

Faith in the Future



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*Healthcare, Aging,
and the Role of Religion*



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To All Those Who Give of Themselves
Because of Their Faith



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Introduction

IN MARCH 2001, a historic conference, “Faith in the Future, Religion, Aging, and Healthcare in the 21st Century,” was held at Duke University. Sponsored by the Gerontological Society of America, Duke University School of Medicine Office of Continuing Medical Education, Duke Center for the Study of Aging & Human Development, Duke Department of Psychiatry & Behavioral Sciences, and the John Templeton Foundation, this conference brought together internationally renowned leaders in medicine, healthcare policy, religion, government, the media, and hundreds of healthcare and religious professionals, as well as lay members of diverse religious communities.

They examined one of the most serious issues in today’s society: What are the challenges facing healthcare in America, and will the members of America’s 350,000 religious congregations be able to help prevent or lessen the looming healthcare crisis unleashed by relentless demographic pressures and rising costs? *Faith in the Future* presents a synthesis of the March 2001 Duke University conference and expands on the themes raised there, citing the most recent available research findings and offering many more compelling human examples to provide readers with empathetic role models they can emulate.

Over the next several decades, our elderly population will swell inexorably, and there will be an equally dramatic increase of older people with chronic health problems and disabilities needing long-term healthcare. At the same time, the costs of providing that care, which are already soaring despite all efforts by government and managed-care organizations to limit expenditures, will continue to rise.

Soon these demographic and health-economic trends will clash in what could well prove to be the most serious societal problem in modern history: widespread shortages of increasingly costly healthcare for the growing elderly population.



But it is not inevitable that the looming crisis ends in catastrophe. The situation is full of opportunities for individuals and institutions to make important contributions unique in our country's history. Seniors will have the opportunity to derive true meaning and purpose in their lives by investing their energies and skills in the care and well-being of other members of their religious congregations and wider communities. Within innovative networks of community support, older adults will have the opportunity to live with dignity in their own homes, rather than being automatically shunted off to anonymous, dispiriting institutions to spend their remaining days. Religious institutions ranging in size from a small alliance of congregations to an entire denomination can lead a critical effort to help alleviate a potentially major social disaster by sponsoring effective volunteer programs that reach out to those in need. While making this contribution, religious institutions will also have the opportunity to make a real difference in society at a time when the perceived role of religion in contemporary culture is losing its importance in the face of the juggernaut of scientific and medical progress. Finally, the pending crisis offers healthcare institutions themselves the opportunity to reorient their approach toward providing whole-person care that is cost effective and satisfying for patients and health professionals alike.



But before examining these opportunities, we must take an honest look at the extent of the problems we face. One of the most pressing current problems concerns Health Maintenance Organizations (HMOs) for senior citizens. Many HMOs no longer accept Medicare patients who cannot afford private insurance, and these indigent elderly are shunted aside to somehow fend for themselves. Those who might believe that even discussing these issues is needlessly alarmist need only reflect on the story of the late Robert DeGray.

The last two years of Robert DeGray's life were haunted by disease and anxiety. In his mid-eighties in 1999, the retired Clearwater, Florida, security guard was afflicted by emphysema, throat cancer, and prostate cancer, which were kept in check through the treatment and affordable prescription drugs he received from his Medicare-funded HMO, Prudential Health Care. Like millions of other older Americans, DeGray lived frugally on his Social Security benefits of about \$1200 a month. Medicare provided his sole health insurance.

DeGray had been satisfied with his HMO until October 1999, when Prudential suddenly announced that, because of rising costs not matched by gov-

ernment reimbursements, the organization would begin charging its members a monthly premium of \$65, an additional fee for clinic visits, raise the patient co-payment for prescription drugs, and also place a drastic cost cap on annual prescription coverage, which would drop from \$2000 a year to only \$750.

One afternoon in December 1999, DeGray's son, Jim, 57, was shocked and saddened to find his father sitting at the kitchen table of the mobile home they shared. The older man was methodically cutting his medication tablets in half, desperately hoping to stretch the supply a little longer.

"Dad," Jim DeGray said, "you can't do that. The medicine won't do you any good at half strength."

His father nodded stoically. "I just can't afford my prescriptions anymore, Jim. They cost around five hundred dollars a month. If I can't spend more than seven-fifty a *year*, I'll be out of pocket for the whole thing by the middle of February. Then there are the new premiums and charges. You know how much my Social Security check is."

Jim DeGray took a part-time job at a drycleaners to help his father pay for the prescription drugs. But that solution did not solve the problem of paying for the older DeGray's most expensive medication. Once every three months, he received a shot of the hormone Lupron to keep his metastatic prostate cancer from spreading. The medication was very effective, but also very expensive: \$2,500 per treatment for an annual total of \$10,000. For the moment, the HMO covered the cost of Lupron, but announced it was reconsidering that coverage. Robert DeGray was tormented by images of the cancer taking root across his body.

While his HMO continued to pay for this costly treatment, he and Jim struggled to meet the steadily rising costs of the older man's care. But in July 2000, Prudential announced it would be shutting down its Medicare HMOs in the area. Like so many other companies nationwide, Prudential was forced to confront mounting expenses and low government reimbursements that did not match these costs.

Feeling abandoned by the Medicare system he had trusted for so many years, Robert DeGray told his son, "I might as well just die. There's no way I can afford a regular doctor."

Jim DeGray was upset by his father's words, but understood the elderly man's pessimism.

Although low-cost managed care was the best option for his multiple afflictions and small pension, health insurance companies all around his region were now closing Medicare HMOs.

Luckily, Jim DeGray was able to quickly enroll his father in a Blue Cross and Blue Shield program that looked like it would provide good care at low costs.

Then that HMO also raised its monthly premium, while imposing a ceiling on prescription drug coverage of \$250 every six months for an annual maximum of \$500. Robert DeGray's primary care physicians were also changed twice in nine months as the company fought to contain costs.

But the true hammer blow to DeGray's morale came in late summer 2001, when he learned that this new HMO would also go out of business the next January 1. Certain he would never receive adequate care, he died in a hospice that October.



Although Robert DeGray had anticipated the pain and discomfort of his failing health, he had never expected the unending complications and frustrations of securing adequate, reliable care just when he needed it so badly.

Originally, he had been well satisfied with his Prudential Medicare HMO, where he had his own regular doctor who also referred him to the specialists working within the system. This sense of stability, as well as the prescription drug coverage that the HMO provided free under DeGray's Medicare coverage, gave him great emotional comfort. Robert DeGray recognized the serious nature of his illnesses, but he also felt he was benefiting from high-quality care paid for by Medicare, which, like his Social Security pension, he would never lose.

But when the security of his healthcare began to crumble, anxiety took grip of DeGray and did not release him. Like millions of other elderly people across the country who faced the problem of their Medicare HMOs suddenly and unexpectedly closing, he was frightened and confused. Would he find an HMO that provided the same coverage he had enjoyed at Prudential? If not, how would he ever cope with the inevitable deterioration of his health while he and his son searched for a practice that would accept Medicare as his sole health insurance and also provide him prescription drugs he could not afford to buy?

This question haunted him up to the time of his death.



How typical was Robert DeGray's troubling experience? Is his unfortunate story representative of his own or future generations of very elderly Americans? According to AARP (known as the American Association of Retired Persons until 2000), the organization has received "countless" letters of complaint from members who—like DeGray—have been abandoned by their Medicare HMOs and have had to scramble to find some form of coverage, which is

invariably much less generous and flexible than their earlier managed care. There are almost always higher premiums, no free prescription drugs, and drastic annual caps on prescription reimbursement, one of the benefits the ill elderly can least afford to lose.

And Medicare-funded HMO coverage is simply disappearing in many states. In December 2000, for example, after aggressively marketing its Medi-CareFirst HMO coverage in the mid-1990s, Blue Cross Blue Shield of Maryland shut down—citing inadequate federal reimbursement for services in the face of rising costs—leaving thousands of elderly patients to search for affordable coverage. Senior citizens in neighboring Delaware faced the same problem in 2000, as Medicare HMOs closed for the second consecutive year. Across the country, a similar healthcare crisis prevailed. By federal regulation, Medicare HMOs can arbitrarily cancel coverage on December 31, and none has an obligation toward its patients beyond a year-by-year contract.

Delaware's insurance commissioner, Donna Lee H. Williams, has severely criticized this policy. "The purpose of the Medicare Program is to give our seniors a sense of security regarding their healthcare needs," she observed. "Under its current structure, however, the Medicare HMO option provides no such security."



But the situation is not likely to improve unless we begin to reconsider our traditional concepts of professional healthcare, as well as personal and community responsibility toward prevention and wellness promotion.

The harsh projections of demographics make it clear that the relentless expansion of our elderly population will overpower the limited resources of our public and privately funded healthcare much sooner than most of us care to contemplate.

In 1999, Edward L. Schneider, dean of the Leonard Davis School of Gerontology, Ethel Percy Andrus Gerontology Center at the University of California, Los Angeles, published a provocative policy article in the journal *Science*, "Aging in the Third Millennium." Citing conservative and widely accepted demographic projections, Schneider showed that the number of Americans 65 and older will most likely increase from 35 million in 2000 to at least 78 million by 2050. His 1999 estimate for 2050 is no doubt on the low side, as the current Administration on Aging of the U.S. Department of Health and Human Services projects the increase in people 65 and older to 77 million as early as 2040.

Further, Census Bureau middle series estimates foresee a population of 80

million Americans over 65 by 2050. But the actual number could be closer to 100 million if advances in stem cell and genetics research continue steadily. According to health scientists, most of the improved longevity in the past two decades has been due to medical advances that have expanded lifespan after the age of 65. These increases in longevity will continue. Ed Schneider has no doubt of this. In the near future, “most Americans will live into their 80s,” he wrote in *Science*.

The projected increase in the population of Americans aged 85 and above will clearly be dramatic. Some demographers envision a jump in this group from about 4 million in 2000 to at least 18 million by 2050. Indeed, Schneider points out that the Census Bureau projects the actual number of these “very old Americans” at over 30 million by 2050, based on high series estimates.

These projections concern numbers, not the relative health or disability of older people.

As one considers these dry estimates, it is essential to remember the lessons of Robert DeGray’s final years. The steady growth of our older population poses a serious threat to the Medicare system itself, not just to Medicare-funded HMOs, which are now collapsing nationwide. If we are struggling even now to meet the needs of 35 million persons over age 65 in this country, how will Medicare, the principal form of health insurance for most elderly, meet the needs of between 18 and 30 million people over 85 — many with multiple disabilities similar to DeGray’s that require expensive treatment — in 2050?

We do not have to look so far into the future to pose that question. Department of Health and Human Services research shows that the cost of Medicare will quickly rise as the population ages. The projected yearly Medicare budget for 2011 is \$450.1 billion (compared to \$224 billion in 2000). But that estimate avoids the fact that the 80 million members of the Baby Boom generation will not reach age 65 until just *after* 2011. No federal agency will make healthcare budget estimates for beyond 2011. That is a sobering reality.

In his article, Schneider has set out two scenarios that address the “major uncertainty” of healthcare and the aging population. Under Scenario 1, the public and private sectors increase their funding to engage in “appropriate levels” of aging research, disease prevention, and breakthroughs in treatment. Dramatic progress is made toward conquering the present-day primary causes of disability among the elderly: cardiovascular disease, cancer, diabetes and its complications, and so on. As a result of such intervention today, Schneider predicts, “the average health of a future 85-year-old in the year 2040 resembles that of a current 70-year-old with relatively modest needs for acute [hospital] and long-term care.”

But in Schneider’s Scenario 2, the current low levels of spending and relative

neglect of health research, disease prevention, and breakthroughs in treatment extend into the future. This results in only small improvements in the average health of the elderly in the future. However, there will be many more members of the over-85 age group. If they are just as infirm as Robert DeGray, they will place an unsupportable strain on the healthcare system.

Medicare-funded HMOs will no doubt have become a distant memory by 2040. Under Schneider's Scenario 2, securing long-term care (in nursing homes and rehabilitation hospitals) for the large numbers of very elderly will be a major challenge. And Schneider indicates that treating these people in their homes or in skilled-care nursing facilities is almost nine times more expensive than similar treatment for people aged 69 and 70.

In the future, the federal government will probably subsidize some form of prescription drug coverage for Medicare beneficiaries. But it is doubtful that this coverage will meet the needs of the huge population bulge of the very old unless they reach this age in relatively good health, even if the stock market turns around, the economy expands steadily, and projected budget excesses are realized. Since Medicare is a universally accepted entitlement, it is not likely that our political leadership will willingly cut benefits until the system is truly facing ruin. To prevent this collapse, Schneider and others foresee senior citizens forced to cover an increasing share of their own healthcare expenses through rising premiums and co-payments and harshly curtailed treatment. Rather than being an entitlement for all older citizens, Medicare may become a "needs-based" program, limited to the poorest elderly, with related healthcare rationing reserved for the oldest and sickest Americans.

Many elderly people, however, will be healthy enough and have the means to live independently, either in their own homes or in retirement communities, locations ranging from traditional neighborhoods to mobile-home parks to resort-like centers featuring their own clinics, recreational facilities, dining, and food catering. These people will have a relatively light impact on healthcare costs.

But for millions of older people in coming decades, even a dilapidated trailer home or camper may be financially inaccessible. It will be this poorest and sickest segment of the swollen elderly population that will present the largest problem. Schneider predicts that assisted-living and acute-care facilities will feel the greatest impact of their numbers. Those who have been paralyzed by stroke, lost feet or legs to diabetes, or are debilitated by emphysema will need specialized long-term care or the help of an assisted-living facility. But it is probable there will not be enough nursing homes to care for these people.

Under Schneider's optimistic Scenario 1, the growing elderly population will reach old age in relative good health. Therefore, the anticipated modest

expansion of nursing homes and assisted-living facilities will meet the needs of future generations of seniors.

But under Scenario 2, tens of millions of older Americans enter the final decades of life in failing health, many with multiple disabilities. These “frail elderly” would require greatly increased home care, admissions to acute-care hospitals, or long-term care in nursing homes, which will have become “semi-acute hospitals with long waiting lists.”

In the worst-case view of this scenario, the poorest and sickest will simply find no place in affordable government-funded long-term care. “If they do not have relatives, significant others, or friends to take care of them, we may face the gruesome prospect of poor, disabled, homeless older Americans living out the end of their lives on city streets and in parks,” Schneider predicts.



Is there any way to prevent this grim view of the future from becoming reality? The simple answer is yes. And one source of this optimism lies in what will be for many an unexpected direction: religious faith and practice and the compassion of America’s 350,000 faith communities and congregations.

There is a steadily growing body of scientific evidence that religious involvement is associated with better physical health, a greater sense of well-being, less depression, and a reduced need for health services, including hospital stays. Hundreds of research studies conducted at our leading institutions seem to indicate that religious beliefs and practices help people of all ages cope better with stress, increase their contact with helpful social-support networks, and discourage activity that has a negative impact on their health: drug and alcohol abuse, smoking, and high-risk sexual behavior, which all contribute to disease and disability. Further, the stress reduction and amelioration of depression that are associated with religious involvement have been demonstrated to be key components in the prevention of serious illness such as cardiovascular disease. Religious faith and involvement have also been shown to foster an overall positive mental attitude, assist in positive decision making, and may reduce the likelihood of acquiring preventable illness at all ages.

This “religiosity” also encourages responsibility, commitment, and concern and generosity toward others. The improved health across the lifespan among religious people, from adolescence through old age, may lower their need for expensive healthcare services. Equally important, religious faith and practice enhance the willingness and ability of elders to provide nonprofessional “healthcare” and sustain their emotional support of others on a volunteer basis.

It is quite possible that these religiously motivated volunteers will emerge

as a pivotal factor preventing the complete degradation of our healthcare system in coming decades. And, by stepping forward to meet the needs of their congregations and broader communities, these volunteers will personally derive unexpected and unique health benefits.

Even sick and disabled elderly can often assume meaningful roles within their caring faith communities: telephoning to check on other homebound elders, praying with them or bringing them into prayer chains within the faith community, simply listening to them to promote a positive outlook and relieve their painful isolation, and organizing get-well card mailings (cards are now available free over the Internet). If they are physically able, the elderly with lesser disabilities can assist at child-care centers and mentor young people in vocational or academic subjects. Such interaction will enhance the meaning of the elders' life-long experiences and foster in the young a sense of respect for people with whom they normally would not have much contact.

When the disabled elderly are still physically capable of volunteering for such activities as speaking over the telephone, folding and addressing get-well cards, or mentoring children, they invariably enjoy a personal shift toward more hopeful, optimistic attitudes, which may also translate into better physical health and less need for health services. Even if the improvement in physical health is not significant in traditional clinical terms, these optimistic seniors are often less of a burden on others and on the healthcare system.

For centuries, religious organizations have reached out to the poor, the elderly and afflicted, and all those in need of care—the very people Edward Schneider suggested might live out their final years in lonely misery on our city streets. Assisting the downtrodden is a theological mandate as well as a central concern for all the monotheistic faith traditions. Therefore, among the potential solutions to the pending healthcare crisis, there is a major role for the faith community.



One of the most important questions we as a nation—indeed, all the industrialized nations of the world—now face is how we will address the lurking societal crisis of our expanding elderly population and steeply rising healthcare costs. How can we encourage disease prevention and healthy living on an unprecedented scale in our population today in order to minimize health problems that will require increasingly expensive care tomorrow?

How should we raise our children so that they will be prepared for the future burdens—as well as for the future opportunities—they will confront when the traditional demographic pyramid with a broad base of youth and a small apex

of the very elderly is turned upside down? This is a crucial question: What can we do now to prepare young people for a society in which they might view such a large proportion of the elderly population as weak, dependent, and simply worthless? Today's children and youth must learn that all people, no matter how physically frail, have spiritual value and are worthy of respect. If this lesson is not instilled today through greater contact between the very young and the very old—perhaps within the nurturing atmosphere of a faith community—the gap between the young and the old will no doubt widen. The disabled elderly will be seen as expendable, obvious candidates for euthanasia or physician-assisted suicide.

Is this prospect overly extreme? Not if you examine the inroads these two practices have already made. The State of Oregon and the European nations of Belgium and the Netherlands (both of which have a high proportion of older elderly) now permit euthanasia or physician-assisted suicide. Experts predict that the practice of assisting the terminally ill (or simply the frail elderly) into death will spread across the industrialized world if the inherent human value of all individuals is not recognized.



How will we provide quality healthcare to older adults who will need it during the next thirty to fifty years? Who will provide this care? How will it be funded? And how can we now establish systems of care in place as demographic and health-related economic pressures mount?

It is essential that we study the actual nature of aging now so that we can nurture *successful* aging and purpose-filled retirement to enhance the quality of the last third of life.

While the monumental policy issues that will affect trillions of dollars in state healthcare expenditures, Medicare, and Social Security budgets over the coming decades are being debated in Congress and in the news media, the nation's religious congregations and faith-based communities are quietly working to build effective practical models of care that bring together the elderly in need with millions of volunteers willing to meet those needs.

How well are they fulfilling that mission? Success requires traditional preaching from the pulpit on the need to care for one another, for the faithful to give of their time and finances, and to train their children to do the same. This approach is not very popular in many congregations that are accustomed to being entertained once a week, not to having new responsibilities thrust on them. But this entertainment expectation is exactly why many churches are dying: They haven't sufficiently involved members of their congregations in

the vision and role of the church, and some clergy and lay leaders do not even understand that vision — particularly with regard to addressing the health needs of their present and future congregations. But there is hope.



Four years ago, Natalie Romine, a retired Kansas City, Missouri, county court social worker in her mid-eighties, suffered severely from advanced osteoporosis. The mineral loss in the bones of her spine had advanced to the point that she was bent over almost 90 degrees from the waist. Her prospects were grim. Because she lived alone, it was almost certain that she would no longer be able to care for herself as the disability steadily worsened. Although she was still able to drive her car during the day, that independence would soon be lost to Natalie as her condition deteriorated. Her worst fear was falling and breaking a hip, which she knew would result in a long — perhaps permanent — stay in a rehabilitation hospital or nursing home.

A life-long devout Protestant, she found comfort in prayer, but did not expect any miraculous improvement in her osteoporosis. Then, one day in 1999, a friend suggested, “Natalie, do go to the Shepherd’s Center. They have a wonderful exercise program that just may help you.”

The first Shepherd’s Center — a reference to “The LORD is my shepherd” of the Twenty-Third Psalm — had been created by the Reverend Elbert C. Cole, pastor of a Kansas City United Methodist church, in 1972. The purpose of the program was to offer senior citizen participants the chance to enrich and fulfill their lives through volunteer work and ongoing study, as well as to provide health-enhancement instruction — screening and monitoring, nutritional advice, and weight management. Shepherd’s Centers were based on the premise that the religious elderly were prepared to serve as volunteers, putting their faith into action and working with community partners for the common good. Centered on religious congregations, seventy-nine Shepherd’s Centers are active thirty years after Rev. Cole started the original program.

The “exercise” classes Natalie Romine found at the Shepherd’s Center involved T’ai Chi Chih, a relatively recent variant of ancient Chinese meditation-and-exercise disciplines adapted for Western practitioners by American Asian expert Justin Stone in 1974. T’ai Chi Chih entails twenty slow, rhythmic, circular arm, torso, and leg movements meant to improve emotional harmony while increasing physical strength and restoring a sense of balance in people like Natalie, whose strength and balance are failing.

Her first Shepherd’s Center T’ai Chi Chih instructor was Jean Smith, an elderly woman who led a small group of people ranging in age from their late

sixties to almost ninety. Natalie learned all the basics from Jean Smith, and when Jean withdrew because of illness, Lucy Ann Fleischman, a T'ai Chi Chih instructor and avid enthusiast, took over the group.

After eleven months of ongoing instruction and practice with Lucy Ann, Natalie's legs were dramatically stronger, her balance greatly improved. She no longer felt that the osteoporosis had seized her in a cruel vise and was bending her in half. Then, one afternoon a year after beginning T'ai Chi Chih instruction, she was combing her hair before the bathroom mirror. It had been several years since she had been able to straighten her shoulders high enough to see her face in the mirror. But suddenly her head and smiling face appeared.

She was overcome with tearful gratitude. Lucy Ann Fleischman and all the others at the Shepherd's Center had devoted so much time to her. Now that devotion had borne fruit.

To repay some of the generosity she had received, Natalie accompanied Lucy Ann to demonstrate T'ai Chi Chih to the elderly residents of a retirement home. Natalie avidly described the dramatic improvements in balance, flexibility, and leg strength she now enjoyed.

Since then, Natalie Romine has undergone open-heart surgery and, during her recuperation, lost much of the strength she had gained through practicing T'ai Chi Chih. But now that she has recovered, she plans to resume the program, practicing at home and with a new Shepherd's Center group.

Her experience with T'ai Chi Chih introduced her to the many opportunities available at the Shepherd's Center, which she enthusiastically describes as "a wonderful place." Beyond continuing her exercises, she looks forward to taking part in the center's oral history program. All her professional life she was involved with the careful record keeping of the court system. Now, with the project, she can bring to new elderly friends many of the skills she acquired in her lifetime.

Through the Shepherd's Center, Natalie Romine has overcome the potential disabilities of crippling osteoporosis and heart disease. She still lives independently in her own home. Instead of being a burden on her community, Natalie is able to make a valid and fulfilling contribution.



Faith in the Future does not flinch in its assessment of the challenge our country faces. America confronts a social and economic threat of unprecedented complexity and severity as the healthcare crisis approaches. Further, the book presents a succinct lesson on the demographics of our aging population, their spiraling healthcare costs, and the potentially crippling pressures those soaring

costs place on our acute and long-term care institutions and systems of privately and publicly funded health insurance.

From a more optimistic perspective, *Faith in the Future* reviews the impressive and growing body of scientific research linking disease prevention with healthy living, which is in turn associated with religious faith and practice. Studies suggest that devout members of religious congregations might be particularly shielded from such chronic debilitating afflictions as heart disease and certain cancers—perhaps due to the reduced stress and lower depression levels they enjoy and their mutual concern for fellow congregants, which in turn follows the millennia-old religious tradition of caring for the ill.

This ancient caring tradition has led to thousands of religious communities nationwide that fill a need similar to that of the Shepherd’s Centers by providing support networks for the elderly. All of the most effective religious social-support communities rely on dedicated volunteers of all ages, who likely derive both emotional and more tangible physical health benefits. For the elderly, spending their mature years in purpose-filled retirement has proven especially beneficial.

As it becomes increasingly clear that “caring” for the frail elderly involves more than medical intervention, we hope that millions of Americans will step forward to help their religious congregations form practical partnerships with healthcare systems, government, and philanthropic efforts to empower faith-based communities to meet the challenge ahead.



This is a book for adults of all ages, of all educational and socioeconomic backgrounds, of all health conditions, and of all faiths. It is of particular relevance for the post–World War II Baby Boom generation and their children, the group that soon will be entering the healthcare foray. The authors also have much to say to the clergy who lead the country’s 350,000 congregations; they have taken sacred vows to help care for aging members and their families who increasingly will have nowhere else to go.

Those among the 7 million healthcare and social-service professionals, desperately searching for resources to provide care for aging patients, will find practical direction and guidance on how to prepare to meet this need by drawing on the resources of volunteers and religious congregations. The general reader will find that the book’s ultimate message is positive, inspiring, and hopeful, one that speaks of the great opportunity for every person to find personal fulfillment by making a true and lasting difference in our society at this critical time in history.