

The Adventist Church and Its American Health Systems

| BY GERALD WINSLOW

"Jesus called the twelve together and gave them power and authority over all demons and to cure diseases, and he sent them out to preach the kingdom of God and to heal."

LUKE 9:1–2

When Jesus commissioned his disciples to preach the Gospel and to heal, we can be sure they were not anticipating the major healthcare systems that now understand their work to be inspired by faith in Him. Eighteen centuries later, when Seventh-day Adventists received visionary messages regarding healthful living, it is similarly certain that no one was planning for the extensive health systems that bear the Adventist name today. Yet, if the five Adventist health systems in North America are considered together, we now see one of the largest faith-based health systems in the land being owned and operated by a relatively small Christian movement. Here are a few personal reflections on how the Advent Movement is doing with its healthcare organizations in North America.

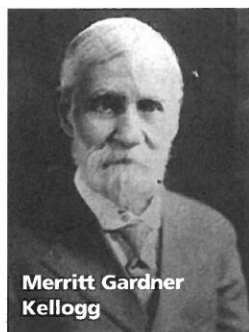
Can twenty-first century American Adventism operate healthcare institutions that are worthy of the mission of a prophetic minority? My belief is that our society needs the distinctive contributions of Adventist healthcare now more than ever. We have unprecedented opportunities to bless the communities we serve with a faithful and evidence-based message of health and wholeness. At the same time, left on cruise control, we could unwittingly miss this historic chance to step up to the leadership role I believe our Creator intends for us. There are important reasons, then, to appeal to church leaders and to those who think and care deeply about the theological and ethical convictions of our church for help. We need to renew the covenant of faithfulness between our church and its healthcare institutions.

First, consider the opportunities. New doors have opened for the kind of whole-person healthcare Adventists,

at our best, have long been committed to offer. When we have remembered *why* we built healthcare institutions, we have given priority to promoting healthful living and preventing disease. The use of the best scientific medical interventions to rescue sick or injured people was supposed to be a backup plan. We developed healthcare enterprises first and foremost as a ministry designed to prevent, to the extent possible, the need for medical interventions. The combination of faith and health has been powerful, especially when supported by the kind of education required to prepare the best healthcare professionals. This plan works. Wherever the Adventist faith has flourished, there is typically a vibrant synergy between growing churches, excellent schools, and first-rate healthcare institutions.

One of the more brilliant examples is in Sydney, Australia. Sydney Adventist Hospital was founded as a "sanitarium" in 1903 by Merritt Kellogg (left), the half-brother of the more famous John Harvey Kellogg. Today, the "San," as it is known throughout Australia, is one of finest healthcare and educational institutions in the nation. With its recent addition, the San will be the largest private healthcare institution in New South Wales, and some say in all Australia. In collaboration with Avondale College and other institutions of higher education, the hospital is providing superb clinical education for nurses, and more recently for physicians. It is also sponsoring significant research on lifestyle and health, with designs on becoming an international leader in this field. The work of the San and other Adventist health ministries, including Sanitarium Health and Well-being Company, has been transformative.

Because of such success stories, Adventists are increasingly invited to participate in, and even lead, high-level planning



Merritt Gardner Kellogg

for the reformation of currently unsustainable healthcare. One of the main reasons for such invitations is the growing recognition that Adventists have a successful record in the prevention of disease. In the so-called developed countries, especially the United States, citizens face the impossibility of bearing the ever-rising costs of rescue medicine. In this nation, we are rapidly entering an epidemic of chronic, lifestyle related diseases. One example suffices: Americans are now experiencing nearly two million new cases of diabetes (Type II) each year.¹ This one disease was the underlying cause of over 200,000 premature deaths in 2010. The costs, both direct and indirect, for treating the disease and its co-morbidities, are incalculable. But an educated and conservative estimate for one recent year put the figure at \$245 billion. Imagine what will happen to such costs as we speed toward the time when it is predicted that one-third of our fellow citizens will be diagnosed with this disease.

Every day, at places like the one where I work, scientists labor to discover new ways to treat the results of what are often preventable diseases. When we are successful in finding new treatments, they are almost never inexpensive. So, every day we also go to work trying to figure out how to pay for healthcare rather than for health. The easily predictable result is the threat of national bankruptcy. Throughout my entire life, the percentage of our nation's gross domestic product being spent for healthcare has outstripped almost every other sector of the economy. The J-curve increases in healthcare spending are now the largest cause of our national debt. Made more personal, catastrophic healthcare expenditures are also the largest cause of family bankruptcy. Increases in family income over the past decade have been almost entirely wiped out by higher increases in healthcare, now averaging more than \$9,000 per person per year—nearly double that of most of the richest nations on the planet.

Our burgeoning costs of healthcare were accelerated by a corrosive scheme for financing the care. Hospitals, and the caregivers who work

in them, were paid per episode of care, while typically being paid little or nothing for preventing such occurrences. This episodic approach to most of American healthcare has provided strong financial enticement to do more of almost everything, including many tests and interventions that are useless or even harmful. What possible incentive could healthcare systems have for investing in the prevention of medical crises while such activities reduced the number of patients needed to keep those systems financially viable?

Recently, however, our nation finally entered, with faltering steps, a long, disruptive process of healthcare reform or, more accurately, healthcare financing reform. Over the next few years, we will see the gradual dismantling of the fee-for-service model of healthcare and the growth of comprehensive health systems that are built for continuity of care across the lifespan. The Affordable Care Act, passed into federal law in March, 2010 is beginning to produce significant effects, both predicted and unpredicted. In the state of California, for example, more than three million people have gained new healthcare coverage. As this enormous social experiment continues, keen attention is being given to the inclusion of preventive measures. Health insurance plans are required to include significant coverage for prevention, while healthcare systems are increasingly being penalized for preventable re-admissions to hospitals. Charitable healthcare institutions are also now required to conduct community health needs assessments and develop plans for elevating health outcomes in the territories they serve.

What does all this have to do with faithful operation of Adventist health systems? The obvious answer is that we have some unparalleled opportunities to lead what we have long called whole-person care. Take one example. Just over two years ago, the White House Office of Faith-based and Neighborhood Partnerships convened the first meeting of what was then called the Health Systems Learning Group. The purpose was to initiate collaborative learning among faith-inspired and charitable health systems committed to community health devel-

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opment. Of the initial forty plus participating institutions or systems, eight were Adventist. The goal is to lead the nation in the redirection of healthcare dollars toward whole community care.² A key strategy for this work is the creation of new forms of partnership between healthcare organizations and communities of faith. For Adventists, this should readily be our stock-in-trade. Deep in our collective DNA is the Adventist commitment to have our convictions of faith lead to practical benefits for human health and wholeness.

There is great potential for our collective influence because of the size and extent of Adventist healthcare in this country. We now operate over eighty hospitals, including one of the largest private hospitals in the United States. These institutions employ more than 124,000 people, and are often the largest private employers in their regions. We also have more than 300 clinics and extended care facilities. With nearly 700,000 inpatient admissions and millions of outpatient visits per year, Adventist healthcare is surely where our fellow citizens are most likely to encounter Adventist ministry personally.

The purpose of citing these figures is not self-congratulation. Rather, it is to awaken inquiry about what we might do for the sake of the Gospel in the service of our neighbors through enhanced collaboration. And we may also wonder: How much greater would the distinctive influence of Adventist healthcare be if our health systems cooperated more with each other and with our church? Let me attempt to sketch an answer to this question by suggesting four things we need to do:

1. We need to continue deepening our understanding of the theological and ethical beliefs that are foundational for our health ministry.

Faith-shaped healthcare can never be stronger than the shared beliefs of those who lead it and give their lives in service to the health of others. Seminal works for Adventists, such as *The Ministry of Healing* need to be re-examined and re-



Jack Provonsha

appropriated in light of twenty-first century realities.³ Fifty years ago, for example, my home institution and many others in Adventist healthcare were blessed by the creative insights of physician

and theologian Jack Provonsha (above).⁴ More recently the works of Richard Rice, Henry Lambertson and Siroj Sorajjakool, James Londis and others have brought added maturity to our shared convictions.⁵ Also noteworthy, in this regard, is the series of publications from Florida Hospital Publishing.⁶

The ethical implications of our theological beliefs are also in need of continual refinement. From 1989 until 2000, the work of the Christian View of Human Life Committee, commissioned by the General Conference, generated most of our officially recognized statements and guidelines for biomedical ethics. Matters such as assisted human procreation, genetic interventions, abortion, and care at the end of life were given extensive scholarly attention before consensus statements were produced and adopted by our church. After a fifteen-year hiatus, the General Conference recently appointed a successor "Bioethics Committee" under the aegis of the Health Ministries Department. This promises to be a salutary step toward renewing a process for our church's official engagement with healthcare ethics. In rapidly developing areas such as human biology and medicine, careful, ongoing attention to major ethical questions is an essential responsibility for a community of faith that operates healthcare institutions.

2. The five Adventist health systems in North America need to continue finding new forms of collaboration.

There is already much to celebrate. After the failed attempt to create a nation-wide governance system in the 1980s, there was little interest in reinventing anything that looked similar.

However, in recent years many cooperative endeavors have emerged that are producing significant benefits. One notable example is the formation of the Adventist Health Policy Association (AHPA) supported by all five of the Adventist systems in North America.⁷ AHPA takes as its primary purpose “to help ensure that high quality, accessible healthcare is available to the communities we serve.” In concert with AHPA, Loma Linda University has recently established the Institute for Health Policy and Leadership, designed to produce scholarship in the areas of population health and the integration of health promotion in comprehensive health systems. Working together, the Institute and AHPA are beginning to convene national conferences of Adventist health policy leaders. AHPA’s recent publication of *Five Steps to Health in America*, created to share positive proposals with the nation’s policy-makers, is another product of collaboration.⁸ Already, policies that affect the lives of millions of our fellow citizens are being influenced in positive ways for the sake of human health. Such work moves our commitments to social justice from rhetoric to reality.

3. Adventists in North America need to renew the covenant of trust between our church and its health systems.

Until recently, the last focused, strategic conversations between senior leadership of the church and the health systems were in the mid-1990s. The resulting publication could have been a basis for ongoing renewal, but that did not happen.⁹ And if the complex, fast-growing health systems could not be completely *overseen*, then they could gradually be *overlooked*.

What is needed now is not some new form of governance. The boards of our health systems take their fiduciary responsibilities seriously. These boards are typically chaired by, and significantly populated with, faithful Adventist church leaders. The other board members are, in my view, highly skilled professional Adventists who care deeply about the mission of our church.

What is sometimes missing, however, is the

strategic collaboration of our church and its health systems. Both our church and its health systems could do much to restore the joy of cooperation between the nearly 6,000 Adventist congregations in our North American Division (NAD) and the healthcare institutions bearing the same family name.

There is good news in this regard. For nearly three years, the mission executives of the health systems joined in fruitful conversations with senior leaders of our Division. This work has resulted in a vision statement that was presented at a summit meeting of NAD in April, 2014.¹⁰ At that meeting were division, union, and local conference leaders, along with executives from Adventist health systems and institutions of higher learning. The final statement was adopted by the NAD at the end of 2014. What difference will this make, if any? The hope is that we can build new forms of creative partnership that will lead to demonstrable improvement of health outcomes for whole communities.

4. We need to increase the number of faithful, highly-talented, well-prepared young Adventist professionals who are willing to enter leadership in the Adventist health systems.

Our current recruitment and development programs, though laudable, are remarkably insufficient. We need a new covenant of collaboration between our health systems and our colleges and universities. At present, we often find it impossible to fill major leadership positions with individuals who share the fullness of our Adventist faith.

It is important to make this point while also being fully appreciative of the essential contributions to our health systems by gifted colleagues who do not share the distinctive Adventist faith. We are constantly made more faithful by the ways in which people who represent other faith traditions help us to understand new depths of our own faith commitments. When, for example, one of my Muslim physician colleagues quietly leaves a committee meeting because it is time for him to pray, the spiritual chemistry of the meet-

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ing seems to change. At such times, if we are open to the Spirit, we may find our own spiritual commitments enriched. And by learning to work closely with colleagues of different faiths, we also learn how better to serve the immensely



Richard Rawson

diverse communities where our healthcare ministry is most needed. Richard Rawson (left), in a recent *Spectrum* interview, offered this helpful insight in a memorable way: "The church will have to

learn to connect with our communities in ways we may or may not be comfortable with. We need to learn to separate Adventist cultural issues from the core of the mission to which we have been called. This can be successful only if we stay firmly connected to Jesus, who is the source of the love that we must share with others."¹¹

There are, of course, also some things we could quit doing. It would be helpful, for example, if church members would stop saying "We've lost our health systems." Every time I hear this, I want to respond by pointing out that they are easily found. The various causes of disappointment that lead to the feelings of loss do need to be addressed. From the food and drink in the cafeterias to the salary structure for the institutions' employees, we could benefit from careful review and the renewal of faithful commitments. Such subjects are important and they need viable solutions, not mortar rounds fired from afar. It would also be helpful if we stopped grading our health ministries in terms of their Adventist purity. There is a place under the big canopy of Adventism for the smallest self-supporting healthcare institutions as well as for the major health sciences institutions we operate. Our society can be blessed by all these ministries. And if we are sufficiently magnanimous, we might come to see how all of them could be richly complementary.

Before coming to the main text of *The Ministry of Healing*, a reader encounters these dedicatory words: "To the physicians and nurses of every

land, who, as co-workers with the Chief Physician, the great Medical Missionary, are laboring bravely and unselfishly to heal the sick, to comfort the afflicted, and to teach the way of life, this book is dedicated."¹² In addition to the professions named by Ellen White, we must now add other allied health professionals, chaplains, financial executives, cafeteria workers, information analysts, and hundreds of others needed for today's healthcare to function safely and effectively. For generations, untold thousands of Adventist healthcare professionals have done their best to bring whole-person care to people around the world. When I think of their service, I am humbled. Those of us who now have responsibilities for guiding Adventist health ministries do well to remember that we carry a torch we did not light. By renewing the covenant of trust between our church and its health systems, we can help to ensure that the light is not diminished but shines more brightly during our tenure. We can help lead a rejuvenated faith and health movement that the people of our planet need now more than ever. ■

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References

1. The statistics regarding diabetes are all drawn from the *National Diabetes Statistics Report, 2014*, produced by the American Diabetes Association and available online at diabetes.org.
2. A 2013 monograph detailing the work of the Health Systems Learning Group is available from the White House Office of Faith-based and Neighborhood Partnerships. It is

also available at the website <http://stakeholderhealth.org/> under the heading for “tools and resources.”

3. Ellen G. White, *The Ministry of Healing* (Mountain View, 1909).

4. David Larson is currently preparing publication of some of Jack Provonsha's most noteworthy essays. The work, expected to appear in 2016, is tentatively titled *Making the Whole Person Whole: Jack W. Provonsha on Religion, Ethics and Medicine*.

5. See for example Richard Rice, *Ministryhealing: Toward a Theology of Wholeness and Witness*, (Loma Linda, 2006), and available from the Loma Linda University Center for Spiritual Life and Wholeness; Henry Lamberton and Siroj Sorajjakool, eds., *Spirituality, Health, and Wholeness: An Introductory Guide for Health Care Professionals*, (Philadelphia, 2004); and James Londis, *Faith-Based Caregiving in a Secular World: Four Defining Issues*, (Hagerstown, 2009).

6. The entire catalogue of publications from Florida Hospital Publishing can be found at <http://floridahospitalpublishing.com/>. See, for example, Randy Haffner, *Holding on to What Is Sacred: How to Protect Organizational Values and Enhance Mission Vitality* (Orlando, 2010).

7. See <http://adventisthealthpolicy.org/> for detailed information about the Adventist Health Policy Association.

8. *Five Steps to Health in America: A Health Policy Agenda for the Next President and Congress of the United States* is available online at <http://adventisthealthpolicy.org/files/Five%20Steps%20to%20Health%20in%20America.pdf>. A *Spectrum* interview about the development of this booklet is online at <http://spectrum-magazine.org/article/2015/12/12/adventist-hospitals-work-influence-national-healthcare-policy>.

9. The document, largely written by Roy Naden, is titled “Defining and Fulfilling the Mission of Seventh-day Adventist Healthcare Institutions in North America in the Twenty-First Century.” It was completed in December 1996, and is available from the North American Division Health Ministries Department.

10. The document, titled “The Vision for Adventist Healthcare Ministry in North America,” is available by sending an email request to gwinslow@llu.edu.

11. The interview of Richard Rawson by Charles Scriven is available at <http://spectrummagazine.org/article/charles-scriven/2014/11/16/ear-richard-rawson-discusses-innovation-and-whole-person-healthca>.

12. Ellen G. White, *The Ministry of Healing*, dedication page.