Chapter Nine

Religion and the Health of the Public: Deep Accountability

> "For the hardest problems, the problems that would not give way without long looks into the universe's bowels, physicists reserved words like *deep*."
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> - James Gleick, *Chaos: Making a New Science*[1]

Better theory enables better choices, or it is not worth the bother. If the theory does not help those in positions of influence to guide efforts and alignments relevant to the health of their community, the theory is little better than intellectual entertainment; a distraction. A good theory helps people in positions of influence (many of whom might not think of themselves as "leaders") to achieve deep accountability for how they use their influence, for how they live their lives. They seek accountability that is deep in the sense of being rooted in an understanding of the complexity of life and in respect for its forms, aware of the turbulence it contains, sensitive to the variety of levels and scales at which human relationships matter, and worthy of the weight their decisions must support over time. If Amartya Sen sees development as freedom and Paul Ricoeur is unable to define the self except in relation to another as the basis of justice, then we see deep accountability for health as defined by the criteria of comprehensive well-being.

The language of accountability pervades discourse around health policy. Recent U.S. reform legislation, for example, includes a move toward "accountable care organizations," simply meaning that somebody be held accountable for the various paid providers who offer services for an episode of treatment. Deep accountability would hold a more rigorous standard intellectually by including all of those involved in the journey of health as understood in light of the theory offered up in the earlier chapters of this book.

Deep accountability, in a time when public health faces many crises and the sphere of the public itself has been variously undermined, challenges many people. The health of the public, for instance, is affected by choices made by people in influential positions, especially in states and markets, who usually do not look beyond the interests of their own organisation or specific field of activity. In the academy, transdisciplinarity, crucial to any understanding of complexity, is often commended but mostly marginalised, leaving the narrower disciplinary guilds that emerged in modernity relatively unscathed and boundary crossing thinkers comparatively isolated. In public health, people largely continue thinking like their employers, the state institutions. Faith leaders may be equally comfortable within their domain of language and logic

[1] James Gleick, *Chaos: Making a New Science* (New York: Penguin Books, 1988), 3.

without ever feeling the need to share accountability with those in the secular state. And all may be insufficiently aware of what people in local communities, however little they have in the way of resources, support or even recognition, do about their own health.

Yet increasingly, the ecology of social life includes ever-expanding hybrid organisational forms, emerging and mutating faster than typologies can name them. Thousands of new non-governmental organisations, exploding like beneficent viruses, play roles previously thought to need a government or, in some societies, in some eras, a religious structure. Their work engages many determinants of health, with proximate and distal effects, using tangible and intangible means, at individual and social levels. If those in public organisations tend to think like states and act as their extension, and those in religious structures (often) think differently and act differently, then those in the hybrids regularly invent their logic as they go.

Alignment in such a cacophony of thinking and doing is accidental at best, and common accountability is rare, especially for distal health improvements that require choices sustained over time. There are many obvious reasons for bad alignment, including differing interests and incentives, the fragmented plethora of professional guilds who influence decisions about policy and practice and the machinations of power and money. Leaders, especially those with titles that imply a capacity to deliver health unto the public—"director of public health," or "archbishop of the diocese of Memphis"—face complexities that affect the health and well-being of entire publics. Their leadership burden is heavy, awkward and slippery. If their theory of leadership is contained within their institutional identities—religious, secular, or public—neither director nor archbishop will adequately be able to be accountable for the health of the whole public. This holds especially true when adopting a theory of dominion, control, and boundary patrols existing within a structural center of power that cannot allow realistic accountability for a complex, turbulent social reality.

It may seem naïve to suggest that better theory would make a difference, but we do. Better theory helps leaders to live their lives accountable to a foundation deep enough to rest their life choices on. Living in a world of turbulent human systems, where should they lend their energy, imagination, presence, and capacity for risk, informed by what hope? Current theories of complexity make clear that linear, reductionist approaches to complex problems are not very effective. They are better suited to standard or "legitimate problems," amenable to any skilled scientist using available techniques after appropriate contemplation and calculation.[2]

Complex problems—and most of the challenges connected to health of the public are such—require some capacity to deal with unpredictability and non-linearity, of both positive and negative aspects inherent to the nature of life. Thus, critiquing the dependency of psychiatry on psychopharmacology, with its general failure to produce cures, Arnold Mandell, neuroscientist, psychiatrist, and McArthur "Genius Award" Fellow, saw the problem as conceptual. Traditional approaches, he argued, are far too linear and reductionist: "The underlying paradigm remains: one gene→one peptide→one enzyme→one neurotransmitter→one receptor→one animal behaviour→one clinical syndrome→one drug→one clinical rating scale. It dominates almost all research and treatment …."[3] In short, life won't sit still.

But if the complex problem is one in which unpredictability (or "noise," as standard science might say) and non-linearity (or non-causal events) are definitive, how does one approach it? The answer in the science of complexity, whether of natural or social phenomena, lies in recognising that certain patterns always repeat themselves at particular scales, with a definable

[2] Ibid.
[3] Ibid., 298.

relationship between those patterns at all scales that can be understood and leveraged. Edward N. Lorenz, an iconic figure in complexity theory, who studied three dimensional dynamical systems in meteorology and introduced fractal concepts, found not just unpredictability, but also patterns: "suggestions of structure amid seemingly random behaviour."[4] Erwin Schrödinger, the quantum physicist, saw half a century ago that life has the "astonishing gift of concentrating a 'stream of order' on itself and thus escaping the decay into atomic chaos."[5] Complexity is not just about problems, as it turns out, but about generative patterns of order and of life. With a proper theory, complexity becomes the friend of accountable leadership, precisely because life is not supposed to sit still.

Actually, this really is a rather precise way of describing what this book addresses. The ideas we develop around religious health assets, causes of life, health seeking, congregational strengths, and boundary leadership are a description of particular patterns that we believe are relevant, in different ways at every scale, to describing the complexities of health and its relation to religion. These patterns are not arbitrary; they variously repeat themselves in multiple contexts and over time, are significant for understanding health interventions and goals, and open up significant avenues of research and investigation into areas of inquiry that are largely undeveloped and poorly understood.

If that is what we mean by "deep," what of "accountability"? Accountability can be viewed in several ways. In its simplest form, it values counting. Better theory makes possible better counting in the sense of tracking and measuring more appropriate, useful, relevant things over more illuminating periods of time. One could count the number of pills an individual person, the "patient," receives from their physician, and one could measure their cost. Better would be to count all the pills the person receives from all health providers they might encounter, make sure the combined effect of all those pills is optimal, and count the cost of the whole in relation to the conditions the pills are supposed to improve.

An even better theory would want to know how the person-as-patient understands their situation and the purpose of the pills sufficiently to enable them to begin to act as a person-with-agency in their own health. Even further, to arrive at an accurate understanding—and thus, appropriate action—of the factors that influence their health, it would include all those involved in the health of that one human being. That most of those factors are beyond the professional competency or interest of specialised providers sharpens the accountability for an alignment between and among "providers" and the whole context of care around that one human.

The best theory allows all involved to be accountable for their individual contribution to the full effect of their combined efforts. That full effect is best understood not in the light of a theory of disease, but in the context of a living person in a social system that is itself alive. *Bophelo* allows for such better theory, even when the political economy of Lesotho does not allow for very good practice—though countries awash with technical, professional, and material resources might equally fail in practice.

Again, the conceptual foundations we have sketched provide one framing set of ideas for establishing a deeper accountability among practitioners on both sides of the interface between religion and the health of the public. We use our own language for expressing them, but they are not merely argumentative. They rest on potent insights and a rich array of empirical and theoretical studies drawn from a wide range of congruent disciplines. Aware , as Chatters puts it, of the still very limited "extent to which the research and practice communities endorse the

[4] Ibid., 44.
[5] Ibid., 299.

proposition that religious involvement is significant for individual and population health,"[6] the grounds for thinking seriously about this interface nevertheless remain powerful and much clearer ten years after Chatters reviewed the relevant literature.

The picture is clearest, however, when one explores the narratives of people who seek their and their community's health in the face of challenges that should defeat them. Instead, we see where the real meaning of religious health assets, causes of life, strengths of people who congregate, and boundary leadership can be discerned in the face of sometimes helpful, sometimes unhelpful, and sometimes downright hostile forces of polity and economy. This is the measure of deep accountability. It is barely visible in the data that makes up the work of epidemiologists and informs public health decisions. For the deepest accountability is to generative life.

DEEP ACCOUNTABILITY IN HEALTH ORGANIZATIONS

Our call for better theory comes at a time when it is increasingly obvious that great opportunities exist for integrated work, for blending many kinds of organisations, networks, associations, and institutions that fill the organisational ecology of our planet. Specific collaborations aimed at particular diseases—some well known and long feared, such as drug resistant TB, polio, and malaria, and others long neglected and unknown in the developed world—have attracted unprecedented resources from coalitions that blend public and private funds. Other initiatives, focusing on developing key technologies such as vaccines unlikely to interest the market, have emerged with demonstrable success at large scale. Fiduciary and governance models are as complex and varied as the underlying conditions and linking opportunities. Leaders are thus constantly hearing about collaboration and being offered toolkits filled with instruments and forms to bring order to the chaos of opportunity.

One example of this heightened priority is *Real Collaboration*, by authors long at home in leadership roles of global health initiatives linked to The Carter Center, the CDC, and the Gates Foundation. They describe a new landscape marked by higher expectations and fragmented organizational architecture that makes collaboration vitally important but also difficult to achieve. Leaders of partnerships now have the opportunity to seek funding from more sources, working harder to connect with ministers and staff in countries with new governmental structures, staying abreast of many others likely to be working in the field of activity, staying alert to changes in official policy and all the time working harder at the human relationships within and around the partnership.[7]

It is important to note that the driving energy here is not a new sense of the problems but the opposite, a new sense of the real opportunities within reach of resources, science, and connectivity. Yet the actual tools remain instrumental, not dynamic, evidencing a trust in order rather than generativity, in structured management of resources rather than animate networks of humans finding life in and through turbulence. The book's toolkit offers list after list of roles and concrete tasks to be filled in and checked off, artificially assigning order.[8] The tools and processes are Newtonian because the theory underneath the tools offers leaders nothing more.

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[6] Linda M. Chatters, "Religion and Health: Public Health Research and Practice," *Annual Review of Public Health* 21(2000): 336.

[7] Mark L. Rosenberg, *Real Collaboration: What It Takes for Global Health to Succeed*, California/Milbank Books on Health and the Public (Berkeley: University of California Press, 2010), 29.

[8] Ibid., 211ff.

And it is remarkable that a book on collaboration, so filled with noble purpose in the great tradition of global public health, fails to mention the role of faith in any fashion, avoiding its problems and blinding the new global partnerships to its assets. It is thus likely to promote the same instrumental projects and activities of the past, with pretty much the same incremental results and missed opportunities. It projects into the future the same self-inflicted blindness public health has shown toward its past, adopting an oversimplified history that does not fully account for its own successes and robs leaders of the full vision of what is possible to achieve with a fuller menu of dynamic assets.

There is more to which leaders can be accountable. The answer is not just to put another category in the toolkit about religion, extending the instrumentalising process to partnerships with faith leaders and their networks, institutions, or assets. Better accountability means paying attention to full generative flow of life that leaders should be expected to appreciate, nurture, encourage, protect, and tend. It requires a blended intelligence: one that integrates a wide variety of information—community wisdom, clinical data streams, academic research, and the best practice knowledge from local and international partners—to enable better practices.[9] Leaders should be accountable (first, to themselves) for such blended intelligence. And from our point of view, the newly successful global collaborations are better explained by a theory of blended intelligence, which is another way of describing the kind of interface between religion and the health of the public we have unpacked, not unlike the history of iconic public health landmarks that we have described in relation to the religious health assets that helped enable them.

Increasingly, innovative thinkers in healthcare are formulating such accountability frameworks for improving care at system level, centered on the needs of the patient (in their lexicon) or the person (in the broader, community based and non-hospital-centric focus). For example, the Institute of Medicine's (IOM) focus on quality care attempts to break out of the linear traps described by Mandell with a call to elevate care to its highest level by attending to the key dimensions of STEEEP: safe, timely, effective, efficient, equitable, and patient-centered.[10] While not as comprehensive as one could hope in seeing the whole system of care outside the walls of the hospital and clinics, the simple recognition from this powerful guild that community and social determinants may play a pivotal role in accessing and delivering quality care, focused on the patient/person journey, signals a huge shift in benchmarking a more complex and multi-faceted view of health.

Our own approach to deeper accountability emphasises this non-linear view of care further and calls particular attention to assets for health beyond formal facilities. Its usefulness can be seen in something as simple as observing one life's journey of health.

Clearly visible from the office of the Senior Vice President for Faith and Health at Methodist Healthcare in Memphis, stands an eight story public housing unit. Here one woman has found her life for more than eight decades. Barely lower middle class, high school uncompleted, marrying, birthing, outliving her husband, she watched her children move north to Chicago. Carried on the currents of minimal public assistance, eventually she approached the ending of her days, close to a religious hospital that has a growing record of her ever more complex medical conditions. Increasingly frequently, she was readmitted into the hospital for reasons that could be addressed or even prevented by non-clinical care giving: taking medication

[9] CoE, "The Memphis Model: Mapping Research Opportunities at the Intersection of Faith and Health in Memphis," (Memphis: Center of Excellence in Faith and Health, Methodist Le Bonheur Healthcare, 2010), 1.

[10] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Committee on Quality of Health Care in America (Washington, D.C.: National Academy Press, 2001).

off schedule, slipping and falling while bathing, unable to care for a wound on her foot without assistance.

A member for many years of a small Baptist congregation, the women in her prayer group visited her, sometimes even the pastor, all quite overmatched by the practical barriers that the medical care system presents to one with so little means. But this particular hospital has begun to follow a different theory, one that locates it as one component in a large complex of religious assets that share the care for this one woman. With eyes that see not just like a state, a medical provider, or a hospital facility, but like the religious health asset it is, it has perceived the possibility of constructing webs of human trust across and between forms and structures that healthcare facilities usually cannot see at all. This involved many detailed changes in the internal ways and means of the hospital, though none involved any substantive change in clinical treatment. The key is a web of trust, of which the hospital is only one part.

The hospital had to work for that trust, which cannot be taken for granted at all. And it had to be institutionally concretised, beyond marketing slogans and great science. At root, it is embodied in the relationship between a paid "navigator," Jean, who is able to follow the thread of trust into the woman's apartment, mediated by the pastor who cares for the woman and trusts Jean. Jean connects what was disconnected and invisible. She makes permeable and communicative (Habermas) those institutional spaces that were opaque and circumscribed. She invites into the shared work of hospitality those who were not just unwelcome, but invisible. Once the embodied web extends into that life, many things previously invisible, unimaginable, or remote become much easier. If this sounds magical, it is entirely natural, in the sense that the new, more inclusive order reflects the nature of life, its capacity for new connections, deeper coherence, relevant agency, generativity and hope. A leader who knows that and does not work with that natural flow of life should be held accountable, in the same way they would be for withholding evidence-based treatment.

A hospital normally can only do things it can pay somebody to do. But with new eyes, it now sees a way to have an employee, Jean, spend her time aligning and animating other human assets and networks the hospital does and should not pay. The pastor, the women of the prayer group, the informal network of residents in the town block: this care-giving "team," loosely but effectively aligned yet working as a social whole, does a very remarkable thing. It creates a web of care that can help her with bathing, general wound dressing, taking medication on schedule and correctly, and getting her to the hospital when she needs to be there, not too late to help. Her continuum of care is rooted in a web of trust that overtly includes and provides critical support for the medical facility

She is one of hundreds of similar patients moving across social webs that influence their journeys in remarkably tangible ways, measurable by the hospital: patients like her, coming across the slender filaments of embodied trust, cost about 25% less, saving the payers about $8,500 per visit, and not because they were denied anything they needed, but because they came at a time in their condition when they needed less costly treatment. Moreover, they tend to come back to hospital about 20% less often, and even show half the mortality, both outcomes apparently affected by the presence of relevant social supports.[11] Such indicators are what the hospital sees in the end, but they are the result of things, invisible and uncontrollable by such systems. In a very practical way, an older woman, appropriately afraid of strangers, can now

[11] Teresa Cutts, "The Memphis Congregational Health Network Model: Grounding ARHAP Theory " in *When Religion and Health Align: Mobilizing Religious Health Assets for Transformation*, ed. Barbara Schmid, James R. Cochrane, and Teresa Cutts (Pietermaritzburg: Cluster Publications, 2010 forthcoming).

safely admit into her apartment visiting nurses who are trusted because someone she already trusts (her pastor) extends the web of trust to include them. Her web of trust now includes people with very tangible relevance to her healing process.

The invisible but highly relevant social assets of the patient's reality change what the hospital cannot change—the journey of health that begins outside its doors—while they affect the hard outcomes of the journey. A new standard of quality, and a different view of collaboration, starts to come into view as this peripheral vision sharpens. What if every patient came at the right time? What if they all came accompanied by a trusted and competent friend? What if they were not afraid and thus prepared to receive treatment?

If all one can see are professional guilds aligned by payment systems accountable to the low standard of legal liability, it is not possible to imagine accomplishing what only a social whole can do. A relevant theory of alignment and collaboration should turn on enough light to see the whole community. The turbulence is then no longer purely threatening but is a condition navigable by leaders building systems appropriate to their fluid environment, ones that enable enough caring people to share the opportunity to enhance the life of the whole. Memphis is an ironic scandal, precisely because it is a small city filled with obvious health assets made distant by equally obvious social and political failures. It would seem clear that connecting things should not be so difficult. They are there to see, if one knows what to look at: a task not of imagining a distant future, but of seeing the images right down the street. The assets are there, and they are good for health, both individual and public.

DEEP ACCOUNTABILITY IN RELIGIOUS LEADERS

Recently we visited the hospital in Mount Fletcher in the Eastern Cape, South Africa, which has one of three sites for HIV anti-retroviral treatment in the wider region. The ART unit is fully staffed and equipped, ready to treat thousands of people living in homesteads spread out across wide-flung hills whose immune systems are crashing. We had brought a patient, a thirty-five-year old woman critically ill from AIDS related complications, who had finally agreed to acknowledge her situation. We travelled in the pickup belonging to *Masangane*, a comprehensive, integrated faith-based initiative that had arisen from the regional Moravian Church to help deal with the pandemic. We left behind another woman, so emaciated and weak that we could not move her into the pickup. A fully equipped ambulance was necessary, but none were at hand then or for a couple of days (she eventually died).

For the many households in this area public transport is seriously limited, private vehicles rare or too expensive to hire, or vehicular access difficult. Lying just below the majestic mountains of Lesotho, the land is worn, the *dongas* or erosion gullies deep. Jobs are hard to come by, and a hundred years of forced labor migration movement to the gold mines and factories of the Witwatersrand is definitive. Home, family, community and land have all been disrupted in the process, traditions undone and reinvented.

This is a reality not peculiar to Apartheid, nor restricted to the African continent. Like many people in rural or marginalised communities worldwide, people from here must look for jobs elsewhere than their home place. On the outskirts of the distant cities, they settle temporarily in tin shacks or under plastic sheets, alienated or undone, but at least within possible reach of work or resources. Perhaps they send remittances back home. They frequently do return, to care for a sick loved one, participate in a family ritual, attend a funeral, or simply to die where their ancestors are buried. And in Africa, they most often conceive of the health and well-being of

individuals and communities through religious narratives, symbols, and rituals, distinctly social in their patterns. Meanwhile, people left behind in the rural areas, mostly women, have begun to die from AIDS, leaving more children orphaned, left to the care of whoever is available. Caregivers themselves—grandmothers especially—either battle to cope, or become sick and die themselves.

Among those increasingly distressed by the devastating effects of AIDS are religious leaders, often despairing and searching for a response. The Reverend Mgcoyi, a leading Moravian pastor in the region, anguished by the visible pain, motivated by the hope his faith proclaimed, was certain that preaching, praying, and visiting the ill and the bereaved was simply not enough. Gathering a small team around him, he began *Masangane*, which in Xhosa means "let us embrace"—directly attacking the problematic religious and cultural stigmatization of those with HIV and AIDS, folding them into a congregation and community instead of casting them out.[12] Masangane workers, themselves beneficiaries of the program and openly HIV positive, had brought this woman to the hospital in Mount Fletcher. Without them, she would never have reached an ART site where she could get help.

For all practical purposes, with no transport at its disposal, the ART unit had no way of reaching people in its area, and they frequently had great difficulty getting to the hospital. Bringing this woman in met a massive need. Finding people in time also mattered. This meant knowing the local communities well enough, being regularly present to them, but also accompanying people in their journey of health, before and after any hospital or clinic visit, mentoring, encouraging, monitoring, supporting, and bringing them into relationship with others to help sustain the life-long treatment that is likely. All these responsibilities cannot be borne by formal health facilities like a hospital.

Despite the daunting challenge, limited resources, and a handful of personnel (much of it voluntary), *Masangane* has done a remarkable job of building such a web of trust for almost ten years now, including local doctors. Reverend Mgcoyi was also intelligent enough to know that his position, used properly, could work towards breaking stigma, how religion could be a health asset. And he offered one priceless asset: trustworthy authority. Religious (or traditional) authority can serve unhealthy ends in support of questionable ideas; but it can equally serve health. This was, after all, a time when South Africa's notorious minister of health repeatedly spoke of ARVs as poison, undermining their use and piling confusion upon confusion among the populace. Mcgoyi had immediate and trusted access to communities through the congregations embedded in them, themselves representing locally rooted, long-standing, and durable religious traditions of care and compassion. A boundary leader, he understood the importance of a web of trusted relationships.

Masangane is more than a single pastor or team, but works through a web of relationships that extend from its members in the community, to local doctors, initially to Médicins Sans Frontières (who provided its first trained nurse), later to the local state hospitals, to a German church worker resident in South Africa able to act as intermediary to international funders and supporters, and to partners in those bodies themselves. Also alongside Masangane are community-based orphan care groups initiated by local people, often from faith convictions or a traditional African religious sense of responsibility for the community. These webs of trust describe the multi-layered nature of accountability, and no layer is less important that the other.

[12] For a description and analysis of the Masangane programme, see Liz Thomas et al., "'Let Us Embrace': Role and Significance of an Integrated Faith-Based Initiative for HIV and Aids: Masangane Case Study," (Cape Town: African Religious Health Assets Programme, University of Cape Town, 2006).

As a whole they represent a vital, complex, but quite understandable pattern of elements that describe a health system adequate to the challenges, much of it resting in religious health assets.

While such assets are all too often misaligned with the formal health system, unrecognized or unsupported by it, or even regarded with suspicion and hostility, religious leaders too have a responsibility for changing that situation. And strategically, given the scale and scope of religious health assets, if only ten to twenty percent of the religious bodies in any particular community were to be engaged in aligned and accountable practices working for the health of the public, potent resources would be unleashed towards the comprehensive well-being of all.

DEEP ACCOUNTABILITY IN THE SOCIAL WHOLE

No conscientious accounting for the health of individuals is possible if one excludes the social, environmental, and economic conditions that impact on community or population scale health. It cannot be done simply by aggregating individuals, as if that describes the social, yet Margaret Thatcher's view that there is no such thing as society, only individuals,[13] permeates much policy and practice. It plays itself out theoretically and practically in the instrumental and mathematical reasoning that dominates much policy and decision making, in the current widespread adoption of rational choice theories of human behavior,[14] and, in the context of public health, in an emphasis on the quality of life defined all too often in terms of individual choices about what foods to eat, exercise to take, and the like. Under the same ethos, as Margaret Radin, arguing for a reinstatement of the vision of the common good has shown,[15] the commodification of health has also intensified in every other aspect of human life, including religion.

We share Radin's view, consciously arguing for the primacy of the social which, following Ricoeur, among many others, may be said to be grounded in the nature of human being. Personal choices are certainly real, and they do carry responsibility. But unless they are wholly trivial, they are affected by and have effects upon others. Even individual choice is thus social.

Consider avian flu and AIDS, or smoking, obesity, violence, suicide, and depression. The specific aetiologies of these phenomena may be quite different, but all are social in various ways. Avian flu becomes a threat in the context of commercial chicken production; HIV is made more likely in the context of fractured family structures and gender asymmetry; smoking reflects a pathological social formation using cynical tools of mass persuasion aimed at the young; obesity appears as an aggregation of bad food choices by individuals only by disguising the complexity of causes that are social and economic. Similarly, violence is patterned, gendered, and located in gross disparities that makes a social framework of understanding primary; suicide (in the USA) is biased towards older white men; and most depression is best understood through the social dynamics of a person's life in relation to socially formed expectations and fears that affect emotional fitness for the journey of life.

Each of these phenomena is social *before* it is personal, each is personal in the context of a social reality. And each offers opportunities for seeing the role of faith—also social, in essence—in understanding how the patterns of pathology rather than generative life gain momentum.

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[13] Margaret Thatcher, "Interview (Douglas Keay)," *Women's Own*, October 31 1987.

[14] See, for example, Gary S. Becker, *The Economic Approach to Human Behavior* (Chicago: University of Chicago Press, 1978); Jon Elster, *Nuts and Bolts for the Social Sciences* (Cambridge UK: Cambridge University Press, 1989).

[15] Margaret Jane Radin, "Response: Persistent Perplexities," *Kennedy Institute of Ethics Journal* 11, no. 3 (2001): 308; see also ———, *Contested Commodities* (Cambridge, MA: Harvard University Press, 1996).

Rather than asking largely functional questions—what does faith *say* about smoking or condoms, for example?—it is more useful to ask how faith in practice is potentially transformative (or complicit) in the social patterning that creates the phenomena. In that regard, though we have at several points indicated our profound personal and theoretical awareness of the pathologies of religion or faith, we have nevertheless privileged the search for transformative understandings, practices, and models of comprehending faith and religion. There are theoretical, practical, and strategic grounds for doing so, we show in this work as we have searched for a more productive view of the interface between religion and public health. We want a stronger basis for mutual accountability between thinkers and actors on both sides of that interface, which may exist not only between different people, but within the same person, perhaps even as a kind of experiential and methodological split personality.

Here we turn, too, to the idea that health is not merely a state of being, but a journey that integrates our social and personal lives. We are in motion from the day we move down the birth canal; we move always, and the cumulative moves are a journey, though never apart from the journeys of others. Even when it appears lonely, we move in social fields of reality that attract, repel, influence, and speed us along, just as our journey influences that of others in ways we may only dimly perceive. Persons, neighbors, societies, and global traditions and cultures are in motion, not necessarily predictably. Indeed, the idea of globalisation can be understood in terms of growing mobility and movement, of people, ideas, information, goods, and services, with mixed consequences. The choices for good and bad we or others make about our journey are important because they shape our well-being.

This too is a way of looking at social accountability, now as something more than a calculus of rights and responsibilities according only to the needs or demands of the moment. To see health as a journey adds to body, place and space the ingredient of time, with important implications for health practices and health institutions, including for the way its leaders behave. Hospitals and congregations and social service agencies have reason to work together because their members and patients and clients are the same human beings, at various points in their lifespan going to, through, and beyond different doorways along the way.

This is not a trivial observation. Institutions that care about the people have good reason to look up and down the journey those people are on, even if only to ensure a smooth, efficient passage along the way. The institutional reality of a healthcare facility is changed if its self-image shifts from seeing itself as a fixed a point of service, to that of a landmark on a longer path toward health. Anything done in a hospital or a clinic is only a part of a larger continuum of care, and this needs to be accounted for institutionally. The key questions will then be: “How does this (or that) medical intervention fit into the journey? To what does it need to be linked? How do we enable that link?”

Accountability then shifts from a focus on the autonomous quality of the event of service in one place, to an optimal alignment with other institutions, upstream and downstream, in the different places that a person occupies in space and time. Advancing the quality of life for the whole—individuals, their families, those who serve them, and the communities that hold them—over a lifespan, becomes the most fundamental point of healthcare. Not the same as controlling disease, or keeping someone alive with the use of advanced technologies, it concerns how one experiences the longer journey. While medical facilities and health systems need to be available for some of that journey, most of it occurs elsewhere. The key question then becomes: what advances the quality of life over the long haul, sustainably? With this as a critical indicator of

what a medical system can offer, or better, of whether or not what it can offer is adequately conceived, we arrive at a different norm of accountability.

A similar point could be made about religion, often a key factor in a person's journey. Better religion is not about stasis, but about informing a life journey in ways that enhance the well-being of persons and the societies within which they exist. Religious bodies that care for sick individuals or work for public well-being may occupy different buildings, speak different languages, or compete with each other for cash, attention, and political support, as with any human institution and, like much other work in the world of health, fail to see the whole to which they are accountable. People who run soup kitchens, for example, rarely spend much time working on mental health policy, although they are sure to observe that many of their clients suffer from at least one chronic mental health condition.

The paradigm we seek must hold in creative tension the moral and intellectual forces that spin away from each other. What kind of religion and what kind of science makes that more likely? What kind of paradigm will undergird those common passions and enable them to find their way toward the choices that lead to life? Those have been guiding questions for what we here term deep accountability. It is the kind of accountability that seeks exemplars, to use Thomas Kuhn's term, capable of illuminating both complexity and the limits to any one route to grasping that complexity. It is accountability that ties targeted, narrowly disciplined but vital health interventions in one aspect of human life to other congruent aspects of life, and ultimately to the totality of life together. It requires building new standards of accountability capable of matching such goals, and ways of measuring or making legible what such standards mean.

This is because life, and not simply death, is at stake. So we need boundary leaders, people alive to the possibilities of lending their influence and energies to life at community scale in complex combinations of skills, disciplines and interests. Moving across divides of language, guild, position, and discipline they see health in a larger conceptual whole, embodied in a more vital social whole. They can imagine not just healing past and present wounds, but nurturing the conditions in which social life, tumbled and turned by positive turbulence, might expand.

Given a theory to guide them, they may even imagine transformation and, testing that imagination against the times, find it not delusional to be accountable deeply for what matters most, generating the life that comes next.

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