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ANALYSIS

Spirituality As A Determinant Of Health: Emerging Policies, Practices, And Systems

ABSTRACT Reimagining public health's future should include explicitly considering spirituality as a social determinant of health that is linked to human goods and is deeply valued by people and their communities. Spirituality includes a sense of ultimate meaning, purpose, transcendence, and connectedness. With that end in mind, we assessed how recommendations recently issued by an expert panel for integrating spiritual factors into public health and medicine are being adopted in current practice in the United States. These recommendations emerged from a systematic review of empirical evidence on spirituality, serious illness, and population health published between 2000 and 2022. For each recommendation, we reviewed current federal, state, and local policies and practices recognizing spiritual factors, and we considered the ways in which they reflected the panel's recommendations. In this article, we highlight opportunities for broader application and scale while also noting the potential harms and benefits associated with incorporating these recommendations in various contexts. This analysis, while respecting the spiritual and religious diversity of the US population, identifies promising approaches for strengthening US public health by integrating spiritual considerations to inform person- and community-centered policy and practice.

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Reimagining the future of public health should address integrating deeply valued spiritual determinants of health that shape ultimate meaning, purpose, transcendence, and connectedness for individual well-being and population health.[1–4] Although the definitions of *spirituality* and *religion* vary by academic discipline, multidisciplinary international consensus conferences have defined *spirituality* as a "dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred,"[3] and *religion* as the search for significance within the context of established institutions oriented to facilitating spirituality.[5,6] Leading scholars of public health, medicine, and religion define *spiritual determinants of health* as the spiritual or religious aspects of a person's life leading to health and well-being.[1]

Although some may view these topics as beyond the bounds of formal public health, a historical view highlights their age-old influence in promoting individual and population well-being. For millennia, faith organizations and networks have integrated spiritual factors into

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their cultures, rituals, and patterns of association. Some of these are now recognized and supported in the health science literature; others are only beginning to be explored.[4] Many world religions, from their beginnings, have encouraged care for the sick and less fortunate, while also espousing ways of promoting maximal health ("flourishing").[7,8] For example, one of the earliest models of the modern hospital emerged in Cappadocia (modern-day Turkey), where, around 370 C.E., Basil of Caesarea built a poorhouse later known as the first Christian hospital.[9] By the twelfth century, religiously affiliated hospitals serving the sick and the poor could be found in nearly every Islamic city.[10] Today, many modern health systems, both in the United States and worldwide, have evolved from similar religious institutions externalizing their mission to care for the sick; a large number still offer large spiritual care departments.[4,9,11]

Despite these and other long-standing connections, philosophical movements, including the Enlightenment paradigm in the eighteenth and nineteenth centuries, framed health as the domain of science and reason, thereby accelerating the separation between spirituality and well-being. Such movements led some cultural observers to describe a "secular age" steadily overtaking a religious worldview.[12] Nonetheless, with more than 80 percent of world citizens claiming religious affiliation in 2017,[13] spirituality, faith, and communal religious activities continue to serve as a grounding, and often health-generating, force in the lives of many. Even with formal religious participation declining in the US, Pew and Gallup data have found that most people identify with a faith tradition.[13,14] Some medical and public health organizations, in response to repeated calls to "reintroduce" the topic of spirituality into public health discourse, have continued to recognize the link between religion, spirituality, and well-being. Examples include early efforts by the National Institutes of Health (NIH) to collate empirical evidence, which produced an annotated bibliography of more than 1,800 scholarly works on religion and mental health,[15] and the emerging focus on spirituality as a determinant of health.[16] For the World Health Organization (WHO), the "spiritual dimension" of health has, throughout much of its history, even influenced a number of important initiatives.[17,18]

More recently, leading public health and medical journals have dedicated special issues to these topics.[19–21] The growing body of robust, empirical research strongly links spiritual beliefs, states of being, communal practices, and private rituals to a range of beneficial health outcomes including lower all-cause mortality.[5,22–24] This has led some public health scholars to call spirituality and religion determinants of health.[23] Meanwhile, the COVID-19 pandemic highlighted the unique health benefits of positive religious and spiritual support.[25,26] For example, the WHO, in demonstrating a new surge of engagement with faith-based organizations, noted the powerful contributions by faith communities working as public health leaders,[17] with many faith communities promoting safety measures such as masks and vaccinations.[27]

Evidence-Based Recommendations On Spirituality In Serious Illness And Health

Recently, Tracy Balboni and colleagues published a comprehensive and systematic review of more than 15,000 empirical papers published between 2000 and 2022 concerning spirituality in serious illness or population health.[5] They convened a national multidisciplinary Delphi panel that, after reviewing the subset of 586 studies that met rigorous eligibility criteria, generated evidence-based recommendations for addressing spirituality in serious illness and health. These recommendations can be summarized as follows: recognize spirituality as a social factor associated with health in research, community assessments, and program implementation; incorporate person-centered, evidence-based approaches of spiritual community participation to improve medical care and population health; educate public health professionals and medical providers about empirical evidence related to spirituality and health; and provide spiritual care and support within health systems through chaplains and other specialists (a full list of recommendations is in online appendix 1).[28]

By design, the systematic review and Delphi panel did not incorporate all of the vast literature describing the complexities of religion, spirituality, public health, and health promotion. Thus, this article builds on the Delphi recommendations to consider where and how these recommendations are being adopted in current practice. Doing so reimagines public health's future by identifying systems integrating spiritual factors into health promotion. First, we convened a diverse authorship team, including researchers who conducted the systematic review by Balboni and colleagues, participated in the Delphi panel, or had applied expertise in spirituality and public health. The members of our authorship group brought their own expertise to bear on these questions; we supplemented this experience and knowledge with interviews and email-based dialogues with ten additional researchers and

The collective evidence suggests a movement toward mainstreaming a model of human health that includes spiritual factors.

practitioners who had additional insight on current programs and policies at the federal, state, and local levels. Next, we reviewed empirical and grey literature to further examine the policies and programs highlighted in interviews, as well as other emerging themes (see appendix 2 for more information on the process and methods employed between September 2023 and January 2024).[28] For this article, we chose to highlight examples that, although far from exhaustive, are both relevant to public health and health policy audiences and supported by published evidence of impact. Our analysis therefore leveraged a broad range of evidence that also included supplemental source material not listed in the endnotes (see appendix 3 for supplemental literature and resources).[28]

Recognizing Spirituality As A Social Factor In Health

The first Delphi recommendation relates to several ongoing initiatives at the national and state levels. To begin, several decades of activity by (what is currently known as) the White House Office of Faith-based and Neighborhood Partnerships and its related federal centers began in 2001 under the George W. Bush administration and has continued under every subsequent presidential administration. This bipartisan effort, involving multiple federal agencies, has built strategic partnerships with diverse faith communities; activities include promoting health insurance coverage, increasing vaccinations, addressing mental health, and preventing suicide.[29,30] Such efforts must abide by all constitutional principles and relevant legal precedents to ensure that government is neutral toward religion and not establishing one religion over another. Despite some criticism[4] and varying priorities under four presidential administrations, the office and its related centers have retained their basic function as a "bridge" between the federal government and diverse faith actors (see notes 49–54 in appendix 3 for books related to the White House Office of Faith-based and Neighborhood Partnerships).[28]

Several large-scale state partnerships between public health departments, universities, and congregational networks have also advanced public health initiatives.[31] Notable examples include North Carolina's Faithful Families Thriving Communities program, which trained lay faith leaders as health educators and was eventually scaled to fifty counties,[32] and the multistate 2009–16 Influenza Initiative, which used similarly diverse local faith and health partnerships to increase influenza vaccinations among hard-to-reach and minority populations.[33] Today, several states are exploring how Medicaid Section 1115 waivers may allow partnerships with faith communities to address social determinants of health and health-related social needs.[34] For example, California's twenty-one-county California Advancing and Innovating Medi-Cal (CalAIM) program[35] contracts with ministerial associations to help qualifying congregation members obtain medical, dental, behavioral health, and housing services, as well as food and shelter.[36] Despite some critiques concerning early operational challenges,[37,38] support remains for California's health care system to engage clergy and integrated services such as housing and food assistance.[38]

Incorporating Person-Centered, Evidence-Based Approaches To Spirituality Into Health

With regard to the second Delphi recommendation, at the population level, numerous examples highlight how faith communities and health systems can integrate spiritual-community participation into health care. Such work builds on long precedents of religious congregations engaging in community-based health promotion and disease prevention (see notes 4, 5, 10, 12, 16, 27, 31, and 34 in appendix 3).[28] Two recent examples with published outcomes highlight how large health systems can work with local congregational networks. In the Memphis Model, in Tennessee, 690 mostly African American churches partnered with the Methodist Le Bonheur Healthcare system to connect hospitalized congregation members with health navigators and more than 4,000 volunteer-trained health ministers.[39,40] The use of electronic medical records helped trigger a hospital-employed health navigator to visit patients to determine how best to work with church liaisons.[39,41] Patients in the

network during the period 2008–11 showed a significantly longer time to readmission and gross mortality rates roughly half those of non–network members.[41] The program in Memphis has been cited as an exemplary population health management practice for underserved communities in an urban setting.[42] During 2021–23, moreover, Wake Forest Baptist Medical Center, in North Carolina, built off this experience by engaging congregations across twenty-six counties employing volunteer "connectors" to link patients to local medical centers[39,40] and related community-based resources.[40] Despite up-front investment costs, the project in North Carolina ultimately saved $2.5 million over previous annual charity care spending.[40]

At the clinical level, the overall spiritual needs of patients remain underaddressed, with patient-reported spiritual care from medical teams ranging from 9 percent to 51 percent.[5] Validated tools may help address these gaps. For example, brief spiritual-history questionnaires, such as the FICA (F: faith, belief, meaning; I: importance and influence; C: community; A: address or action in care) spiritual assessment tool, can enhance whole-person care by identifying which patients might benefit from spiritual support or spiritual community participation.[3,5,21,43–45] A major randomized study of spiritual-history taking by oncologists showed that patients who were asked these questions, compared with controls, had fewer depressive symptoms, better quality of life, and a stronger sense of interpersonal caring from their physicians.[46] When appropriate, community participation could also be encouraged, in religious and nonreligious settings alike, as part of well-being and health promotion efforts.[21]

Providing Spiritual Care Education For Health Professionals

The third Delphi recommendation addresses exposing health professionals to training on spirituality and health. Some schools of public health and academic health centers have developed courses and workforce training programs using empirically based content about spirituality and health; the textbook *Why Religion and Spirituality Matter for Public Health* details several of these.[24] Established programs at Duke, Yale, Harvard, and Emory Universities offer training on spiritual factors in health to health professionals and researchers.[24] Studies suggest that medical and public health professionals who receive such education are more likely to inquire about the spiritual needs of people and communities from diverse spiritual or religious backgrounds[47,48] in ways that can improve quality of life, advance person-centered care, increase family satisfaction, and possibly even reduce disparities among underrepresented racial and ethnic groups.[5,49]

Still, a nationwide study showed that 53 percent of public health graduate students reported insufficient education regarding spiritual factors in health; of those, 46 percent reported no mention of empirical evidence about relationships between spiritual and religious factors and health outcomes in their training.[24] Another study showed that only 7 percent of medical schools required coursework on religion, spirituality, and health, although 90 percent reported sponsoring optional courses or content.[50]

Allowing health professional and public health students to hear student and community perspectives on spirituality and receive longer trainings at early stages of the educational process could improve understanding about its impact, including both benefits and harms, in people's lives. It could also boost confidence in students' ability to communicate with patients about such themes.[51] One promising practice is George Washington University's Interprofessional Spiritual Care Education Curriculum, an empirical- and evidence-based course to train health care providers to address patients' spiritual needs.[45,52] The program, which has trained more than 500 health professionals since 2018 (as reported by coauthor Christina Puchalski), incorporates hospital chaplains as coteachers. A twelve-month follow-up of forty program participants found that 92 percent reported being confident or very confident in their spiritual care leadership skills; more than 60 percent had trained other medical professionals (the primary objective of the program) on providing spiritual care.[53]

Providing Spiritual Care And Support Within Health Systems

The fourth Delphi recommendation addresses the provision of spiritual care within health systems. According to the American Hospital Association, during the period 2010–19, an average of 76.6 percent of hospitals offered patients spiritual care services, representing a steady increase over the past decade.[54] Hospitals that were more likely to provide chaplaincy services shared a number of features, including Joint Commission accreditation, a higher percentage of Medicare inpatient days, nonprofit or government ownership (versus for-profit), and church affiliation.[54] A 2022 in-depth Gallup survey randomly sampling 1,096 US adults found that one in four Americans have been served by chaplains, half in a health care setting, and that the most common topics discussed were death and dying

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(53 percent), mental and emotional health (53 percent), and dealing with change (52 percent) and loss (50 percent).[55]

Insufficient spiritual care resources and heavy patient loads constitute pervasive challenges,[56] suggesting a need for models that can address costs, scale, training,[57] and the appropriate integration of chaplaincy services. Large systems such as the Veterans Health Administration have recently established Healthcare Common Procedure Coding System (HCPCS) codes to integrate chaplaincy services into clinical care.[58] The Centers for Medicare and Medicaid Services (CMS) includes spiritual counseling as a hospice benefit[59] and recently approved the use of HCPCS chaplaincy codes for all health care facilities,[60] opening a new path for supporting and measuring such services in health systems.

Discussion

To our knowledge, this analysis provides the latest assessment of the extent to which the US health care system reflects recent evidence-based recommendations for integrating spirituality and health. Although far from exhaustive, the assessment notes a range of national, state, and local examples of spiritual and faith-based organizations serving as community partners[19,31,61,62] in program implementation and service provision, especially in low- and middle-income settings.[4] Such efforts suggest ways in which spiritual communities can foster resources and relationships, including among minority populations,[63] to serve as bridges to resources related to other social determinants of health (for example, environments where people live, learn, work, play, and pray). Faith communities can also partner with health care and public health entities, as well as private and public payers such as Medicaid. The collective evidence suggests a movement toward mainstreaming a model of human health that includes spiritual factors (for example, biopsychosocial-spiritual). Some scholars refer to the strong intersection of spirituality and health as one word—FaithHealth—that represents a powerful system for strengthening population health (see notes 33 and 56 in appendix 3).[28]

Considerable work remains. Deeper and more expansive empirical research is critical, particularly regarding methodology; geographic, spiritual, and religious diversity; attention to both benefits and harms; and tradition-specific health interventions. Our analysis focused on the US only, and future work can broaden to a global context. Many studies we examined have potential value in clinical or highly controlled contexts but may be challenging to scale for population health or need more rigorous outcome evaluations. Notably, many faith communities actively involved in health efforts may lack expertise in formal empirical methods of evaluation and measurement, leaving their work invisible to public health and health policy audiences. Ensuring that evaluation efforts are familiar and appropriate to faith communities and empirically meaningful to policy makers and public health leaders will require cultivating deep multisectoral partnerships.

Considerations For The Future Of Public Health

Public health systems must expressly consider how best to incorporate the Delphi recommendations, being fully aware of potential benefits and harms, into highly pluralistic, diverse, and often sensitive contexts. Because spiritual community participation can represent, for many, a multifaceted "black box" of physical, emotional, social, and spiritual experiences,[64] understanding of how the collective assets within faith communities can lead to health benefits must be refined. These assets are particularly meaningful for minority populations[63,65,66] and offer equity and access for groups that have not always felt welcome or at ease in formal health establishments. Tailoring tradition-specific materials for health promotion can potentially connect new people, including those who have experienced abuse within spiritual and religious contexts, to local resources for healing.[21]

Public health systems must also heed concerns about cross-sector engagement that risks generating uncritical advocacy efforts[67] or, conversely, "professionalizing" approaches to spirituality in a way that leads it to overly conform to secular priorities—for example, grant-making processes that require action and outcome plans along purely secular lines.[68–70] Public health systems must consciously tailor efforts to respect the na-

tion's multifaceted spiritual diversity, including people from traditional religious backgrounds and Indigenous spiritual backgrounds, as well as those who identify as spiritual but not religious.

Finally, to reimagine a future public health system that thoughtfully engages spirituality as a determinant of health, we recommend the following.

First, foster basic spiritual and religious literacy as an extension of cultural humility in public health training and continuing education. Doing so can improve understanding about ways to build a more diverse and inclusive system that respects not only spirituality's impact on individual health but also the vital role of faith communities in promoting well-being. A first step may be a national review of current public health curricula to assess how spiritual and religious literacy is currently incorporated, and can be improved, as a benchmark for future growth.

Second, strengthen communication, relationships, and trust building between leaders from public health and spiritual communities, which should, in turn, lead to collaboration focused on common goals (for example, the well-being of patients and communities, new forms of peer support, and adopting whole-person health frameworks). Such efforts should welcome perspectives from different worldviews. Cross-sectoral relationships can build on previous successful collaborations between local health departments and faith communities[4] to enrich future efforts both in everyday matters and in crises. Furthermore, communication to the public can highlight the link between spirituality and health.

Third, build on recent CMS developments to spotlight payment issues, especially for chaplains, medical care providers, and faith-based services that provide appropriate spiritual care and other essential public health services for diverse populations. Reimbursement for these activities will require balancing professional requirements (for example, appropriate medical- or service-provider training and awareness of privacy issues) with flexibility toward forms of spiritual care or activities falling outside current models of reimbursable activities.

Fourth, improve national coordination between academic and faith-based groups to better understand and measure public health efforts (for example, through common databases, coordinated research initiatives, dedicated focus in academic journals, and national leadership). Efforts under way at the NIH and WHO and many others (see notes 65 and 71 in appendix 3)[28] hold promise for the type of national and international coordination needed; activities should move beyond interest groups and convening activities toward broader coordination and research.

Fifth, dedicate funding that maps activities, documents best practices, and evaluates the impact of spirituality and faith-based interventions on health. In 2023, the National Institute on Minority Health and Health Disparities approved "spirituality and religiosity as psychosocial determinants of health" as a research concept,[16] which will allow for new streams of much-needed research, including topics highlighted throughout this article. Local, state, national, and global funders should consider following suit with dedicated funding to sustain empirical exploration of these powerful intersections.

Conclusion

In a reimagined clinical and public health system, spiritual factors would be routinely considered in creating person- and community-centered policy and practice. Although the intersections between spirituality and well-being have existed through millennia, a compelling body of empirical research currently allows policy makers to learn from and build on numerous contemporary models of integrated health policies and practices. The approaches identified in this article are merely a starting point for future public health systems. As empirical scholarship increasingly illuminates these connections, public health systems must seek additional ways to recognize spiritual determinants of health as a vital dimension, and extension, of whole-person, whole-community well-being. ■

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