increased exercise and weight loss, reduced emergency room visits, and trained a new generation of medical professionals.

Health is not just a personal responsibility — it is a shared social outcome. When we advocate for justice in health care, we reflect the love of Christ and help build a society where all people can thrive.



PART 1

REFLECTION QUESTIONS

- When you think about “health,” what assumptions do you usually make about personal responsibility? How does the idea of health as a social outcome challenge or expand that view?
- Where do you see social determinants of health in your community (housing, food access, safety, job security, chronic stress)? Who is most affected?
- What would it look like for your church to treat health inequity as a neighbor-love issue — not only a political issue?



PART 2

U.S. HEALTH CARE

HOW THE WORLD'S MOST EXPENSIVE SYSTEM
DISCRIMINATES AGAINST THE POOR AND PERPETUATES
PREVENTABLE DISEASES



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In Part 2, Dr. DeHaven dissects the moral failure of a profit-driven “sick care” system that prioritizes corporate gain over human well-being. He outlines how systemic barriers deny the working poor, racial minorities, and uninsured families access to basic care. With data and prophetic urgency, he urges Christians to remember that God does not measure justice in dollars, but in dignity.

Americans are increasingly frustrated and angry about the state of health care in the U.S. The horrific assassination of a health care system CEO recently shocked the industry, but was met with complacency — and even acceptance — among some segments of the public. Insurance companies and hospitals routinely deny approved medical procedures and erect barriers to processing legitimate claims. Medical bills account for 40% of all personal bankruptcies.

Most Americans support the Affordable Care Act (ACA) and feel the federal government should guarantee health care for all. Yet, the ACA faces an uncertain future, and Medicaid coverage for the underserved is being reduced rather than expanded.

According to every indicator, the U.S. health care system is a failing system. It is the least efficient, most expensive, and least equitable among all wealthy nations. It ranks first in only one category: cost — it accounts for 7.6% of total costs in the U.S. compared to 3.8% in comparable countries.

It accounts for 17.6% of GDP and costs \$5.0 trillion annually. The per capita cost is \$14,570 — compared to \$6,600 in other wealthy countries. Although more costly, the U.S. system ranks last in overall performance, access to quality care, administrative efficiency, health equity, and health care outcomes.¹ Americans die earlier and are less healthy than people in other wealthy countries.

A “NON-SYSTEM” OF “SICK CARE”

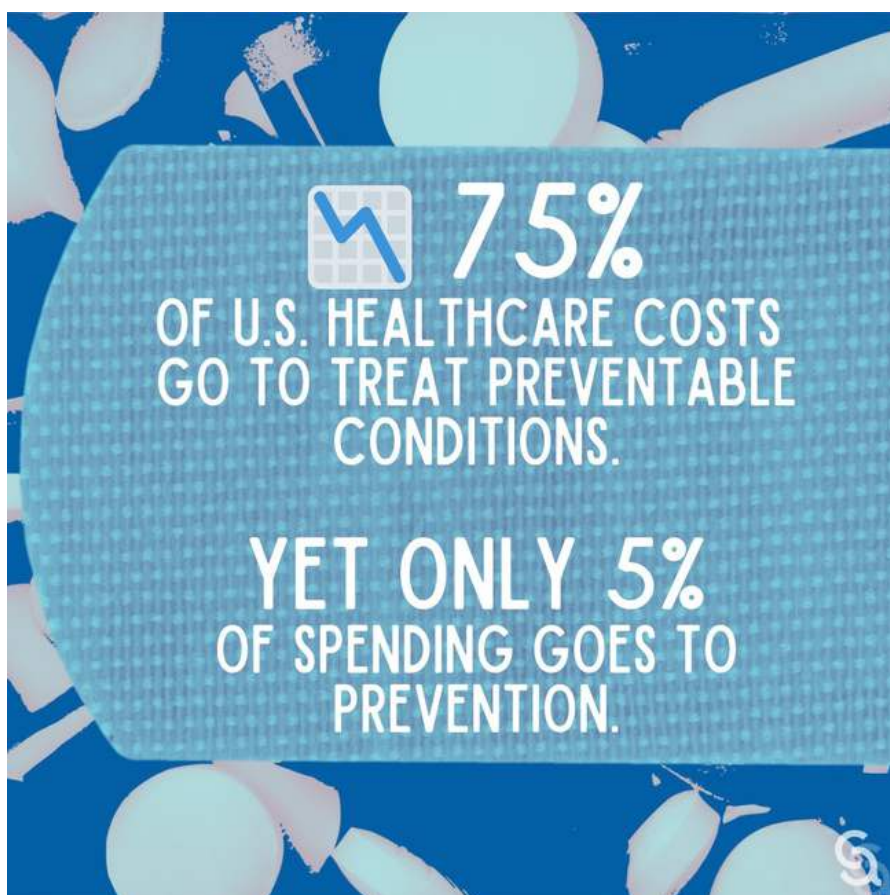
The U.S. health care system does not align with World Health Organization (WHO) standards for a well-functioning health care system and is considered a “non-system” of care.

Non-systems lack a unified structure for managing care delivery, so care is fragmented and uncoordinated, and places emphasis on an individual's ability to pay. Non-systems have broad variations in quality, high costs, poor outcomes, and favor treatment over prevention.²

The American Medical Association (AMA), American Public Health Association (APHA), National Council of Churches (NCC), most major religious denominations, and the majority of the American public all support Universal Health Care (UHC). UHC ensures that all people have equal access to the full continuum and quality of health services— from health promotion to palliation — without personal financial hardship.

Since the U.S. rejects UHC, it is often portrayed as a “sick care” system, focused more on treating rather than preventing disease. Sick care is more expensive, since it relies on costly treatments.

The APHA estimates that every dollar spent on prevention saves \$5.60 in treatment costs. About 75% of U.S. expenses go to treating preventable conditions like heart disease, cancer, type II diabetes, and stroke. Yet, 95% of U.S. spending is for treatment and only 5% for prevention.³



HEALTH CONSEQUENCES OF A FAILING SYSTEM

Preventable chronic illnesses have become a way of life for multiple generations of Americans. They now account for more than 70% of deaths. Although chronic illness is multicausal, overreliance on treatment-based health care is a primary factor. And although access to health care accounts for only about 20% of health outcomes, it is essential for living a long and productive life.

Before the ACA, 45 million Americans had no health insurance. Today the number is 25 million. The uninsured are more likely to not seek — or to postpone — needed care due to cost.

Thus, they are less likely to receive preventive care, more likely to be hospitalized for preventable conditions, and more likely to be diagnosed with late-stage cancer.⁴ Inequitable access to care contributes to increased levels of chronic disease, and lower overall levels of health, length of life, and untreated disease based on race, ethnicity, and income.^{5 6}

The uninsured tend to be the working poor—people who work low-wage jobs and live in poverty. They are disproportionately racial and ethnic minorities: American Indian and Alaska Native (AIAN; 18.7%), Hispanic and Latino (17.9%), Native Hawaiian and Pacific Islander (NHPI; 12.8%), and Black (9.7%), compared to their white counterparts (6.5%).⁷

As a consequence of health care access and outcome inequities, wealthy Americans now live as much as 15 years longer than poor Americans.⁸

PROFITS OVER PEOPLE: COMMUNITY BENEFIT AND THE NEED FOR REFORM

Health care options for the poor are becoming more limited as health care has become a major industry, often more focused on the corporate bottom line than on patient health. The number of public “safety net” hospitals whose mission is to provide care for the underserved has declined by almost half since 1980.



The remaining for-profit and non-profit hospitals are part of corporations that see health care more as a business than a social responsibility. They seek to maximize profits and do not welcome the poor.

Nonprofit hospitals are required by the IRS to provide community health benefits, including charity care for low-income patients without insurance. However, there are no minimum standards, and hospitals decide who and what qualify for charity care.

According to the nonpartisan Lown Institute, 80% of hospitals receive far more in tax benefits than they provide in charity care. For example, the non-profit system in North Carolina with the largest tax exemption dedicates less than 60% of its tax benefit to caring for the poor. The system has accumulated \$8.4 billion in unrestricted reserves, and many of its hospitals have profit margins exceeding 30%.⁹

THE NEED FOR REFORM

The need to reform health care in the U.S. is long overdue. The current system is inequitable and contributes to epidemic levels of persistent chronic disease.

Especially troubling are the human costs inflicted on the poor, who suffer a disproportionate share of the disease burden. When groups of people are systematically denied routine access to medical care and are subjected to increased risk of disease and diminished quality of life, it is unjust and contradicts every basic Christian value.

And when large health care corporations focus on profits and stockpile wealth at the expense of people in need, it is obscene — and challenges Christians to act on behalf of those whose lives and well-being are at peril.

After dedicating his life to eliminating disease among the world's poorest and most vulnerable citizens, the Harvard physician/anthropologist Dr. Paul Farmer concluded,

“...THE IDEA THAT SOME LIVES MATTER LESS IS THE ROOT OF ALL THAT IS WRONG WITH THE WORLD.”

He spoke eloquently of putting the needs of the poor and vulnerable first, as instructed by Catholic Social Teaching and Matthew 25:31–46. In the face of discrimination in health care and impending reductions in the ACA and Medicaid, Christians cannot remain silent. We are being called into action, as was Esther, “...for such a time as this” (Esth. 4:14).

The Hebrew phrase Tikkun Olam means “repair the world,” and in modern usage refers to social action and the pursuit of justice. Trinity Moravian Church in Winston-Salem, NC, embodies the spirit of Tikkun Olam with their Debt Jubilee Project begun in 2022.¹⁰ The congregation raises funds for the sole purpose of purchasing medical debt for pennies on the dollar from third-party debt collectors. So far, they have retired \$21 million of medical debt from thousands of local families.

In such a time as this, Christians must think creatively about our role in reducing health inequity in ways that will:

“...LOOSE THE CHAINS OF INJUSTICE... TO SET THE OPPRESSED FREE.” (ISA. 58:6)



PART 2

REFLECTION QUESTIONS

- Where have you seen the health care system operate more like a business than a public good? How has that affected you or someone you love?
- What emotions come up when you read about medical debt, denied care, or preventable illness? What might those feelings be revealing?
- What is one concrete step you could take in the next 60 days to support health justice (learning, advocacy, giving, volunteering, showing up)?



PART 3

THE GROWING MENTAL HEALTH CRISIS

THE LARGELY IGNORED EPIDEMIC OF CHRONIC MENTAL
ILLNESS



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In Part 3, Dr. DeHaven and Dr. Daniel Gutierrez expose the scale of untreated mental illness, rising suicide rates, and emotional despair that now touch nearly every community. They explore how isolation, stigma, and systemic neglect deepen suffering, especially among marginalized groups.

In the past two months, thousands of federal workers have been abruptly uprooted from their lives — fired without notice, publicly criticized by leaders, and mocked on social media as lazy or wasteful. The new Director of the White House Office of Budget Management even stated he wants federal workers to feel “traumatized.” Unsurprisingly, many report debilitating stress, suicidal ideation, personal crises, weight loss, insomnia, panic attacks, and complete mental breakdowns.(1)

I (DG) have been a psychotherapist for 15 years — long enough to become attuned to the rhythms of a typical therapy session. I know the cadence of depression, anxiety, and addiction.

I recognize the thudding of my own heart as I lean in to hear a client’s story of trauma. I’m familiar with the quiet moments of reflection, the occasional tears, and the sharp inhale that marks an emotional breakthrough. But lately, something has changed. The sounds are quieter, heavier. Clients still speak of their struggles, but now their words are blanketed by a deeper despair. Grief feels accelerated. More often than not, they carry with them a dangerous absence of hope.

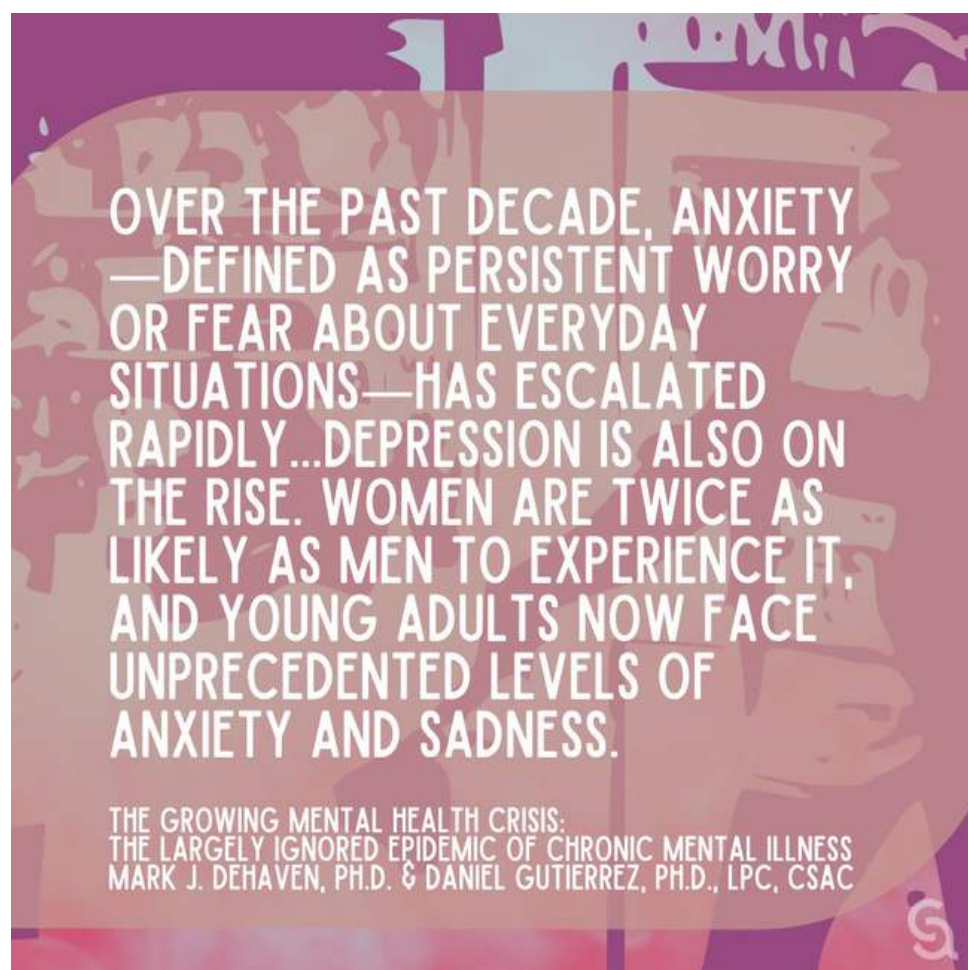
Policies designed to “traumatize” others violate every principle of decency, compassion, and justice. They create climates of fear and retribution, rooted in “othering” — making people feel isolated, threatened, and vulnerable. We’ve seen

MENTAL HEALTH DISORDERS: A GROWING EPIDEMIC

This trauma is unfolding during a time when most Americans are already experiencing heightened stress, and mental health conditions are at record highs. Each year, 25% of adults suffer from a diagnosed or undiagnosed mental health disorder.

By comparison, heart disease — the leading cause of death — affects just 5–6%. Up to 60 million Americans suffer from conditions such as depression, anxiety, bipolar disorder, schizophrenia, and PTSD. These illnesses impact their thoughts, emotions, and behaviors, often making daily life unmanageable by disrupting relationships, work, and basic self-care.

Over the past decade, anxiety — defined as persistent worry or fear about everyday situations—has escalated rapidly, rising from 11% in 2019 to 40% in 2020. By 2024, 43% of Americans reported feeling more anxious than the year before. Depression is also on the rise. Women are twice as likely as men to experience it, and young adults now face unprecedented levels of anxiety and sadness.



While health and longevity improve in other wealthy nations, the opposite is true in the U.S. Deaths of despair — suicide, drug overdoses, and alcohol-related illnesses — are rising here, even as they decline globally.(2)

Fueled by the fentanyl epidemic, over 109,000 Americans died from drug overdoses in 2022, and 51,000 died from alcohol-related causes — a 70% increase in just 10 years. Suicide is a growing public health crisis, especially among youth. It is now the second leading cause of death for children aged 10–14 and young adults aged 25–34.

Over the past decade, suicide rates increased 56% among 10–24-year-olds, contributing to the U.S. having the highest pediatric death rate among wealthy countries.(3,4)

Poor mental health often comes hand-in-hand with isolation and a lack of meaningful social connection. Over 30% of Americans describe themselves as “seriously lonely.”(5) The burden is even greater for LGBTQ+ individuals and people from marginalized communities, who face daily political attacks, stigma, and shame. LGBTQ+ youth, in particular, are more likely to be estranged from family and struggle with suicidal thoughts.

TREATMENT — AND THE LACK THEREOF

Despite growing need, access to mental health care remains dangerously inadequate. Only about half of those who need help receive treatment.

Among the 48 million people aged 12 and older with substance use disorders, only 10% get care.(6) Recent federal funding cuts to the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NIH) threaten to reverse gains made in prevention and early intervention.

A few years ago, John Oliver dedicated an episode of his show to the mental health crisis. In his characteristically brilliant (and biting) tone, he concluded:

“LOOK, IN THE PAST, SO MUCH OF THE PROBLEM HERE IS THAT PEOPLE WOULD NOT ASK FOR HELP. BUT, THANKFULLY, NOW THAT IS LESS OF AN ISSUE... BUT WHEN PEOPLE DO REACH OUT FOR HELP, WE ARE JUST NOT ABLE TO GIVE IT TO THEM. IF WE TRULY WANT TO BE A SOCIETY THAT VALUES MENTAL HEALTH, WE NEED TO BE A SOCIETY THAT VALUES MENTAL HEALTH CARE — AND THAT MEANS SUPPORTING THE PEOPLE WHO DELIVER IT.”(7)

Research supports this.

The Kaiser Family Foundation reports that nearly 50% of the U.S. population lives in a mental health workforce shortage area.(8) By 2037, we're projected to face alarming shortfalls:

- 113,930 addiction counselors (meeting only 45% of demand)
- 43,660 adult psychiatrists (43%)
- 6,780 child and adolescent psychiatrists (65%)
- 87,840 mental health counselors (57%)
- 79,160 psychologists (55%)(9)

Over one-third of clinicians leave the profession, citing poor compensation and burnout.

MOVING FORWARD: A ROLE FOR CHRISTIANS AND CONGREGATIONS

Behind every statistic is a person caught in a storm of despair — a life marked by struggle, a family facing heartbreak, a community searching for hope.

Christians cannot meet this crisis with silence. Yet, for many, that's exactly what they'll receive—even from their congregations. Their pain is dismissed, their stories unheard. In place of compassion, they may encounter oversimplified solutions or harmful, anti-scientific rhetoric that further alienates them.

But it doesn't have to be this way. Excellent resources already exist to help congregations respond well to mental health needs, including:

- Mental Health: A Guide for Faith Leaders by the American Psychiatric Association ([psychiatry.org](https://www.psychiatry.org))
- Interfaith Network on Mental Illness video series (inmi.us)
- Pathways to Promise Mental Health Ministries (pathways2promise.org)(10)

Ministering to one another within the church is essential, but it's not enough. Christians also bear a broader responsibility to care for the vulnerable. The biblical mandate is clear: extend mercy, pursue justice, and love the "other."

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In Matthew 25:31–43, Jesus calls us to care for the hungry, the sick, the stranger. In Matthew 7:12, He reminds us:

“SO IN EVERYTHING, DO TO OTHERS WHAT YOU WOULD HAVE THEM DO TO YOU.”

We’ve heard much political posturing about mandates in recent years. But Christians already have one:

“TO ACT JUSTLY AND TO LOVE MERCY AND TO WALK HUMBLY WITH YOUR GOD.”(MICAH 6:8)



PART 3

REFLECTION QUESTIONS

- Where do you see signs of despair in your community — especially among youth, parents, elders, or marginalized neighbors? What do you think is driving it?
- What messages about mental health did you absorb from church culture (spoken or unspoken)? Which of those messages need healing or correction?
- What would it look like for your church to become more “mental-health literate” — in language, practices, referrals, and care?



PART 4

HEALTH, COMMUNITIES, AND THE ROLE OF THE CHURCH

A CALL TO CHRISTIANS TO PROMOTE HEALTH JUSTICE



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In the final of this series, Dr. DeHaven challenges Christians to see health as an expression of faith — both personal and communal. He offers practical ideas for congregational health ministries, partnerships with social services, and prophetic advocacy on behalf of the vulnerable. Rooted in Scripture and powered by love, he reminds us that the call to “heal the sick” is a mission we’re meant to live.

My heart sank as I considered the devastating health consequences of the White House’s January 20, 2025, order to pause all U.S. foreign aid immediately. Half a million metric tons of surplus U.S. food — already promised to hungry people in Haiti, Bangladesh, and Sudan, packed and loaded, or shipped and awaiting delivery in foreign ports — was halted without warning. Enough food to feed 36 million people was left to rot, with no regard for the starving recipients’ needs.(1)

While the global health community watched in horror, the plan’s architect — and richest man in the world — tweeted this cavalier message:

“WE SPENT THE WEEKEND FEEDING USAID INTO THE WOOD CHIPPER. COULD GONE [SIC] TO SOME GREAT PARTIES. DID THIS INSTEAD.”(2)

The callous indifference to the health and well-being of the poor continued throughout the week. Programs, staff, and funding at the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) were disrupted or halted. Health data systems used to monitor and prevent disease were taken offline.

Medical and health research programs suspected of supporting diversity, equity, or inclusion (DEI) were shut down. An existing presidential order to protect and strengthen Medicaid — which provides health care for low-income families — was revoked.

Then, on February 13, 2025, the White House issued an order establishing the Make America Healthy Again Commission (MAHA). Its purpose? To determine the causes of elevated levels of chronic disease in America. The irony of creating MAHA while dismantling health programs was lost on many.

WHY AMERICANS ARE SO UNHEALTHY

MAHA got one thing right: America does have a health crisis. Americans die younger and suffer from higher levels of preventable disease than in any other wealthy country.

What it got wrong was claiming we don't know why. The reasons for our poor health outcomes. In truth, the causes are well documented and have gone unaddressed, understood among health professionals and policy makers—especially preventive and episodic care. In the U.S., this is not the case. American health care is a broken system. Only one-third of the World Health Organization (WHO) and most other wealthy nations recognize health as a human right. The U.S. does not. As of January 20, 2025, the U.S. is one of only two countries — alongside Liechtenstein — that is not a WHO member.

Second, the WHO and many developed countries endorse Universal Health Care (UHC) and Primary Health Care (PHC). UHC ensures that all people, regardless of income, have access to medical care without financial hardship. PHC integrates health care with social services, recognizing that housing, education, and employment significantly affect health outcomes. The U.S. supports neither

The rest supports a sprawling industry, including costly treatments, hospital stays, drugs, devices, physician fees, bloated administrative costs, and outsized executive salaries and bonuses.

U.S. insurance companies often pour funds into “denial management”—systems designed to deny care in order to increase profits.(4)

HEALTH INJUSTICE AND THE NEED FOR CHRISTIAN COMPASSION

Recent policy decisions threaten the already fragile health of all Americans — especially the marginalized. Because health is a social outcome, people’s ability to live healthy, productive lives is shaped by their social circumstances.

Simply put, those who are socially marginalized have fewer opportunities to be healthy. This injustice reflects a deep moral failure and presents a challenge to Christians.

Scripture calls us to “Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy” (Prov. 31:8–9).

HEALTH IN INDIVIDUALS AND CONGREGATIONS

All Christians and congregations are responsible for promoting and maintaining both personal and communal health. As individuals, we are called to honor and glorify God by caring for our bodies, which are “temples of the Holy Spirit” (1 Cor. 6:19–20).

One of the simplest ways to do this is by adopting a healthy lifestyle. On average, people who live healthfully live a decade longer than those who do not.(5)

Practicing our faith through worship and fellowship also has health benefits. Dr. Harold Koenig of Duke University has estimated that a lack of religious involvement has a mortality effect equivalent to smoking one pack of cigarettes a day for 40 years.(6)

Going to church is linked to better well-being, lower rates of depression and anxiety, improved physical health, less use of medical services, stronger immune function, reduced cancer mortality, fewer heart issues, and greater longevity.(7)

Congregations also benefit from establishing health ministries — initiatives that increase awareness, provide education, and promote health programming. These programs help members lower cholesterol and blood pressure, manage diabetes and hypertension, lose weight, become more active, and utilize preventive services. (8, 9)

ADVOCATING FOR HEALTH JUSTICE FOR OUR NEIGHBORS

More than at any other time in modern history, Christians are needed to protect the health of the vulnerable. Medical care for the marginalized did not exist until Christians recognized the need and responded.(10) As John Dickerson writes:

“THE SEEDS THAT PRODUCED THE MODERN HOSPITAL AND MODERN MEDICINE WERE PLANTED BY DEVOUT CHRISTIANS WHO WERE MOTIVATED BY CHRISTIAN BELIEFS. MANY OF THE BEST-RANKED HOSPITALS TODAY WERE FOUNDED BY CHRISTIANS... ENABLED BY CHRISTIAN DONATIONS AND STAFFED BY DOCTORS WHO TRAINED AT CHRISTIAN UNIVERSITIES.”(11)

Today’s health crisis demands Christian compassion. It is rooted in unjust systems and policies that favor the wealthy at the expense of the vulnerable. When Jesus sent out his disciples, he told them to preach the Gospel and “heal the sick” (Luke 9:2). He taught that when we care for the sick, the hungry, and the stranger, we are caring for him (Matt. 25:40).

Devout Christians must take up the cause of health equity. This means making visible the injustices in health care and health outcomes — both within our congregations and in our communities. We can invite neighbors into our health ministries, volunteer in community programs, and partner with local social services. When we help our neighbors, we not only improve their health, but also experience emotional and physical benefits ourselves.(12)

I've heard it said that "hope is the song in a weary throat." In today's crisis, Christians may be the only hope left for many who are weary, struggling, and deprived of a healthy life. When asked what the Law requires, Jesus responded simply: love God and love your neighbor.

"ALL THE LAW AND THE PROPHETS HANG ON THESE TWO COMMANDMENTS." (MATT. 22:37-40)

We are called now, as we were then, to go and do likewise.



PART 4

REFLECTION QUESTIONS

- What health burdens are carried quietly in your congregation — chronic illness, disability, grief, addiction, anxiety, burnout, medical debt, etc? How might your community become safer for honesty?
- Which is more natural for your church: direct care (meals, visits, support) or public advocacy? What would it look like to hold both?
- If your church chose one “health justice” focus for the next year (mental health, food insecurity, medical debt, access to care), what would be realistic and faithful?

WAYS TO TAKE ACTION

LEARN (BUILD WISE COMPASSION)

- Host a discussion night using this series + guide.
- Invite a local public health worker, counselor, or community clinic leader to speak.

CARE (REDUCE SUFFERING NEARBY)

- Create a confidential “care connector” team for mental health referrals and support.
- Start a meal train + transportation support for treatment appointments.
- Partner with a local clinic, free pharmacy program, or community health initiative.

ADVOCATE (PROTECT THE VULNERABLE)

- Call or write your elected officials about protecting Medicaid and public health funding.
- Show up at a local meeting where health resources and access are being decided.
- Support organizations addressing social determinants of health in your city.

REPAIR (LONG-TERM COMMITMENT)

- Establish a health ministry that includes prevention, education, and community partnerships.
- Launch a small fund to assist with medical debt, prescriptions, or urgent care gaps.

A PRAYER FOR HEALTH, JUSTICE, AND NEIGHBOR-LOVE

GOD OF MERCY,

YOU SEE BODIES BURDENED BY STRESS, SICKNESS, AND SYSTEMS THAT DO NOT PROTECT THE VULNERABLE.

YOU HEAR THE CRIES WE HAVE LEARNED TO IGNORE —

THE QUIET FEAR OF A DIAGNOSIS,

THE SHAME OF DEBT,

THE LONELINESS OF UNTREATED PAIN,

THE EXHAUSTION OF THOSE CARRYING DESPAIR.

MAKE US A PEOPLE WHO LOVE OUR NEIGHBORS WITH MORE THAN WORDS.

GIVE US EYES THAT NOTICE SUFFERING.

GIVE US COURAGE TO TELL THE TRUTH ABOUT WHAT HARMS.

GIVE US WISDOM TO BUILD COMMUNITIES OF CARE — STEADY, HUMBLE, AND SAFE.

AND GIVE US ENDURANCE FOR THE LONG WORK OF REPAIR.

WHERE PEOPLE FEEL FORGOTTEN, MAKE US PRESENT.

WHERE CARE IS DENIED, MAKE US ADVOCATES.

WHERE STIGMA THRIVES, MAKE US GENTLE AND INFORMED.

WHERE DESPAIR GROWS LOUD, MAKE US BEARERS OF HOPE.

IN JESUS' NAME,

AMEN.

REFERENCES

1. Sturmberg JP, Martin CM. “Universal health care — a matter of design and agency?” *J Eval Clin Pract.* 2020;1-7.
2. Starfield B. “Politics, primary health care and health: was Virchow right?” *J Epidemiol Community Health.* 2011;65(8):653-655.
3. Corchow R. Public Health Service. Medical Reform, No.8, 25 Aug 1848. In: Rather LJ, ed. *Rudolf Virchow: Collected Essays on Public Health and Epidemiology.* Boston, MA: Science History Publications; 1985:204–319.
4. Silver AL, Rose DN. Kurt W Deuschle and community medicine: clinical care, statistical compassion, community empowerment. *Mount Sinai J of Med.* 1992;59(6):439-443.
5. Koplan JP, Thacker SB. Deuschle: the clinician in the community. *Mt Sinai J of Med.* 1992;59(6):444-446.
6. DeHaven MJ, Gimpel NA, Kitzman H. Working with communities: Meeting the health needs of those living in vulnerable communities when Primary Health Care and Universal Health Care are not available. *J Eval Clin Pract.* 2020;1–10.
<https://doi.org/10.1111/jep.13495>
7. Remington et al. The county health rankings: rationale and methods. *Popul Health Metr.* 2015;13:11. <https://doi.org/10.1186/s12963-015-0044-2>.
8. Schroeder SA. We can do better — improving the Health of the American people. *NEJM.* 2007;357:1221-1228.
9. Khullar D and Chokshi DA. Health, Income, and Poverty: where we are and what could help. *Health Affairs Health Policy Brief*, October 4,2018. DOI:
<https://doi.org/10.1377/hpb20180817.901935>.
10. Galea S, Tracy M, Hoggatt KJ, DiMaggio C, Karpati A. Estimated deaths attributable to social factors in the United States. *Am J Public Health.* 2011;101:1456-1465.
<https://doi.org/10.2105/AJPH.2010.300086>.
11. Conway C. Poor Health: When Poverty Becomes Disease. *UCSF Magazine* 2015. Fall: 1–11.
12. Weissman J, Pratt LA, Miller EA, Parker JD. Serious Psychological Distress Among Adults: United States, 2009-2019. *NCHS Data Brief* 2015; No. 203: 1–8.
13. Dihwa V, Shadowen H, Barnes AJ. Medicaid can and should play an active role in advancing health equity. *Health Serv Res.* 2022 Dec;57 Suppl 2(Suppl 2):167-171. doi: 10.1111/1475-6773.14069. Epub 2022 Sep 29. PMID: 36125126; PMCID: PMC9660413.

REFERENCES

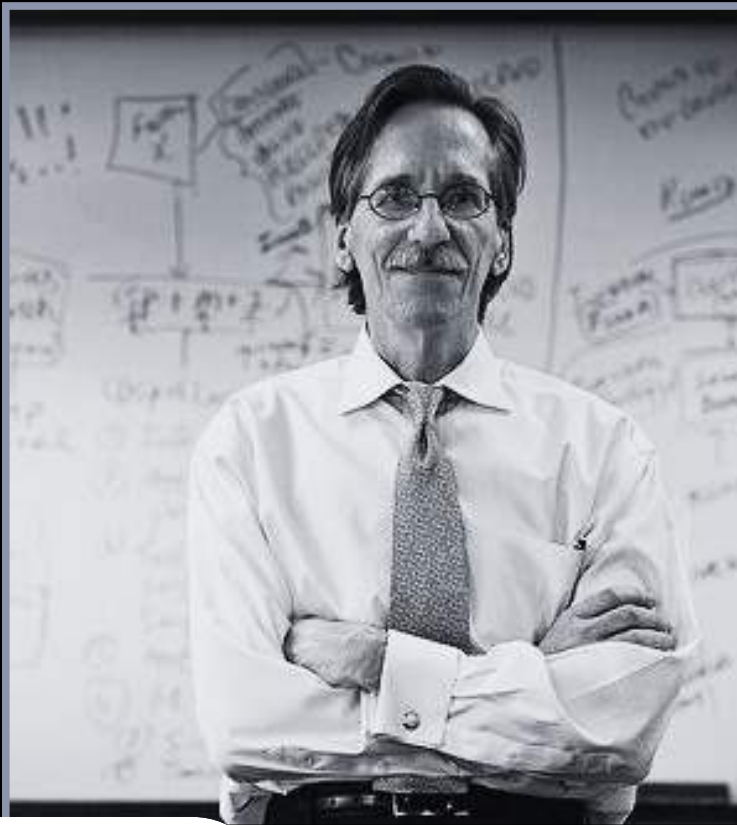
1. Schneider E, Sarnak D, Squires D, Shah A, Doty M. Mirror, mirror 2017: international comparison reflects flaws and opportunities for better U.S. health care. *Commonw Fund*. 2017;9:1-30.
2. Moseley GB. The U.S. Health care non-system, 1908-2008. *Virtual Mentor*. 2008 May 1;10(5):324-31. doi: 10.1001/virtualmentor.2008.10.5.mhst1-0805. PMID: 23211988.
3. U.S. Department of Health and Human Services. Steps to a healthier U.S. Washington (DC): Office of Public Health Promotion; 2001. Available from: URL: http://www.healthierus.gov/steps/steps_brochure.pdf
4. The Kaiser Commission on Medicaid and the Uninsured. Access to care for the uninsured: an update (2003). Available from <http://www.kff.org/uninsured/4142.cfm>.
5. Fiscella K, Franks P, Gold MR, Clancy CM. Inequalities in racial access to health care. *JAMA*. 2000;284(16):2053.
6. Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic disparities in health in the United States: what the patterns tell us. *Am J Public Health*. 2010;100(suppl 1):S186-S196.
7. Hill L, Artiga S, Damico A. Health Coverage by Race and Ethnicity, 2010-2023. Kaiser Family Foundation. Published: Feb 13, 2025
8. Chetty R, Stepner M, Abraham S, et al. The Association Between Income and Life Expectancy in the United States, 2001-2014. *JAMA*. 2016;315(16):1750-1766. doi:10.1001/jama.2016.4226
9. North Carolina Hospitals: Charity Care Case Report. North Carolina State Health Plan & Johns Hopkins Bloomberg School of Public Health. Oct. 27, 2021.
10. Craver, R. Church's Debt Jubilee Project surges past latest fundraising goal. *Hickory Daily Record*. January 13, 2025.

REFERENCES

- [1. Korecki N. 'You lose all hope': Federal workers gripped b mental health distress amid Trump cuts. NBC News. March 9, 2025.
2. Sterling P, Platt ML. Why Deaths of Despair Are Increasing in the US and Not Other Industrial Nations — Insights From Neuroscience and Anthropology. *JAMA Psychiatry*. 2022;79(4):368–374. doi:10.1001/jamapsychiatry.2021.4209
3. Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WISQARS). 12 Leading Causes of Death, United States, 2022.
4. Woolf SH, Chapman DA. Excess US Deaths Attributable to High All-Cause Mortality Rates Among Youths Aged 0 to 19 Years. *JAMA Pediatr*. 2024;178(9):942–944. doi:10.1001/jamapediatrics.2024.1869
5. Bruss KV, Seth P, and Zhao G. Loneliness, Lack of Social and Emotional Support, and Mental Health Issues — United States, 2022. *Morbidity and Mortality Weekly Report (MMWR)*, 2024, 73(24);539–545
6. Saunders H. A Look at Substance Use Disorders (SUD) Among Medicaid Enrollees. Kaiser Family Foundation. Feb 17, 2023.
7. Oliver J. Mental health care: Last week tonight with John Oliver. August 1, 2022. YouTube video. Accessed March 12, 2025.
8. Kaiser Family Foundation. Mental Health Care Health Professional Shortage Areas (HPSAs). December 31, 2024. Accessed March 12, 2025.
9. National Center for Health Workforce Projections. Projected supply and demand of health care workers through 2037. Data.HRSA.gov. Accessed March 13, 2025.
10. Ramsey-Lucas C. The Necessity of a Mental Health Ministry. *Sojourners*. April 22, 2019 (<https://sojo.net/articles/necessity-mental-health-ministry>).

REFERENCES

1. Mersie A. Devex Dish: The fate of food aid stranded by USAID's unraveling. February 12, 2025.
2. Musk E. @elonmusk X post February 3, 2025.
3. Schneider E, Sarnak D, Squires D, Shah A, Doty M. Mirror, mirror 2017: international comparison reflects flaws and opportunities for better U.S. health care. *Commonw Fund*. 2017;9:1-30.
4. Jones GH, et al. Health care in the United States — basic human right or entitlement? 2015. *Annals of Oncology*, Volume 26, Issue 10, 2193 – 2195
5. Li Y, et al. Impact of Healthy Lifestyle Factors on Life Expectancies in the US Population. *Circulation*. 2018 Jul 24;138(4):345-355.
6. McCullough ME, Hoyt WT, Larson DB, Koenig HG, Thoresen C. Religious involvement and mortality: a meta-analytic review. *Health Psychol*. 2000 May;19(3):211-22.
7. Koenig HG, Vanderweele TJ, & Peteet JR. 2023. *Handbook of Religion and Health*. Third Ed. Oxford University Press. Pp. 1-1088.
8. DeHaven MJ, Hunter IB, Wilder L, Walton JW, Berry J. Health programs in faith-based organizations: are they effective? *Am J Public Health*. 2004 Jun;94(6):1030-6.
9. DeHaven MJ, Gimpel NA, Gutierrez D, Kitzman-Carmichael H, Revens K. Designing health care: A community health science solution for reducing health disparities by integrating social determinants and the effects of place. *J Eval Clin Pract*. 2020 Oct;26(5):1564-1572.
10. Tangelder J. A history of health care . . . and why Christians have done it different. *Reformed Perspective*. September 21, 2018.
11. Dickerson JS. Christianity and the Origins of Hospitals and Modern Medicine. *Christian Research Institute* October 18, 2021.
12. Luks A. *The Healing Power of Doing Good*. 2001. iUniverse.com, Inc. pp. 1- 386.



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