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## Evangelical Protestants and the ACA: An Opening for Community-Based Primary Care?

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### ABSTRACT

Evangelical Protestants make up the largest religious subgroup in the United States, and previous research has shown that Evangelical churches are disproportionately active in community engagement and efforts toward social change. Although Evangelical Protestant perspectives have been considered with regard to persistent socioeconomic stratification and racial discrimination, less focus has been given to how churches interpret poor health outcomes within the United States. In particular, this research addresses how enduring health disparities are understood within the larger discussion of healthcare reform. Due to the similarity of approaches favored by participants in this study and community-based philosophy, a suggestion is made for future health policy dialogue. Although Evangelical Protestants have been most likely to reject all aspects of the Affordable Care Act, in many ways the findings of this study suggest the potential for successful future health policy collaboration. In particular, community-based primary care might appeal to Evangelicals and health professionals in the ongoing effort to improve population health and the quality of healthcare in the United States.



### KEYWORDS

Evangelicalism; Affordable Care Act; community-based health; primary care

### Introduction

Contemporary debates over the nature and delivery of healthcare in the United States have become increasingly heated with passage of the Patient Protection and Affordable Care Act (ACA) in 2009 (Harrington, 2010). Americans continue to debate what healthcare services should be covered and whether government intervention is warranted. Among the more controversial aspects of the ACA's reforms is a mandate that all Americans carry health insurance coverage or pay a penalty when they file their yearly taxes, and mandated "essential health benefits" categories that all qualified plans must cover. In both cases, challenges to these reforms have included specifically religious arguments, especially when mandated coverage such as contraception poses a problem for people of faith (Lipton-Lubet, 2014). A series of high-profile legal challenges, most notably *Burwell v. Hobby Lobby Stores, Inc.* (2014), have underscored the issue of religious liberty. Of particular contention have been questions vis-à-vis the ACA's contraceptive requirements regarding the obligations of religious institutions and for-profit companies led by people with strong religious beliefs.

As passed, the ACA attempts to advance reforms aimed at addressing pressing health inequities and needs that are grounded in considerable evidence (Krieger et al., 2014; McGrail, van Doorslaer, Ross, & Sanmartin, 2009; Palloni & Yonker, 2015). The mandate to carry insurance, for example, is grounded in an attempt to ensure that health insurance for all Americans is affordable and sustainable. This goal is driven by an attempt to use cost-sharing mechanisms provided by comparatively healthy (and often younger) populations to offset the more expensive healthcare needs of comparatively unhealthy, often older, and

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more vulnerable populations (Frakt, 2012). The ACA's essential health benefits requirements—including the religiously controversial contraceptive requirements—are not an outcome of a political process but are grounded in recommendations made by the widely respected Institute of Medicine in an attempt to ensure a certain baseline of quality in health plans available on state healthcare exchanges (U.S. Department of Health and Human Services, 2011). The overarching aim of these essential health benefits is to address health inequities, including significantly different plans being offered to women and “catastrophic” plans purchased mainly by poor Americans but often lacking in real actuarial value.

Although some religious groups have been vocal in criticizing changes introduced by the ACA, there has in fact been a spectrum of responses. Preliminary evidence suggests that Evangelical Protestants, a sizeable and politically influential sect of Protestantism, have opposed most recent healthcare reform efforts, as compared to mainline Protestants, Black Protestants, and Catholics (Grant, 2012). Further, this opposition is considerably greater than that found among the general American population (Brodie, Hamel, Deane, & Cho, 2013). The qualitative data collected as a part of this study provide a more nuanced understanding of these general findings.

Evangelical Protestants' beliefs about government intervention in addressing persistent socioeconomic stratification and racial discrimination have been widely studied (Edgell & Tranby, 2007; Emerson & Smith, 2000; Hinojosa & Park, 2004; Hunt, 2002). However, very little research has addressed the relationship between evangelical religious doctrine and views toward healthcare reform. This study used qualitative methods to investigate evangelical beliefs about non-Evangelicals more generally and the nature of community to understand how these religious individuals interpret the meaning of health and illness and possible reform in the organization of healthcare. Ultimately, we argue, these data may inform a more robust picture about the specific aims of healthcare reform, especially in the area of primary care. Specifically, these findings suggest possibilities of engaging community-based primary care, which are promising not only as a way of encouraging “buy in” from Protestant Evangelicals, but as clinically and socially sound secular approaches to health services delivery.

### **Conservative Protestant theology and social responsibility**

To establish why Evangelicals might be unique with regard to thinking about healthcare reform, key aspects of evangelical faith must be distinguished from other variants of conservative Protestantism. Such distinctions are especially necessary given the historical confusion regarding conservative Protestants and the tendency to combine many different groups under the heading of “fundamentalist” or “evangelical” (Woodberry & Smith, 1998). Although most conservative Protestants share specific beliefs about the authority of the Bible and the relationship between the individual and God, there are important differences with regard to thinking about responsibility toward others and involvement in the secular world. Such differences among religious groups in considering how best to integrate religious beliefs with social involvement have been a concern recently of sociologists and religious scholars. How religious worldviews might legitimate specific duties, and the relative significance of this life or the next, have been key concerns in this literature (Hunter, 2010; Lindsay, 2007; Putnam, 2001; Smith, 1998; Wuthnow, 1999; Wuthnow & Lawson, 1994).

Within this body of work, however, relatively little consideration has been given to the theoretical connections between various conservative Protestant theologies and their explanations for persistent social inequality and the possibility of social change, particularly within the context of healthcare organization. The question remains therefore whether there might be an Evangelical-specific strategy for thinking about social change, and whether this approach could be tied to notions of religious individualism. Such individualism has been linked theoretically to thinking about important questions of human nature, ethical responsibility toward others, and the notion of community (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985; Dussel, 1993; Putnam, 2001; Slater, 1976).

Specifically, we ask whether individualism is a key aspect of evangelical theology, and whether such thinking is compatible with the collective strategies necessary to address the healthcare needs of the general population and persistent health inequalities (Braverman, Cubbin, Egerter, Williams, & Pamuk,

2010). Although many critics have posited a historical relationship between evangelicalism and individualism (Bellah et al., 1985; Hervieu-Leger, 2001; Smith, 1998), very little qualitative research has sought to understand how individuals negotiate these beliefs. One recent ethnographic study concluded that Evangelicals cannot be uniformly reduced to individualism because social relationships are so highly emphasized in these communities (Elisha, 2011). Because Evangelicals believe that caring for others is an ethical imperative, they maintain a concerted effort to be involved personally in the lives of those around them. However, what is not clear is whether such responsibility to others is understood to occur primarily on a personal level, and to whom more generally this responsibility pertains. One interpretation is that such ethical duties refer to personal acts of charity and require that individuals form lasting relationships with those in need. If so, such strategies might be understood as fundamentally incompatible with a strong role for government in contemporary healthcare reform. Within the framework of health services, it is reasonable to ask whether the current focus on expanding access to primary care services, where close relationships with a supportive team engaged toward the end of wellness, can be mobilized to help patients play an active role in developing habits inclined toward wellness. In other words, might a synthesis of religious and health services positions be possible?

Past polls suggest that many Evangelicals reject the versions of healthcare reform currently being implemented (Grant, 2012). Less clear, however, is how these political beliefs are interpreted within an evangelical worldview. Further, there is important evidence that health disparities, to which contemporary healthcare reforms are aimed, relate to more persistent problems of inequality and lack of resources in American society (McKinlay, 2009; Phelan, Link, & Tehranifar, 2010; Robert & House, 2000; Ross & Mirowsky, 2000). Our analysis does not assume that healthcare reform alone will be able to eradicate such disparities. Indeed, the need for reforms such as the ACA is in this view cast as symptomatic of a deeper problem stemming from fragmented support and frayed community ties. In a theological vernacular, they may be understood to mark a spiritual problem.

Evangelical views are particularly important on this matter because they provide a specific example of thinking about the nature of social involvement and responsibility toward others. For example, key aspects of evangelical theology include an ethical imperative to care for one's neighbor, a belief that though the world is imperfect Evangelicals should be a redemptive force, and that because God has been faithful to humans, persons share a responsibility to be accountable with good works (Allsopp, 2003; Geisler, 2010; Noll, 2001; Smith, 1998).

And though the relationship between such beliefs and interpretations of healthcare reform are important, the more basic question will address whether evangelical theology is understood by individuals as being compatible with more general social interventions that address inequality. Because Evangelical Protestants represent at least one fourth of the American population (Chaves, 2011) and are one of the few religious subgroups that are not declining (Maschi, 2015), they have the potential to be politically influential. Indeed, Evangelicals have been involved significantly in many public debates over the nature of social responsibility and subsequent interventions (Putnam, 2012). Thus, their perspectives on such policies are important to consider.

## Method

The data for this study were collected as part of a broader project that considered how Evangelical Protestants interpret health and illness, healthcare utilization, social responsibility, and the organization of healthcare in the United States. The data were collected through semistructured in-depth qualitative interviews. To facilitate understanding of a particular "life world" or context (Schutz, 1964), an interpretive strategy known as constructivist grounded theory was used (Charmaz, 2006). The particular focus therefore was on how contemporary health policies such as the ACA are discussed in relation to the importance of social engagement within evangelical churches. This qualitative technique, however, does not begin with fixed hypotheses but rather aims for theory to emerge through data analysis (Charmaz, 2006; Glaser & Strauss, 1967). The intended outcome is a fuller appreciation of an interpretive process that links individual values to the construction of more permanent worldviews.

In all, 29 interviews were conducted with participants from three evangelical churches. All interviews were audio-recorded and field notes were taken by the primary researcher. The interview length ranged from 30 minutes to 3 hours. All but one of the study participants self-identified as an Evangelical Protestant. Table 1 contains these participants' demographic information. Ages ranged from 29 to 65 and included 19 females and 10 males. The racial and ethnic characteristics of the sample were White ( $n = 26$ ), Black ( $n = 1$ ), and Asian ( $n = 2$ ). Participants working in health-related occupations numbered 10, whereas 17 were employed in other sectors, and two worked at home as primary caregivers to children. Although persons employed in the healthcare industry were not specifically sought, this relatively high number might be due to the health-related subject matter of the interviews and participants volunteering and suggesting others with a shared personal or professional interest in healthcare reform. All names of individuals, churches, and cities are pseudonyms.

The data were collected at three churches in the midwestern and southern regions of the United States. Although five churches were initially contacted, three agreed to participate and sent formal letters of agreement to secure Institutional Review Board approval. Church 1 is located in an urban neighborhood in a major midwestern city and has approximately 600 regular members. This church is denominationally affiliated with the Presbyterian Church in America. Church 2 is nondenominational, with 6,000 regular members and is located in a suburban area of a major midwestern city. Church 3 is located in the suburbs of a large southern city. This church is nondenominational and has approximately 30,000 regular members. Each church publicly self-identifies as evangelical.

Participants were recruited after initial contacts were made with each church. Initial interviews were completed and participants were asked to recommend further church members to contact. In this way, a modified snowball sampling approach was used. A foundational principle of grounded theory methodology is simultaneous data collection and analysis. In this project, each interview was transcribed, and preliminary coding completed before the next interview. As early codes emerged, theoretical sampling was used to seek out additional participants with perspectives that had not yet been included. *Theoretical sampling* refers to the process of using preliminary codes to direct future sampling to make sure the data are comprehensive and thorough. In this case, the preliminary findings revealed gaps that suggested particular perspectives that might be missing. This sampling process continues until no new themes arise. In this study, theoretical saturation was reached at 29 interviews, which is within the usual range for grounded theory methodology (Charmaz, 2006).

The interviews included questions relating to four major areas of interest: religious beliefs, health beliefs and behaviors, social engagement, and perspectives on the ACA. The final analysis commenced once all interviews had been conducted, transcribed, and preliminarily coded. As a result of this

Table 1. Participant Demographics.

Gender	
Male	10
Female	19
Total	29
Age	
Under 30	1
30–39	13
40–49	3
50–59	8
60–69	4
Total	29
Race/ethnicity	
White	26
African American	1
Asian	2
Total	29
Occupation	
Employed in healthcare industry	10
Employed in non-healthcare profession	17
Out of workforce	2
Total	29

analysis, major themes were compared between interviews and a final structure was developed to present findings. The goal of this analysis was to understand a process of how Evangelical Protestants connect religious beliefs on social engagement to contemporary health policies such as the ACA.

## Findings

Several important ideas emerged relating to how the ACA is evaluated with respect to current healthcare crises. The interpretation of the ACA within the context of government intervention and socialized medicine was also discussed. As we explain, alternatives to the ACA were often cited as more appropriate for improving healthcare.

### *Problems in the American healthcare system*

Whether problems are even thought to exist is an important factor in understanding evangelical reactions to healthcare reform. The more traditional policy question of problem definition is secondary. For some Evangelicals, allowing health inequalities to persist is incompatible with their Christian responsibility to care for others. One nurse responded in this way:

I don't see how we can look at the life of Jesus and then not care about this. How can our hearts not be moved? You know if our hearts are not moved by that we need to take a serious look on why they're not. Is it that we're too far removed from it? Is it that we want to pretend that it's not existing, we want to stay in denial? I don't know . . . you know I would say if you're not moved by that you really need to take an inventory. A deep look at yourself.

Others explained that they had witnessed health inequalities in their own lives. A healthcare attorney described a story from his town where a man robbed a bank and waited outside to be arrested because he had heart problems and knew one way he could get treatment without insurance was to go to prison. For some participants, such problems suggest a need for changes to the healthcare system:

I was one of the few of my close friends that I know of that are Evangelicals that would have said that Obamacare was good. And I said it was good for this reason. The system was so badly broken that whatever we did would be better to at least make some changes.

For other participants, the current healthcare system is considered satisfactory when placed within an international context. Because many Evangelicals have been exposed to developing countries' healthcare systems, primarily through Christian organizations that emphasize international missions, some participants found America's medical infrastructure to be impressive. For example, Tara described the American healthcare system:

I think that we are a country that has some of the best advances in medicine and healthcare. I think our doctors are some of the most capable in the world. I think we are lucky in that aspect to have needs and the resources to get the best care we need . . . I think we have the best advances in medical science. And the best procedures and the best doctors that you can find, but it just depends on I guess what your need is. Does the US have that? I think there's a lot of options out there that people might not know about either.

Other participants expressed disbelief that American healthcare outcomes were bad when compared to comparable industrialized countries, especially considering the amount of technology used and money spent. One married couple suggested that America's health outcomes appear poor only because most countries do not report statistics honestly:

Barbara: So . . . we count ours and the other countries fudge on theirs. So that twists our numbers.

Jim: It makes their socialized medicine look better.

Finally, several participants questioned whether inequalities in healthcare are always wrong. For some, healthcare should be provided at some minimum level, but the idea that all people should have equal

access is inappropriate in light of an economic system that allows for a variety of material outcomes. One male participant expressed that equal outcomes should not be expected:

I struggle with that to some extent. Do I believe that everybody should have access to healthcare? Yes. Do I believe that the access should be the same for a wealthy individual versus a poor individual, meaning the same quality of care . . . . I don't think that I do.

Although Evangelicals have mixed opinions about whether significant problems exist in the current healthcare system, these different perspectives are important for thinking about whether changes are needed and how they might come about.

### ***Compatibility of evangelicalism and the Affordable Care Act***

In considering whether the ACA is compatible with evangelical religious beliefs, most participants thought that providing access to care was consistent with Christian beliefs; however, some questioned whether the ACA was the most appropriate approach. For example, when asked whether the ACA is in line with personal religious beliefs, Ann responded in this way:

I can't think of how . . . it's not . . . in theory . . . in theory trying to take care of everybody and offering healthcare for everybody is a wonderful idea. I think they have no idea what they're getting themselves into and really, really, really believe that the people they are helping have to meet certain standards for them to help them you know?

Despite significant disagreement with various particulars, the abstract goal of the ACA to improve health outcomes was thought to be compatible with the Christian duty to care for others at least on an abstract level.

Others questioned whether the ACA, though appropriate in the abstract because of its emphasis on providing care to others, would actually improve health outcomes. For some, this concern related to increased federal regulations that require doctors to complete more paperwork instead of spending time with patients. Some respondents worried that decreased physician compensation with public insurance options might further stratify the quality of healthcare. These concerns were significant because most Evangelical participants described quality healthcare and good health as important building blocks for strong communities. Jake, a young surgeon, describes how healthcare reform might increase current health inequalities:

I think the inequality will be vastly enlarged. Because then you're going to have people who have money that can see these doctors that don't take insurance, but right now even you know . . . uh a low-income impoverished 65-year-old who has Medicare can pretty much see anybody in the city. Can see anybody, can see anybody he wants . . . because almost everybody takes Medicare. That's what's on the blocks right now. That would change huge. And now that 65-year-old better be a pretty wealthy 65-year-old to be able to afford insurance . . . maybe he'll have Anthem on top of it or whatever it may be. Um and so I think inequality gaps will increase significantly.

For others, the ACA accords with evangelical beliefs. Many participants expressed frustration that Evangelicals reject this policy. Brad described how he found the law to be compatible with the Bible:

I think few things have driven my wife and I more crazy of late than the incredible outspoken backlash against the Affordable Healthcare Act from conservative Evangelicals. Which especially for my wife, I cannot think of a more unbiblical, ungodly attitude. Like, it doesn't mean that there isn't complexity to it, that it isn't difficult . . . like you know certainly I think Anna and I would be the first to say that there are sort of flaws in the law. But like . . . but there's flaws in everything we do as human beings . . . . If anything, I feel like there is a ton about it that is very compatible with what I believe actually.

Although most participants believed the ACA is positive in the abstract, our findings suggest that the most significant differences between Evangelicals exist in the legislation's details. In many ways, the ACA's complexities appear to give rise to a proliferation of different views among Evangelicals. As such,

considering the diversity of views, it is often misleading and unhelpful to comment on “evangelicals” views of the ACA. Moreover, though we did not test different framings for the bill, one can assume that evangelical views of the ACA would vary—as other studies have shown—depending on whether one asked about “The Affordable Care Act,” or “Obamacare” (Liesman, 2013), or if respondents were asked about specific components of the legislation (Zengerle, 2012).

### **Government intervention**

Respondents often raised a question of whether the government should be involved with the organization of healthcare at all. One woman favored providing universal access to care on an abstract level but wondered if the government should be responsible for organizing healthcare:

I think the intent is good. I think that government rarely is able to do things very well. I mean every time even in my job here . . . anytime government gets involved it makes it much worse and just running an art center it's crazy the things we have to do anytime you open the doors for government. So, just from that . . . so again the intent is good. I question whether that's the best way to do it, but I don't have a better solution.

For some, government-mandated health coverage is an intrusion into an individual decision. These individuals believe the ACA is unconstitutional because the ACA impinges on individual rights. Others questioned whether the government is capable of running an effective business at all. Barbara describes a commonly expressed sentiment that government is inefficient:

Well you would never do it by the government. They could never achieve that. They're going to add more workers, their early retirement and their huge pensions. You know and most of these states can't pay their pension obligations right now anyway so it would not be through the government, it would be through free market principles.

Finally, some respondents felt that the government must get involved because that is the only way important changes can be made. For example, Lynn described how government intervention is necessary in the particular case of American healthcare:

Politically I'm probably . . . I tend to be more opposed toward big government. I just say that's probably my political orientation. But who is going to be the voice of these people? Who is going to be the advocate? And the system we have now . . . I don't see them. We've had a chance, we've established this system that has deep roots, but the advocacy is obviously not there. And so someone has to be a voice for them. If you're disenfranchised you don't have power and so I don't know how it will be accomplished outside of the government to be honest with you. It's too big of a problem.

In addition to whether government intervention is appropriate in the organization of healthcare, many other respondents expressed concern about the potential impact that the ACA would have on doctors and businesses.

### **Harm to small businesses and doctors**

Many participants shared stories of how small businesses and healthcare professionals they know will be affected by the ACA. Many Evangelicals thought that small businesses would be required to provide health insurance and thus would be particularly vulnerable.<sup>1</sup> Furthermore, there was concern that compensation for healthcare providers will be reduced. One woman described the potential impact that lower reimbursements might have:

I am concerned . . . I don't know if this is the question or not . . . that because the reimbursement rates of the healthcare mandate are going to once again cut physicians . . . it's that whole incentive thing. Why would a doctor go to school for 3 years of medical school . . . 3 years of residency and 5 years of internship and have all that debt when they come out, have huge malpractice insurance and go into a specialty? They're not going to do it and not get paid? And we are going to lose our neurosurgeons and heart surgeons and



our specialty physicians. And you talk about longer waits? And I do think ... I'll think they'll be bad consequences because of that. Unintended consequences.

Although many participants thought the ACA would have consequences for doctors and businesses, this outcome was not always thought to be negative. Natalie suggested that both businesses and doctors would survive, even with these changes:

I think for medical providers there seems a loss in income and you know what? That's ok. But I mean seriously why do we put so much emphasis on wealth and cost but ... yeah this does not sound good at all for these businesses. But then I had a day to think about it and I realized there is ... there should be a responsibility for employers to provide insurance so yes it's going to cost them money.

Nonetheless, for some participants, healthcare providers and business owners shared a collective responsibility for the well-being of others. Any additional responsibilities created by the ACA therefore would be justified if healthcare and health outcomes might be improved.

### ***Exemptions for faith-based organizations***

Another common concern is that the ACA mandates religious organizations to provide funding for things that are contrary to certain religious beliefs. As we have noted above, these have constituted some of the most high-profile public debates about the ACA and religious belief. Interviewees expressed apprehension about mandates requiring that religious organizations and businesses owned by people of religious conviction provide insurance plans that covered contraceptives that they believed to be abortion-causing medications. Others expressed concern that ACA plans supported facilities that provide abortions and afforded benefits to same-sex domestic partners. Many participants felt that these mandates made healthcare reform difficult to accept. For example, Shelly described how a guest speaker at her church spoke out about potential problems when the government forces religious groups to act in ways that are inconsistent with important beliefs:

It's actually trying to force Christians to not only ... uh ... not only accept, but to actually pay for things that we believe are directly against Scripture ... . And so he said those two things it's kind of a slippery slope he feels those are two things where the church does need to stand up and say "these go against our religious beliefs and this is why and we have Scripture to say." It doesn't mean that we're to pass judgment on those people and it doesn't mean that we're not to love those people ... because I want them to love me. I sin too. So it's not a judgment. But you know that really stuck with me when he said those are two things, that's exactly how Hitler started. And that regime started. They started mandating that people pay for and tolerate things that are directly against the tenets of their faith ... or basic human rights ... so ... that was very interesting to think about. I think there's such a fine line.

Other individuals thought that the lack of religious exemptions explained the disapproval of the ACA among many Evangelicals.

### ***Potential alternatives***

Many participants discussed alternatives to the ACA, including permitting healthcare to operate like a business, moving to a single-payer or socialized system, and allowing the church to address healthcare needs. For some respondents, the only efficient way to control healthcare costs and improve outcomes is to let free market principles guide insurance companies and healthcare organizations. For example, Jim described a business model for healthcare:

The only real reforms that were going to work is to apply the market principles to it. Give people the incentive to stay healthy. Uh you know ... give them the incentive to shop for their healthcare ... introduce a competition into the system. Um ... you know those are all the things that were wrong with it obviously ... you know the government got involved in it and that's what made the costs spiral out of control. Just like anything else the government gets involved in. People look at it as a gravy train. You have

get the government out of it or it will destroy it . . . dismantle it down to uselessness just like everything else they get involved in . . . or completely take it over like they're doing now.

Others disagreed and thought that free market principles would not address the problem of health inequities. One respondent believed that free markets could make things worse:

You see this in Jesus' teachings too . . . this is not just contemporary sociopolitical understanding, this is like Biblical understanding. That when a society in general functions very hands off it's not that that equally benefits everybody. It actually preferences the people who have more.

Participants described what they called "socialized medicine" in positive and negative ways. For some, a "single-payer" system, in which coverage for all Americans is funded through taxes, should be avoided at all costs. The most common reason for this position appeared to be the potential for a reduction in the quality of care. Many suggested that providing care for more people is just not possible without sacrificing quality given the already-existing problems with healthcare costs. Further, Ann described how the ACA could potentially bring about negative consequences associated with socialized medicine:

I think that's what the negative part of it will be. It's going to turn in to long waits to get procedures done and you're not going to be seeing a physician. Because there are not enough physicians to see all these people.

Others thought that the ACA does not go far enough, and that a true single-payer system is a viable solution to meeting American health needs. Accordingly, Jake describes how socialized medicine, though less beneficial to him, is in line with his Christian ethic to provide care to everyone:

If the goal is ultimately to provide the best healthcare for the most amount of people . . . I don't see how you can get away from believing in a one-payer system as the way to go. Everyone's going to make less money you know . . . the level of skill and physicians is going to decrease . . . That system um seems like the best answer even though I don't think it's beneficial to me. Financially, it's not beneficial to me. But I think it's for the pure course of taking care of the masses in the best way possible, it's the solution.

Others agreed that socialized medicine is an appropriate alternative and suggested that Evangelicals in other countries are puzzled by the rejection of government healthcare among those American Christians. Brad describes socialized medicine in this way:

And you know British . . . I've interacted with Evangelicals from all around the world . . . almost all of whom have socialized medicine, like single-payer system medicine . . . like way, way more socialized than what we have, or what we will have eventually with the Affordable Care Act I would say . . . and they feel that it's one of the best things their society does to care for people. In a very sort of Biblical sort of way and it makes no sense to them that American Christians think that it's actually bad or incompatible with their beliefs.

For Brad and several other participants, the transition to socialized medicine would be compatible with their moral duty to care for others.

The church's role was also interpreted variously. Many participants stated that the only long-term solution to American health problems is for the church to be more involved in providing care. Although this prospect involves creating various interventions for different groups, from public-private partnerships to church-run clinics that operate on a volunteer basis, many participants called for the church to address Americans' health needs. For one minister, the church's mission to care for others could contribute to building a healthcare system that would satisfy the health needs of Americans, "I firmly believe that it's going to be Christ's teachings and how that affects people, pushing forward a sustainable healthcare." Other participants, like Shelia, described specifically how churches could be involved in providing services:

I believe that you have doctors and people in the medical field that want to do something and we just need to pool those resources together and come together in some way as the church and do what we've been called to do. Again like a First Christian Church, I mean why not partner several churches with First Christian Church and just expand that? And have the sliding scale and or make it more affordable. Just regular routine visits.

A common sentiment among participants, therefore, was that churches have the desire and capacity to be a part of improving the health of American communities. Although there was considerable uncertainty regarding how churches could collaborate effectively with government initiatives, many churches saw their existing outreach programs as crucial elements in the future organization of healthcare. For example, John describes an alternative healthcare strategy that could have been successful:

In the private sector . . . and I would include the churches in the private sector. Figuring it out . . . but government staying in the how can we help you and enable you and rather than here's what you're going to do. And I think that's where the conservative side of the aisle missed an opportunity in not stepping up to the plate with a really viable option.

For other participants, the ACA duplicated existing community efforts. Because churches have historically been involved in improving the health of others and know the communities they are a part of, many persons saw their involvement as key to sustainable programs.

This strategy of developing relationships in communities was thought to be significant to success. Because church outreach programs facilitate close contact with community members in need, they might be well positioned to offer practical interventions. Furthermore, if churches are enmeshed in a community, they might understand specific problems and be able to respond appropriately. For Chris, a pastor, this relationship to the community could lead to a more enduring impact on health inequalities. One example he gave was of a church facilitating a community garden project:

And I would go to more of a community/relational model as opposed to what you're saying is kind of more of the standard in current academia . . . . And so then the ownership of the community, this is my garden. So I'm just like . . . yes let's do that . . . . Because Brownstown has a lot of vacant lots. And so if we just worked with the city, can we just buy one of these vacant lots for \$1000–\$2000 bucks. What would it look like if the whole community just chipped in. Because I think ownership is actually an important thing.

In other words, the relationships forged between churches and communities could address health problems in a particular context and help foster a healthy environment in which prevention might be possible.

Several interviewees similarly suggested that American health outcomes were tied to much more than access to good healthcare. In particular, formal medical care was thought to intervene after the onset of illness and was therefore thought to be inefficient. Although the ACA emphasizes physical aspects of health and illness, many participants considered good health to involve a more comprehensive set of factors including socioeconomic and spiritual well-being. For example, Elaine describes how churches might provide a more integrated solution:

I think we need to use healthcare professionals . . . nurses, diabetes educators, I think we need to use them so much more holistically in the United States than what we do. I think we should use the physicians to truly treat disease-based people that are truly have a state of disease that needs to be treated. But I think . . . and we need that, we need that technology, we need that medicine, and we need that knowledge, we need that. But I think we can utilize all of our support-type individuals in healthcare, and if we focused on prevention, and if we focused on some of the dynamics like you were talking about. Like going in to public health, going into communities, trying to do more education, being there, doing things that would prevent them then from making an ER visit, having a CAT scan when you're talking already \$6–7,000 dollars just right there. I think that's where it goes. I think it's holistic.

Although not all participants believed that churches should have a role in providing healthcare, many felt that they should be a part of the process, if not entirely responsible for improving healthcare outcomes.

## Discussion and policy recommendations

Overall, our findings suggest that Evangelicals espouse a variety of different perspectives on how social responsibility should be enacted within the context of addressing national health concerns. These data

also remind us that Evangelicals do not constitute a monolithic group. Although Evangelicals, in the last 30 years, have been associated mostly with the religious (and political) Right (Wilcox & Robinson, 2010), divergent views clearly exist and might be important in future debates on healthcare (Lerner, 2006; Marsh, 2007; Pally, 2011).

Our findings provide a nuanced understanding of how some Evangelicals interpret recent healthcare reform. Specifically, the issues raised by participants suggest that many factors lead Evangelicals to reject the ACA in national polls (Grant, 2012), but also that monolithic narratives are insufficient for capturing the many dynamics at work in evangelical views of healthcare. In many ways, the fact that ACA was generally compatible, at least in the abstract, with the evangelical ethic of caring for others may be one of our most significant findings. This is particularly important because actors in American political debates, particularly on the Left, tend to assume otherwise (Silliman, 2014). However, the ACA was considered by some to bypass individuals and churches, limiting the reach of local, community-based institutions, at a minimum, and possibly serving as an obstacle to their faith-based efforts. Yet, because Evangelicals are generally concerned with caring for others and developing healthy communities, future policies could capitalize on evangelical priorities to garner widespread support. In light of these findings, how could future collaborative efforts be planned?

An important shared value that should be emphasized in future policy discussions is improving local communities. According to Evangelicals in this study, key aspects of good health arise from healthy communities, not national or even state-level insurance reforms. For this reason, interventions that emphasize community-based primary care might be compatible with evangelical strategies for community engagement. Although there is increased support for community-based work in the ACA (2010), most of the public discussions have focused on the insurance exchanges and improving widespread access to insurance. Lost in these conversations is a framing of healthcare as an important social responsibility. In this sense, a shift to healthcare on the community level might appeal to many Evangelicals who value personal relationships and envision local change.

### ***Community-based primary care***

Community-based primary care has become a popular framework for improving population health (Cohen, Chavez, & Chehimi, 2010). The central aim of community-based primary care is the cultivation of partnerships among community members in programs that comprehensively address causes of ill health and promote well-being (Bath & Wakerman, 2015). By developing strong and sustainable communities, these interventions aim to prevent health problems and develop appropriate systems for treating illness. For example, some recent community-based programs have trained local persons as community health workers who conduct community health needs assessments, provide health education, and accompany patients to medical appointments (Boutin-Foster, George, Samuel, Fraser-White, & Brown, 2008; Cosgrove et al., 2014; Mutamba, van Ginneken, Paintain, Wandiembe, & Shellenberg, 2013). Most important, the foundation of community-based primary care is that community members know their environment and neighbors and should participate fully in planning and maintaining sustainable healthcare (Rifkin 2009). In many ways, this principle is compatible with the evangelical emphasis on working collaboratively to improve community problems. A critical empirical question for future study is whether these strongly held beliefs lead to actual service to communities. Our findings suggest four areas in which the pursuit of community-based primary care may be particularly impactful.

1. **Prevention:** A principle of community-based primary care holds that traditional healthcare systems often intervene too late and miss the opportunity to affect the development of preventable diseases and promote good health. In response, community-based primary care focuses on promoting good health as a human right, rather than a commodity. Following the Alma Ata Conference in 1978, many community-based organizations have adopted primary care principles as a means to eradicate health inequalities (Walley et al., 2008). But these same

concerns were evident when speaking to Evangelicals about the organization of healthcare. In particular, some participants thought that many health problems that were visible in their communities could be prevented with appropriate community-level interventions. Respondents described existing programs exemplifying local efforts to prevent smoking, improve nutrition, and increase exercise. For example, members of a church participated in grocery shopping and cooking events with community members to increase the consumption of healthy foods. Such strategies were thought to promote prevention as a tool for improving outcomes and containing healthcare costs.

2. **Holism:** Holism is a second facet of community-based primary care that is relevant to evangelical interpretations of good healthcare (McGarry, 2003). Community-based planners look to the local community to understand what health problems exist and how they are interpreted (Minkler & Wallerstein, 2008). Accordingly, they see good health as related to a variety of factors including, but not limited to, environmental pollution, access to quality foods, levels of stress, and residential segregation (LaVeist, 2002). Health is thought to be a multifaceted construct that cannot be addressed only by healthcare systems.

Many Evangelicals described health as a constellation of physical, spiritual, emotional, and social components. For this reason, health policies that focused only on physical needs were thought to be inappropriate. Instead, many Evangelicals envisioned community-level programs that were concerned with improving health more broadly. Furthermore, local initiatives were thought to have the flexibility and knowledge to address health needs effectively.

3. **Full participation:** A third aspect of community-based primary care is that community members should be intimately involved in discussions of improving health (Rifkin, 2009). Symptoms and definitions of illness are thought to be socially constructed within communities, and therefore appropriate programs must rely on this local knowledge. Although participants in this study did not invoke the language of social construction, they emphasized the importance of community participation in understanding and addressing health disparities.

Because the development of personal relationships is central to evangelical theology, it is unsurprising that interviewees identified working closely with community members as an important value. In particular, interviewees suggested getting to know neighbors in need of help as a means for ensuring personal accountability. This requirement for persons to learn to act responsibly and care for themselves has been described as a key factor in the evangelical rejection of the ACA, which is not thought to appropriately vet those receiving care. Nonetheless, despite different explanations for the importance of participation, this facet could be an important basis for dialogue. After all, the ACA does invest significantly in community-based solutions (Calman, Golub, & Shuman, 2012; Islam et al., 2015). Although the ACA's investments are not religious, *per se*, there is nothing in the bill preventing significant investments from those religious institutions willing to play a larger role in addressing health inequities and meeting the needs of communities, particularly among rural and underserved populations. In fact, considering the controversies that arose around faith-based exemptions and opposition to the ACA, it is likely that the Department of Health and Human Services would welcome and support such strategies.

4. **Developing community partnerships:** A final tenet of community-based primary care is that local collaboration is necessary to reduce disparities in disease and improve community health (Minkler, 2005). These partnerships can take a variety of forms but are thought to be significant due to the merging of stakeholders with varying skills and knowledge bases. Some examples of partnerships include utilizing health professionals to train community members to measure levels of illness in the community and local organizations or academics supporting community meetings and dialogue (Minkler & Wallerstein, 2008). The point of these collaborations in community-based primary care, however, is that partnerships help develop local skills that will stay in the community and provide neighborhoods with the power to leverage future help if needed.

Evangelicals in this study confirmed this emphasis on community collaboration. For many participants, local churches were key components of a broader collaboration comprising health and other professionals, community members, and nonprofit organizers who had the experience to make collaborative projects possible. In other words, these skills already existed nearby and partnerships could exploit otherwise unused potential for community-wide development and change.

## Conclusion

Given the results of this study and the recent popularity of community-based primary care, emphasizing aspects of compatibility could allow, at a minimum, for the foundation of an important dialogue. These conversations might be significant if shared interests are considered and health disparities are addressed. Although differences certainly exist regarding the role of spiritual concerns in healthcare and the priority of personal responsibility in evangelical community outreach, collaborative efforts might be worthwhile (Cnaan, 2002). Particularly in regard to persistent health inequalities in the United States, creative partnerships that encourage the participation of local communities should be seriously considered.

Although health disparities have been connected to more systemic issues, particularly socioeconomic inequality, community-based health interventions have been used to negotiate broader policy changes (Freudenburg & Tsui, 2013). In this way, community-based strategies don't have to be seen as only producing local or microlevel changes. Instead, community-based work could be an important bridge between local, regional, and even national efforts. Such work could provoke the broad engagement from below that many Evangelicals seek, providing a forum for evangelical "buy-in" along the way. Yet, when engaged outside of unhelpful and rancorous political rhetoric, Evangelicals show that they care deeply about health and are interested in solutions compatible with their worldview.

Ultimately, these findings suggest that the culture wars of the last decades might have highlighted important differences of worldviews but have perhaps made bipartisan policy efforts more difficult (Hunter, 1992; Hunter & Wolfe, 2006). Many Evangelicals described the ACA as not including their perspectives, thereby foreclosing important spaces in which churches could contribute to health-based community solutions. Clearly there are common interests, the most obvious of which is the shared commitment to improving the health of underserved populations and developing sustainable communities. In this sense, community health should be a key arena in which bipartisan efforts are aimed to keep chipping away at American health inequalities.

## Note

1. In fact, there is no mandate for small businesses to provide health benefits. Instead, the ACA provides "Small Business Health Care Tax Credits" to offset costs should companies with fewer than 25 employees opt to provide such benefits. It also establishes a small business marketplace in which businesses can shop for affordable plans that meet ACA quality standards. Companies with fewer than 50 employees are not subject to ACA penalties for not making affordable health insurance plans available to employees.

## References

- Allsopp, M. E. (2003). *Models of Christian ethics*. Scranton, PA: University of Scranton Press.
- Bath, J., & Wakerman, J. (2015). Impact of community participation in primary health care: What is the evidence? *Australian Journal of Primary Health, 21*(1), 2–8.
- Bellah, R., Madsen, R., Sullivan, W. M., Swidler, A., & Tipton, S. M. (1985). *Habits of the heart: Individualism and commitment in American life*. Berkeley, CA: University of California Press.
- Braverman, P. A., Cubbin, C., Egarter, S., Williams, D. R., & Pamuk, E. (2010). Socioeconomic disparities in health in the United States: What the patterns tell us. *American Journal of Public Health, 100*(Suppl 1), S186–S196.
- Brodie, M., Hamel, L., Deane, C., & Cho, S. (2013). *Kaiser health tracking poll: September 2013*. Menlo Park, CA: Henry J. Kaiser Family Foundation.

- Boutin-Foster, C., George, K. S., Samuel, T., Fraser-White, M., & Brown, H. (2008). Training community health workers to be advocates for health promotion: Efforts taken by a community-based organization to reduce health disparities in cardiovascular disease. *Journal of Community Health, 33*(2), 61–68.
- Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751 (2014).
- Calman, N. S., Golub, M., & Shuman, S. (2012). Primary care and health reform. *Mount Sinai Journal of Medicine, 79*, 527–534.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, England: Sage.
- Chaves, M. (2011). *American religion: Contemporary trends*. Princeton, NJ: Princeton University Press.
- Cnaan, R. (2002). *The invisible caring hand: American congregations and the provision of welfare*. New York, NY: New York University Press.
- Cohen, L., Chavez, V., & Chehimi, S. (2010). *Prevention is primary: Strategies for community well-being*. San Francisco, CA: Jossey-Bass.
- Cosgrove, S., Moore-Monroy, M., Jenkins, C., Castillo, S. R., Williams, C., Parris, E., . . . Brownstein, J. N. (2014). Community health workers as an integral strategy in the REACH U.S. Program to eliminate health inequities. *Health Promotion Practice, 15*(6), 795–802.
- Dussel, E. (1993). *Ethics and community*. Maryknoll, NY: Orbis Books.
- Edgell, P., & Tranby, E. (2007). Religious influences on understandings of racial inequality in the United States. *Social Problems, 54*(2), 263–288.
- Elisha, O. (2011). *Moral ambition: Mobilization and social outreach in evangelical megachurches*. Berkeley, CA: University of California Press.
- Emerson, M. O., & Smith, C. (2000). *Divided by faith: Evangelicalism and the problem of race in America*. New York, NY: Oxford University Press.
- Frakt, A. (2012, March 26). What is the economic rationale for the health care law's individual mandate? [Web log post]. *JAMA Forum*. Retrieved from <http://newsatjama.jama.com/2012/03/26/jama-forum-what-is-the-economic-rationale-for-the-health-care-laws-individual-mandate/>
- Freudenberg, N., & Tsui, E. (2013). Evidence, power, and policy change in community-based participatory research. *American Journal of Public Health, 104*(1), 11–14.
- Geisler, N. L. (2010). *Christian ethics: Contemporary issues and options*. Grand Rapids, MI: Baker Academic Publishing.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory*. Chicago, IL: Aldine Publishing Company.
- Grant, T. (2012, June 28). Most evangelicals likely to lament Supreme Court health care ruling. *Christianity Today*. Retrieved from <http://www.christianitytoday.com/ct/2012/juneweb-only/supreme-court-health-care-decision.html>
- Harrington, S. E. (2010). U.S. health care reform and the Patient Protection and Affordable Care Act. *Journal of Risk and Insurance, 77*(3), 703–708.
- Hervieu-Leger, D. (2001). Individualism, the validation of faith, and the social nature of religion in modernity. In R. K. Fenn (Ed.), *The Blackwell companion to sociology of religion* (pp. 161–175). Malden, MA: Blackwell Publishing.
- Hinojosa, V. J., & Park, J. Z. (2004). Religion and the paradox of racial inequality attitudes. *Journal for the Scientific Study of Religion, 43*(2), 229–238.
- Hunt, M. O. (2002). Religion, race/ethnicity, and beliefs about poverty. *Social Science Quarterly, 83*(3), 810–831.
- Hunter, J. D. (1992). *Culture wars: The struggle to control the family, art, education, law and politics in America*. New York, NY: Basic Books.
- Hunter, J. D. (2010). *To change the world: The irony, tragedy, and possibility of Christianity in the late modern world*. New York, NY: Oxford University Press.
- Hunter, J. D., & Wolfe, A. (2006). *Is there a culture war? A dialogue on values and American public life*. Washington, DC: Brookings Institution Press.
- Islam, N., Nadkarni, S. M., Zahn, D., Skillman, M., Kwon, S., & Trinh-Shevrin, C. (2015). Integrating community health workers within Patient Protection and Affordable Care Act implementation. *Journal of Public Health Management and Practice, 21*(1), 42–50.
- Krieger, N., Kosheleva, A., Waterman, P. D., Chen, J. T., Beckfield, J., & Kiang, M. V. (2014). 50-year trends in US socioeconomic inequalities in health: US-born black and white Americans, 1959–2008. *International Journal of Epidemiology, 43*(4), 1–20.
- LaVeist, A. T. (2002). *Race, ethnicity, and health: A public health reader*. San Francisco, CA: Jossey-Bass.
- Lerner, M. (2006). *The left hand of God: Taking back our country from the religious right*. San Francisco, CA: Harper Collins.
- Liesman, S. (2013, September 26). What's in a name? Lots when it comes to Obamacare/ACA. *CNBC*. Retrieved from <http://www.cnn.com/2013/09/26/whats-in-a-name-lots-when-it-comes-to-obamacareaca.html>
- Lindsay, M. (2007). *Faith in the halls of power*. Oxford, England: Oxford University Press.
- Lipton-Lubet, S. (2014). Contraceptive coverage under the Affordable Care Act: Dueling narratives and their policy implications. *American University Journal of Gender Social Policy and Law, 22*(2), 343–385.
- Marsh, C. (2007). *Wayward Christian soldiers*. Oxford, England: Oxford University Press.

- Masci, T. (2015, May 15). Compared with other Christian groups, evangelicals' dropoff is less steep. *Pew Research Center*. Retrieved from <http://www.pewresearch.org/fact-tank/2015/05/15/compared-with-other-christian-groups-evangelicals-dropoff-is-less-steep/>
- McGarry, J. (2003). The essence of 'community' within community nursing. *Health and Social Care in the Community*, 11(5), 423–430.
- McGrail, K. M., van Doorslaer, E., Ross, N. A., & Sanmartin, C. (2009). Income-related health inequalities in Canada and the United States: A decomposition analysis. *American Journal of Public Health*, 99(10), 1856–1863.
- McKinlay, J. B. (2009). A case for refocusing upstream: The political economy of illness. In P. Conrad (Ed.), *Sociology of health and illness* (pp. 578–591). New York, NY: Worth Publishers.
- Minkler, M. (2005). Community-based research partnerships: Challenges and opportunities. *Journal of Urban Health*, 82(2), ii3–ii12.
- Minkler, M., & Wallerstein, N. (2008). *Community-based participatory research for health: From process to outcomes*. San Francisco, CA: Jossey-Bass.
- Mutamba, B. B., van Ginneken, N., Paintain, L. S., Wandiembe, S., & Schellenberg, D. (2013). Roles and effectiveness of lay community health workers in the prevention of mental, neurological, and substance abuse disorders in low and middle income countries: A systematic review. *BMC Health Services Research*, 13, 412.
- Noll, M. A. (2001). *American evangelical Christianity: An introduction*. Oxford, England: Blackwell Publishers.
- Palloni, A., & Yonker, J. (2015). A search for answers to continuing health and mortality disparities in the United States. *Journal for the American Society on Aging*, 38(4), 12–18.
- Pally, M. (2011). *The new evangelicals: Expanding the vision of the common good*. Grand Rapids, MI: W.B. Eerdmans Publishing Company.
- Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).
- Phelan, J. C., Link, B. G., & Tehranifar, P. (2010). Social conditions as fundamental causes of health inequalities: Theory, evidence, and policy implications. *Journal of Health and Social Behavior*, 51(1), S28–S40.
- Putnam, R. D. (2001). *Bowling alone: The collapse and revival of American community*. New York, NY: Simon and Schuster.
- Putnam, R. D. (2012). *American grace: How religion divides and unites us*. New York, NY: Simon & Schuster.
- Rifkin, S. B. (2009). Lessons from community participation in health programmes: A review of the post Alma-Ata experience. *International Health*, 1(1), 31–36.
- Robert, S. A., & House, J. S. (2000). Socioeconomic inequalities in health: An enduring sociological problem. In C. E. Bird, P. Conrad, & A. M. Freemont (Eds.), *Handbook of medical sociology* (5<sup>th</sup> ed., pp. 79–97). Upper Saddle River, NJ: Prentice Hall.
- Ross, C., & Mirowsky, J. (2000). Does medical insurance contribute to socioeconomic differentials in health? *The Milbank Quarterly*, 78, 291–321.
- Schutz, A. (1964). *Collected papers volume 2: Studies in social theory*. The Hague, The Netherlands: M. Nijhoff.
- Silliman, D. (2014). *Why millions of Christian evangelicals oppose Obamacare and civil rights*. Retrieved from [http://www.salon.com/2014/12/10/why\\_millions\\_of\\_christian\\_evangelicals\\_oppose\\_obamacare\\_andcivilrights\\_partner/](http://www.salon.com/2014/12/10/why_millions_of_christian_evangelicals_oppose_obamacare_andcivilrights_partner/)
- Slater, P. (1976). *The pursuit of loneliness*. Boston, MA: Beacon Press.
- Smith, C. (1998). *American evangelicalism: Embattled and thriving*. Chicago, IL: University of Chicago Press.
- U.S. Department of Health and Human Services. (2011). *Affordable care act rules on expanding access to preventive services for women* (Fact Sheet). Retrieved from <http://www.hhs.gov/healthcare/facts/factsheets/2011/08/womensprevention08012011a.html>
- Walley, J., Lawn, J. E., Tinker, A., de Francisco, A., Chopra, M., Rudan, I., . . . Lancet Alma-Ata Working Group (2008). Primary health care: Making Alma Ata a reality. *The Lancet*, 372, 1001–1007.
- Wilcox, C., & Robinson, C. (2009). *Onward Christian soldiers? The religious right in American politics*. Boulder, CO: Westview Press.
- Woodberry, R. D., & Smith, C. S. (1998). Fundamentalism et al.: Conservative Protestants in America. *Annual Review of Sociology*, 24, 25–56.
- Wuthnow, R. (1999). Mobilizing civic engagement: The changing impact of religious involvement. In T. Skocpol & M. P. Fiorina (Eds.), *Civic engagement in American democracy* (pp. 331–366). New York, NY: Russell Sage Foundation.
- Wuthnow, R., & Lawson, M. P. (1988). *The restructuring of American religion: Society and faith since World War II*. Princeton, NJ: Princeton University Press.
- Zengerle, P. (2012, June 24). Most Americans oppose health law but like provisions. *Reuters*. Retrieved from <http://www.reuters.com/article/2012/06/24/us-usa-campaign-healthcare-idUSBRE85N01M20120624>