The New Adventist Health Care Corporations

by Geri Ann Fuller

Pat Horning left her post as associate editor of *Listen* magazine late in 1980 to become public relations director of Florida Hospital. The year before, Fred Hauck resigned his job as academic dean of Columbia Union College to accept a position as personnel director at New England Memorial Hospital. Don Prior, who was vice president for public relations and fund development at Andrews University and held a similar vice presidency at Loma Linda University, left in 1979 to assume a post with the same title at Glendale Adventist Medical Center.

Don McAdams, president of Southwestern Adventist College, reports that "Since I've been here, we've lost three nursing instructors, two maintenance people, and one computer person to Adventist hospitals, all for increases in pay. Colleges and hospitals are in direct competition in areas like public relations and development, maintenance, nursing, computer science, and business administration."

Geri Ann Fuller, community relations director of the Washington Adventist Hospital, graduated from Columbia Union College and received a master's in journalism and public affairs from American University.

The intensified lure of medical institutions — in part due to their higher pay scales — for employees in other denominational institutions is only one of several issues raised by Adventists forming large health care organizations. With a total of 65 hospitals, 9,300 beds and combined assets of more than $661 million, the four Adventist health care corporations are big business. According to an October 1980 article in *Modern Health Care,* one of the major hospital management journals, "A merger of the four corporations would make the consolidated Adventist system the nation's seventh largest operator of acute care hospital beds behind the five large investor-owned chains and New York City's municipal Health and Hospitals Corporation. (The regional) Adventist health systems (already) rank first, second and fourth among all Protestant multihospital systems." Adventist health care corporations were organized in the 1970s as a response to the need for greater expertise and control in dealing with government regulations, third-party payers and increasingly sophisticated technology.

Adventist health systems are part of a national trend. According to a recent American Hospital Association survey, such multihos-

pital systems already operate 1,400 of the 5,805 community hospitals in the United States. It has been estimated that as many as 80 percent of eligible community hospitals, if not already members, are at least negotiating involvement with a multihospital system. Adventist hospital administrators make strong arguments in favor of Adventist hospitals being organized into such corporations. But the support of the Adventist health care corporations for salaries higher than those paid in some other Adventist institutions fuels strong feelings.

Dr. McAdams sees the church's wage and benefit policies as a source of widespread and deeply rooted bitterness among those in the higher education field. "I think we should be either fish or fowl," said McAdams. "Either we all sacrifice or we all get community rates. . . . Almost everybody, including ministers, elementary and high school teachers and hospital people, are already getting community rates, and some are getting even more."

The $45,000 to $50,000 salary an administrator earns in the top echelons of the Adventist health care work in North America may appear to be a sacrificial wage when compared to the $125,000 or more he could earn in the same job outside the church, but next to a salary in the low $20,000's earned by his counterpart in the Adventist educational work, it seems generous indeed. Although neither church leaders nor educational administrators seem individually to resent the large salaries commanded by those in the health care work, most admit that the disparity between hospital corporation salaries and denominational wages is one of the most sensitive problems raised by the formation of Adventist health care corporations.

A crucial factor in the decision to approve the higher wage scales was that, unlike in other areas of church work, hospital employees are not paid out of church funds. As North American Division President C. E. Bradford put it, "The church is not going to benefit if we pay these people less — only Blue Cross and Blue Shield."

Also, many believe it would be impossible to attract competent management personnel capable of running a financially sound institution at wages at or below those being paid to rank and file employees. And with nursing shortages which have reached crisis proportions in some areas in recent years, hospitals have had no reasonable choice but to offer competitive wages to the rank and file employees. Thus, the present guidelines for administrative salaries are based on a formula which takes into account the size of the hospital and the community rates for floor-duty registered nurses. When the General Conference blessed the large wage scales for administrators, it was with the understanding that other benefits, except those specifically approved by the General Conference (such as medical and educational benefits) would be dropped. Previously, some medical institutions were quietly recruiting personnel by offering perquisites ranging from luxury cars to low-cost housing.

Of course, hospital administrators defending the creation of the health care corporations believe it is unfortunate that attention has focused on salaries. They say that they organized the corporations to lower purchasing costs, increase efficiency and facilitate expansion of the Adventist health work into new geographical areas. The concept of such corporations was formally introduced to the Adventist Church in 1972 at General Conference-sponsored meetings in Mexico City. A committee was appointed at that time to study setting up health care corporations along union lines in response to difficulties experienced by many of the smaller hospitals in coping with complexities like Medicaid. The committee, chaired by R. R. Beitz, then a vice president of the General Conference, included such veteran Adventist hospital administrators as George Nelson, Harley Rice, and Irwin Remboldt, as well as other administrators from large and small hospitals. The committee agreed on a concept whereby corporations would be supported by dues from the member hospitals and would provide centralized services in areas where cost savings could be achieved or effectiveness maximized by centralization.

From that stepping-off point, however, the individual unions developed at their own

pace and according to their own structures. Hospitals in the Southern Union were probably the earliest to develop a strong corporation, followed by those in the Pacific Union. Other corporations, like Eastern States Adventist Health Service, in the Columbia Union, remained for several years little more than loose federations of hospitals.

Because of their additional power and therefore ability to deal with outside agencies, union-based corporations in the late 1970s began to form across union lines. The corporations in the Southern and Southwestern Union conferences formed Adventist Health Systems/Sunbelt; Pacific and Northern Pacific Union Conference corporations became Adventist Health Systems-West, and the Columbia and Central Union corporations merged into Adventist Health Systems/Eastern and Middle-America. As recently as early 1981, the health care corporations in the Great Lakes region and New England formally merged into Adventist Health Systems-North.

Why the rush of Adventists and others to form such corporations? They can provide financial and management expertise, added power to deal with regulators, and financial assistance to allow some hospitals to survive. Corporate offices can also provide assistance in dealing in capital markets, data processing, credit collections, accounting and auditing, insurance programs, purchasing, recruitment, and a whole host of other areas of skills that most institutions could not afford to buy on their own. Although funds have been spent by the Adventist health corporations on such unlikely items as bailing out an ailing medical school in Mexico and the purchase of corporate jets, corporate executives justify the expenses as either furthering the aims of the church at large or producing long-range savings.

The services available and degree of centralization varies from one Adventist hospital corporation to another. In Sunbelt the hospitals have pooled their cash resources to institute a cash management system which has enabled the hospitals to reduce borrowing from outside sources and to automatically invest cash balances on a daily basis. Eastern and Middle America, which only merged formally in January 1980, already has made available centralized data processing. Adventist Health Systems-West, in addition to pioneering the group purchasing and group malpractice insurance programs, was the first system to have a consolidated financial statement for all member hospitals, and it has also standardized the articles of incorporation and the bylaws for all its hospitals. Adventist Health Systems-West also has a more centralized structure than the other corporations. The corporate office staffs a collection center for hospital accounts, a department specializing in maximizing third-party reimbursements, a foundation for fund-raising activities, and several marketing corporations, among other things.

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The crossing of union lines to form hospital corporations has raised some questions about who is in control (since formerly the unions were in lines of authority). But union presidents seem satisfied that the church is maintaining its authority, even in the new, larger structures. Not only do the corporation presidents report to union leadership, which makes up a large portion of both the corporate board and membership, but the North American Services Board adds another layer of official church influence. The board was set up at the 1976 Annual Council to set guidelines and provide an oversight function. Board representation is made up of the presidents of the health care corporations, union presidents, and General Conference representatives. The board sets

goals, objectives, and standards for the operation of Adventist hospitals; oversees group purchasing for all Adventist hospitals; determines group malpractice insurance policies; and sets administrative salary scales.

Even though most hospital administrators indicated support for the corporations, all are not necessarily convinced that they are yet getting their dollar's worth of value from the corporations, especially when part of that dollar value can look very much like a loss of autonomy. However, Herb Shiroma, president of Washington Adventist Hospital in Takoma Park, Maryland, defends the cost of corporations on the basis of "intangibles" received. "I think every administrator has pet areas where he questions the money being spent by the corporation," he said. "But what price do you put on having a financially sound hospital? When you have somebody looking over your shoulder to doublecheck and it happens to save you $50 to $100 thousand, how much is that worth? I also feel that the corporate dues are part of the price I pay to help my church," he adds, referring to the fact that in many situations, larger hospitals pay a disproportionately high share of dues to help make available the services of the corporation to smaller hospitals that can less well afford them.

One of the intangible benefits that comes from the corporations is a new sense of cooperation and teamwork among member hospitals. More than one hospital executive indicated that before the corporations were established, about the only time Adventist hospitals had anything to do with one another was when they were trying to steal each other's best people.

Under the management agreement by which Adventist health care corporations operate their hospitals, administrative staff draw their salaries from the corporations and are responsible to it. The corporation appoints the administrator, although corporate executives are quick to point out that they would not put an administrator in a hospital where he was unacceptable to the board. The corporations also set standards for management and provide expertise where it is needed to assist in running the hospital. The local board retains responsibility for quality of care, making sure the hospital meets standards for accreditation and state licensure, medical staff relationships and operating according to the budget. Each hospital in the corporation is still self-contained in terms of legal ownership and has its own bylaws and articles of incorporation. But at least one corporation has already standardized the bylaws and articles of incorporation for all its hospitals, and with other corporations considering a similar move, hospitals may be in for tighter, more direct control by the corporations.

Adventist involvement in developing health care corporations was not motivated simply to improve efficiency. Besides preventing Adventist hospitals from joining other health care consortiums (and thus jeopardizing the peculiarly "Adventist" character of the institutions), developing the corporations was an aggressive move to strengthen Adventist influence through acquisition of hospitals in communities where Adventist presence had been minimal or nonexistent. "Within five years," says Russell Shawver, president of Adventist Health Systems/Eastern and Middle America, "The potential for expansion of the Adventist Health System by acquisition will be past — and it is now impossible, except in most unusual situations," he says.

Already, acquisition is really the only route left by which the Adventist health care work can expand, because health planning agencies have nearly put an end to the construction of brand-new hospitals. In the Washington, D.C. area, for example, Shady Grove Adventist Hospital opened in 1979 amid widespread public debate over whether Montgomery County actually needed 225 more hospital beds.

Corporate executives point to thriving Adventist communities — such as those in Tillamook, Oregon; Moberly, Missouri; Durand, Wisconsin; and Hackettstown, New Jersey — where there was no Adventist presence until an Adventist hospital was established, as evidence that this expansion of the health care work is helping the church to accomplish its mission.

What happened in Moberly, Missouri, may in fact be a prime example of what the corporations can accomplish. The 18,000-member community had two hospitals, one proprietary and one nonprofit, but both had inadequate facilities and were failing financially. Tensions between the two hospitals were creating such a divisive atmosphere in the community that both hospitals were having trouble holding on to their medical staffs and more than half the residents of the town were going outside the area for their health care. When executives from what was then Mid-America Adventist Health System heard of the problems, they went to the local health planning agency and learned that even the regulators were baffled by the problems. So they approached the nonprofit hospital and proposed to rebuild the hospital in exchange for taking over the management of the hospital. "They were a little startled by our approach," admits Shawver now. "I think they felt at first that it was like giving away city hall. But then they realized that our goal was to run a good hospital, which was what their goal was."

Mid-America then offered to buy up the stock of the ailing proprietary hospital. When the corporation was able to show the health planners that both hospitals were willing to cooperate, it obtained permission to dispose of both hospitals and rebuild a single new facility. And when they presented the approved Certificate of Need for rebuilding to the first hospital, the board of trustees resigned and Mid-America took over.

At the time the negotiations were going on, says Shawver, "the Adventist Church in Moberly was a tiny little clapboard facility that was just off the campus of one of the two hospitals. There were about 15 regular members. It was astounding that we were able to convince them that we could do all these things for them when they looked out their window and saw that kind of representation of the church." Today, however, Moberly has a new Adventist church school, a new 120-bed hospital scheduled to open in May and land has been purchased for a new Adventist church. To be sure, most of the increased Adventist population is due to imports rather than converts, but even so the influence is there today.

Hospital executives and church leaders disagree on just how many Adventist employees in a hospital there needs to be to provide an effective witness; hospital people usually believe the needed proportion is smaller than estimates given by church leaders.

C. E. Bradford, president of the North American Division and chairman of the North American Health Services Board, an advisory board overseeing the affairs of the hospital corporations, believes that at least 50 percent of rank and file employees in an Adventist institution should be Adventist, not to mention administration and department heads. "The greatest challenge the hospitals face is in maintaining their Adventist character. Our greatest contact with non-Adventists is through our hospitals. How do we reach these people — how do we develop programs that will be a benefit without offending people?"

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Others, like Francis Wernick, a general vice president of the General Conference and vice chairman of the North American Hospital Services Board, says the church should set guidelines based on articles of incorporation, procedures with regard to distribution of assets on dissolution, structure of the board, constituency, and similar criteria to determine whether an institution is Adventist or merely Adventist-managed or operated. Church and hospital leaders alike, however, seem to agree that top management — administration and in most cases, department heads — should provide a nucleus of Adventist support and identity for any Adventist hospital.

The four corporations have different mechanisms for exerting an Adventist presence on the board of trustees. In some communities, the local Adventist community must be supplemented with church members from surrounding areas to come up with enough individuals experienced in leadership to fill a board.

While some church members fret over the difficulties of fostering an Adventist philosophy within an institution, local communities also demand representation in determining the direction of their hospitals. In Ellijay, Georgia, because of difficulties with Adventist philosophy, Adventist Health Systems/Sunbelt recently lost its management contract with the 50-bed Watkins Memorial Hospital which the church had controlled at the request of county government for more than 20 years.

Russell Shawver acknowledges that the local community does have a right to demand representation on the board. "Hospitals are being viewed more and more like public utilities. In effect, we are being given a franchise to operate our facilities by the local community."

Interestingly, excessive centralization is a danger raised by experts in hospital management themselves. Robert Cunningham warns in an article in the August 1980 issue of *Trustee* that "when decisions . . . are in some part removed from the local institution to a more remote authority, . . . local vigilance and local concern may also be diminished accordingly. If there is a risk, it is mostly to the caring component of quality. . . ." And that caring component is an element that most hospital executives agree is fundamental to what makes an Adventist hospital.

Nevertheless, as Adventist hospital corporation leaders look for greater opportunities to both save money and expand the denomination's health work, it seems likely Adventist health care will be further centralized. Although the four regional corporations have no formal linkage, a recent public relations publication on "The Adventist Health Systems" referred to "the four regional divisions of the Adventist Health System" and described the system as "the largest nonprofit Protestant health care system in North America."

Such a merger has already been recommended. Mardian Blair, president of the 800-plus bed Florida Hospital in Orlando, formally proposed the formation of a single corporation called Adventist Health System/North America to the NAHSB in June of 1980. But at this point, the only action taken has been for the President's Executive Advisory Committee to approve a committee to make a formal study of the proposal.

Several problems would have to be solved before a single large corporation could succeed. "My concern," said Herbert Shiroma, president of Washington Adventist Hospital, "is that we not set up a structure with so many checks and balances that by the time an administrator gets past all the checkpoints the crisis is gone and so is the hospital."

A national merger would also create an additional bureaucratic layer which would mean three of the regional corporate presidents would suddenly find themselves reporting to a superior. As Charley Eldridge, a regional vice president with Adventist Health Systems/Eastern and Middle America, pointed out, "The biggest stumbling block to a national merger is personal feelings. You're talking about people's careers." Also, many in church leadership share Francis Wernick's apprehension: "We've always been reluctant to place large numbers of institutions under a single head."

The church has never forgotten the specter of Battle Creek. It probably should be noted, however, that John Harvey Kellogg wrested the Battle Creek Sanitarium away from the hands of the church by buying up the stock in what was then a proprietary corporation. Adventist hospitals today are nonprofit corporations with no stock. The membership of the church is equivalent to stockholders, and indirectly it elects the boards of the hospital corporations.

Some believe that a national corporation is not needed since questions such as whether or not to further standardize wage and benefit packages can be handled by the present

North American Health Services Board. The board is now, for example, working on a national retirement program.

However, most corporation executives think that a national corporation could provide further cost savings for the hospital and the church. Adventist Health Systems/West president Frank Dupper has proposed, for example, that some of the costs of the General Conference Health Department activities on behalf of the hospitals would be eligible for reimbursement by government funds if the health department were under a national corporation.

In fact, elements of a national organization are already in place, such as group purchasing and insurance plans, through the General Conference. These elements are described in the recent article in *Modern Health Care:*

> The Adventist's medical malpractice and general liability insurance program . . . provides coverage for all Adventist hospitals in the U.S. at premiums roughly 75 percent of what individual hospitals would pay to local shared insurance programs for similar coverage. The program . . . covers up to $5 million per occurrence and $25 million aggregate through the National Union Fire Insurance Company of New York. . . . The Adventist national group purchasing program . . . is expected to buy some $200 million worth of equipment and supplies this year. . . . Chief financial officers of Adventist hospitals have agreed to use uniform financial statements and 27 key financial rations. . . . The chief financial officers of the systems will meet this month [October 1980] to discuss pros and cons of merging their data processing systems . . . and Adventists systems hospitals and the church's Health-Temperance Department are discussing consolidating their human resource departments.

In spite of all the complications that must first be solved, many hospital executives anticipate that sooner or later a single Adventist health care corporation in North America will be formed.