REINVENTING HOLISTIC HEALTHCARE: PASTORAL PERSPECTIVES OF BIBLICAL INSIGHTS FOR THE AMERICAN HEALTHCARE SYSTEM

by

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ABSTRACT

The purpose of this case study was to examine pastoral perspectives of Biblical healthcare. These perspectives are essential to consider due to the long history of the connection between spirituality and healthcare and the church's successful intervention worldwide for increasing healthcare outcomes. Since the church has been successful worldwide at creating faith-based organizations that meet community needs, it is vital that research focus on how churches might continue this success within the United States. This study used semi-structured interviews to examine the research questions of 1) What is the Biblical responsibility of healthcare? 2) How does culture influence the role of the Church in healthcare? and 3) What current programming in local Churches supports the Biblical responsibility of healthcare? Data was collected from 10 semi-structured interviews with pastors located throughout the United States. Qualitative analysis indicated that pastorals generally held that health is important to God, and that healthcare resources need to ideally be available to all. Overall, this study demonstrates that pastoral perspectives of health and healthcare are not united or clear, and that there may be opportunities for pastoral education to increase understandings of both the *why* and the *how* behind the biblical responsibility of healthcare. Pastors expressed a general openness to learning more about the topic, presenting an opportunity that may exist within the system to bring science and faith back together in a way that honors the foundations of the historical past while holding space for change and growth to provide professional resources within Church walls, and in doing so, reinventing holistic healthcare.

Keywords: Healthcare, pastor perspectives, Biblical understanding, faith-based organizations

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Dedication

For my mother: This dissertation is a testament not only to the many years of academic endeavor but also to the love, sacrifice, and unwavering belief you have poured into my life. From the earliest days of reading aloud to me while I colored, to this crowning moment in my academic journey, you have shaped me into the person I am today. Your dedication to my holistic growth went beyond my academic education; you taught me to question everything, explore curiously, and find joy in learning (except math… never in math). You nurtured a drive in me in all things that has been a force behind my academics and modeled a resilience that has been a compass to guide me through challenges. In you, I have had a mom, teacher, coach, mentor, and friend whose wisdom, intelligence, and insights have laid the foundation of strength that I stand on today. Your sacrifices do not go unnoticed, and your love has been vital. This dissertation is a tribute to your enduring influence, and I share this accomplishment with you. I love you.

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CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction

The intersection of Christianity and healthcare in the United States is a complicated topic that is nuanced with a discussion of American healthcare, healthcare organization alternatives, Biblical understandings of health and wellness, and cultural focuses on health and wellness resources. There is much current discussion in the United States and worldwide about what healthcare should look like. Understanding the Biblical responsibility of healthcare is important because it sheds light on how Christians might contribute to the healthcare crisis in the United States. Throughout history, the Church has been involved with healthcare services worldwide (Jarlsberg, 2014). Although past research has acknowledged the American Christian Church maintains some involvement in healthcare, there is little research understanding the pastoral views of reasoning for the involvement, especially across multiple cultures within one community.

Background

The Current American Healthcare Climate

Healthcare is a common topic within American culture because there is not a streamlined system of healthcare nationwide, unlike other world-leading countries. Many other countries have government-funded healthcare accessible to everyone without stipulations, and although there are some government assistance options in the United States, there are many qualifications necessary to maintain enrollment. Otherwise, the majority of people use a free-market healthcare system, buying healthcare insurance either as individuals, through their places of work, or choosing to pay doctors directly for

services. This leaves room for a lengthy discussion of healthcare barriers, government interventions, and the impact of COVID-19.

Barriers to Healthcare

Healthcare within the United States is a complex topic. This topic is convoluted with many complicated elements that form significant barriers to general access, including insurance, geography, ableism, and racial and cultural concerns. (Choi et al., 2020; Coombs et al., 2022; Matin et al., 2021; Rachoin et al., 2021). For example, a patient's environment and demographics affect their intrinsic risk factors and access to care, including things such as biological differences, types of treatment offered, and outcomes (Culhane-Pera et al., 2021; Degrie et al., 2017; Rachoin et al., 2021; Yearby, 2018). Being of a specific race or socioeconomic status might significantly impact the ability to find adequate healthcare services that are trustworthy. The American government has a dark past of using medical experimentation on racial minority communities, as well as withholding the distribution of available medical resources (Bolger et al., 2018; Yearby, 2018). These barriers still exist emotionally for many of these populations (Bolger et al., 2018; Yearby, 2018). Additionally, geography itself contributes to levels of access in areas such as inner cities and rural communities, therefore presenting unique struggles (Coombs et al., 2022). It is well documented that many people in America do not have access to healthcare services because of these barriers (Bolger et al., 2018; Culhane-Pera et al., 2021; Degrie et al., 2017, Yearby, 2018).

Government Interventions

The recent Affordable Care Act passed into law was aimed at reducing costs and penalties for marketplace healthcare for private purchase (Choi et al., 2020). The act also required companies to provide healthcare insurance options for organizations having 50 or more employees (Choi et al., 2020). However, new presidential leadership and economic recessions change these systems continually, leaving many Americans struggling to understand how insurance works, where to purchase it, and the services it covers (Choi et al., 2020; Oberlander, 2019). The alternative to paying for health insurance is to pay for services out of pocket unless a person qualifies for government assistance. Paying out of pocket has been shown to be a risky choice as uninsured patients do not always receive the same quality of treatment as those who are insured, leaving many groups facing discrimination and a lack of trust in the healthcare system (Choi et al., 2020; Culhane-Pera et al., 2021; Matin et al., 2021; Yearby, 2018).

Recent Presidents of the United States have recognized the potential for faith-based organizations to play a role in the healthcare crisis by signing an executive order acknowledging the union of religious and secular resources (U.S. Office of the President, 2021; White, 2021). This executive order has been signed by both the Obama administration and Biden administration since the original signing by George W. Bush and aims to encourage religious organization involvement in meeting community needs (U.S. Office of the President, 2021). Interestingly, although this has existed for many years, few seem to know this partnership exists or understand how it supports churches in meeting healthcare needs.

The Impact of COVID-19

The COVID-19 pandemic increased the struggles people faced with insurance and access to healthcare due to job losses caused by COVID and increased pressure on the healthcare system (Coombs et al., 2022). In developed countries, there is a continued influx of reliance on telehealth services following the onset of the pandemic (Bhatia et al., 2021; Osman & Bennett, 2018; Perrin et al., 2020). This shift in the industry can be viewed as a possible double-edged sword because while it did provide accessibility to populations that have internet and technology in the home, those without technological resources were left with even less access to services than before as the goal at the time was to reduce the spread of COVID (Coombs et al., 2022). Minority communities struggled throughout the COVID-19 pandemic, as research found higher rates of COVID-related deaths within these communities (Louis-Jean et al., 2020). Overall, COVID-19 complicated an already struggling healthcare economy.

The American Church Involvement

Starting in the 2000s, there has been a worldwide focus on global health (Magezi, 2018). This increased focus has seen many organizational involvements, as well as world leaders joining the cause to help the needy and hurting throughout the world (Magezi, 2018). The churches in these communities have played a significant role in the increased focus on health worldwide because churches are generally a hub for local people, especially in communities in non-western cultures (Magezi, 2018). This increase in the Church's role in healthcare worldwide leads to an understanding of how faith-based organizations have been beneficial in targeted countries, while also fostering a discussion of the development of these kinds of organizations in western cultures.

Worldwide Faith-Based Organizations

Faith-based healthcare organizations have been a way The Church has been involved with healthcare worldwide throughout history (Bopp & Fallon, 2013; Fort, 2017; Jarlsberg, 2014; Levin et al., 2022; Marin et al., 2019). Although these organizations are effective in other places, there is little research about the models these organizations use and how they might be effective here in the United States (Abbey & Keogh George, 2020; Magezi, 2018). Health fairs, community health workers, health classes, and community outreach are things that have been alternatives to traditional healthcare funded by churches in the U.S.A. and abroad (Adekeye et al., 2018; Javanparast et al., 2018; Morris, 2015; Stansfield et al., 2020). However, income or insurance qualifications are often required to use these services, making them harder to access for those in need (Adekeye et al., 2018; Javanparast et al., 2018; Morris, 2015; Stansfield et al., 2020). Faith-based organizations have done amazing work in other countries, however, there is still much to understand about their effectiveness here in the United States (Abbey & Keogh George, 2020; Culhane-Pera et al., 2021; Stansfield et al., 2020). Faith-based organizations are funded by white and non-white churches alike in other countries (Jarlsberg, 2014), however, understanding healthcare alternatives and the spiritual motivation in the United States is still a need, and only certain churches seem to be prioritizing this mission.

Minority Community Needs

Minority Church congregations are much better at prioritizing the healthcare needs of their communities in the United States than the general Church population (Barnes & Curtis, 2009; Bolger et al., 2018; Campbell et al., 2007; Derose & Rodriguez, 2020; Patel et al., 2013). Previous research has indicated that pastors from minority

backgrounds are concerned with their congregation's physical and mental health (Bolger et al., 2018; Galiatsatos & Hale, 2016; Gross et al., 2018), something that is not a well-researched area across multicultural congregation church leadership. This understanding seems to leave a gap in understanding as to why certain American church leaders prioritize healthcare needs in their congregations, and others do not, often divided by the racial makeup of the Church.

When considering the prioritization of local health promotion and intervention within the Church, we must discuss where the motivation for these programs stems from. Past research has shown that people are more generous with resources like time and money to people who are closer in proximity to them (Law et al., 2022; Strombach et al., 2014; Xu et al., 2020). Family, friends, neighbors, and the like are likely those the average joe will help and support first (Law et al., 2022; Strombach et al., 2014; Xu et al., 2020). There is one very important exception to these findings, however, and that is when the investment is motivated by morality (Xu et al., 2020). In other words, when a person is intrinsically helping another person out of a desire to be more moral, they are more likely to help someone farther away, potentially in another country (Xu et al., 2020). The reason for this would be to expand their moral reach to the world, perhaps feeling like they are making a bigger impact (Xu et al., 2020). Research shows that there are cultural differences here within how collectivistic and individualistic cultures might prioritize this distance differently (Law et al., 2022; Strombach et al., 2014), perhaps aiding in understanding how different cultural groups prioritize health programming in their own congregations in different ways.

Church Leadership Understandings

In order to see the Church increase in effectiveness within the healthcare crisis within the United States, it is vital to understand the reasoning behind the involvement of the Church leadership. Some churches offer healthcare services in their local communities for their congregations or the public; however, research is lacking in understanding the cross-cultural motivations of these programs. Previous research has identified that pastoral perspectives on healthcare often include discussion of personal mission, modeling behavior, specific health needs of their communities, and lack of trust in the government healthcare system (Baruth et al., 2015; Bolger et al., 2018; Cheon et al., 2016; Drovdahl & Jones, 2020; Gross et al., 2017). These studies have focused on minority communities only with established programming. Continuing to understand pastoral perspectives across communities is vital to understanding how the Church might play a significant role in the development of healthcare services in the United States. The future of healthcare needs to include action steps to increase inclusivity and minimize inequality and injustices surrounding the various barriers (Culhane-Pera et al., 2021; Rachoin et al., 2021), and churches with leadership that value healthcare interventions might play a role in that future.

Problem Statement

Healthcare is a complex issue worldwide that is made more complicated in the United States because of concerns regarding access, quality, and affordability of care nationwide (Culhane-Pera et al., 2021; Degrie et al., 2017; Rachoin et al., 2021). More specifically, race and ethnicity, geographic location, insurance, affordability, and physical ability are all barriers to adequate healthcare in the United States, with a lack of clarity on what steps can be taken to work toward the resolution of these issues (Choi et al., 2020;

Coombs et al., 2022; Matin et al., 2021; Rachoin et al., 2021; Yearby, 2018). Throughout history, the Church has prioritized meeting the holistic healthcare needs of the underserved due to the deep connection between the health sciences and Christian morality (Abbey & Keogh George, 2020; Oberlander, 2019). The parable of The Good Samaritan in Luke 10 is a reminder that Biblical love is closely connected with loving one's neighbor, something Jesus clarifies is anyone who is found while journeying (Barbieri et al., 2014; Duvall & Hays, 2020; English Standard Bible, 2001). Over the years, research shows that mainstream American culture has shifted into increasing the separation of Church and State, resulting in Christians separating the once-connected idea that the Church should be involved in issues of things like healthcare (Oberlander, 2019). In turn, the result is less Church leadership advocating for the health and wellness of their congregations (Oberlander, 2019). The exception to this reality seems to be in Churches that are primarily of a minority group (Bolger et al., 2018; Cheon et al., 2016). Research has seen an increase in resources within these minority communities and pastors' perspectives shared and documented (Baruth et al., 2015; Bolger et al., 2018; Cheon et al., 2016; Gross et al., 2017). Although each culture has slightly different focal points, these pastors hold perspectives that resemble the connection between prioritizing resources within the health sciences within their local communities and abroad (Bolger et al., 2018; Gross et al., 2017; Jo et al., 2010). Studies have identified that pastoral focus on their congregation's health comes from their congregations' physical health needs and the lack of trust in mainstream American healthcare (Baruth et al., 2015; Gross et al., 2017; Rowland & Isaac-Savage, 2014; Senteio, 2019). More specifically, Black pastors often report a specific duty they feel to their congregations to offer health services and health

education for the direct needs of their congregations (Rowland & Isaac-Savage, 2014; Senteio, 2019; Williams & Cousin, 2021). There is a lack of research documenting Church leadership's perspectives that are not specific to minority groups, however (Abbey & Keogh George, 2020). Understanding how Christian leadership across cultures perceives Biblical spirituality and healthcare will help develop faith-based organizations locally in multiethnic communities that are as effective as those internationally. This is accomplished by research focused on exploring pastoral understandings of Biblical healthcare. Therefore, the purpose of this study was to examine pastoral leadership perspectives across multicultural churches throughout the United States regarding the Biblical responsibility of healthcare and the role of the Church in modern healthcare systems.

Purpose of the Study

The purpose of this qualitative case study is to explore cross-cultural pastoral leadership's perspectives on what the role of the Christian is within healthcare. The qualitative interviews explored concepts such as resource investment, multicultural expectations, barriers to Church involvement, and Biblical understandings of caring for the sick.

Research Question(s) and Hypotheses

Research Questions

RQ1: What is the Biblical responsibility of healthcare?

RQ 2: How does culture influence the role of the Church in healthcare?

RQ 3: What current programming in Churches supports the Biblical responsibility of healthcare?

Assumptions and Limitations of the Study

In a qualitative research exploration such as this one, there are some important assumptions and limitations of the study. The first assumption is that those that are interviewed will be honest in their presentation of their answers. Secondly, there is an expectation for a variety of perspectives. Given the variability of opinions on the topic, it can be assumed that participants will also have varying perspectives. Lastly, it is assumed that this research is based on inductive logic and reasoning. Social desirability is a primary limitation of this study. Pastors and church leaders are understood to be trusted and powerful individuals in their communities, therefore, it is possible that responses given could be biased towards their reputation. Another limitation for this study is generalizability. Although this study aims to be as diverse and inclusive to represent various perspectives, this does not guarantee other multicultural communities would also breed similar results if studied.

Theoretical Foundations of the Study

Understanding that health is a construct that is holistically focused on overall well-being requires knowledge of the model of health that includes social, economic, and environmental contexts (Bispo Júnior & Santos, 2021). Health is not simply the absence of disease, instead, it is the foundational understanding that society flourishes on (Salvador-Carulla et al., 2014). Although quality of life is not a primary factor within the

current study, it is a measurement of health used by WHO since 1991 that helps assess cross-cultural health and human functionality (Salvador-Carulla et al., 2014). The health model adapted for the current study is similar, aiming to define health as accessible, holistic well-being for the physical, mental, and spiritual functionality of individuals.

Foundational to this model of healthcare from this framework is the human right to healthcare. Healthcare is needed for survival, and with philosophical ethics based on the principles of doing no harm to other humans, therefore becomes a right to be upheld (Cernadas & Fernández, 2021; Culhane-Pera et al., 2021; Meier et al., 2018). This is even more starkly clear within a Christian worldview, as caring for the sick was not segregated or withheld from certain populations within a Biblical context (Basil & Schroeder, 2009; Bolger et al., 2018; Gross et al., 2018).

Even before COVID-19, millions of people worldwide dealt with a disparity in healthcare (Haeri et al., 2022). This disparity has only increased since the COVID-19 pandemic, resulting in compromised health networks throughout the globe (Haeri et al., 2022). Haeri et al. (2022) developed a model that focuses on developing the efficiency of health facilities to decrease the disparity in healthcare services that involve collaboration between community members, non-government organizations, and government healthcare interventions.

Societal responsibility within the context of the current study relates to non-governmental interventions to aid in bridging gaps (Haeri et al., 2022). This construct holds that humans are responsible for one another, as the success of one impacts the success of the whole (Haeri et al., 2022). This concept is challenging for individualistic

cultures to grasp, and the American healthcare system evidences the lack of societal responsibility (Coombs et al., 2022; Osman & Bennett, 2018).

The Biblical perspectives on the constructs of focus in the study are intertwined with conflict of opinions, directly aiding in the research itself. As will be discussed, the Bible does address the importance of health throughout the text, however, interpretations of it have been varied throughout time. What is clear is that health as a construct is important throughout the Bible, and finding a more clear understanding of the implication of that truth is a primary concern with this current study.

Definition of Terms

The following is a list of definitions of terms that are used in this study.

Health – The World Health Organization (1948) defines health as, 1) health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, 2) a fundamental right of every human being without distinction of race, religion, political belief, economic, or social condition, 3) fundamental to the attainment of peace and security and requires the cooperation of individuals and governments, 4) an important pursuit of the government, 5) vital to the development of children, and 6) requires education and cooperation for and with the public.

Healthcare – The organized provision of medical care to individuals or a community (Oxford English Dictionary, 2023).

Biblical Responsibility – The knowledge of and action toward what The Bible instructs on a particular topic.

Significance of the Study

This research is vital to conduct because of the vast gaps in current American healthcare including lack of access, affordability, and racial concerns. If the Biblical responsibility of healthcare is to care for the sick, and past research has shown some pastors act within their church towards this aim, what are the barriers to the church getting more involved in filling the major gaps in the American healthcare system overall? This study adds to the current research because it lays a foundation for how the church might offer solutions for aiding in the healthcare divide in the United States while also allowing for churches to take a more active role in their communities in a way the Bible describes as appropriate. Research has shown that faith-based healthcare organizations are working in other countries on a broader scale, and to make way for that kind of healthcare in The United States, we must explore how church leadership conceptualizes Biblical responsibility in healthcare locally.

This research also has the capacity to revolutionize the partnership and collaboration of the American government system and churches at the community level. As previous research has shown, although there is a history of some collaboration, results from this study might aid in increasing, redefining, and revolutionizing this partnership. In doing so, it would have impact on government-sponsored healthcare options including the functionality of healthcare centers and resources and beyond. Increasing this collaboration would intrinsically increase access for vulnerable populations, promoting well-being, dignity, and flourishing at the individual, family, and community level.

Summary

As demonstrated, the topic for the current study is complex and multidimensional. Understanding the Biblical responsibility of healthcare includes exploration of the history of the connection between Christianity and healthcare and involves identification and exploration of the many barriers to accessing healthcare within the American healthcare system. The church has a long history of playing a role in caring for the sick and needy both locally and around the world, and yet there is a gap in understanding what has altered this involvement. The current study aims to add to the understanding of what role the church should play according to pastoral perspectives. Although there are limitations and assumptions of social desirability, generalizability, and honesty, the study is valuable information to aid in bridging the gap for healthcare access in the United States.

CHAPTER 2: LITERATURE REVIEW

Overview

To establish a comprehensive and integrative review of the current literature on the topic of the Biblical responsibility of healthcare, it is vital to explore both the foundations of spirituality and healthcare in more depth as well as the Biblical foundations of healthcare. In reviewing the literature, there will be an exploration of 1) healthcare throughout history, 2) the current American healthcare climate, and 3) the American church and health. These sections will delve into topics such as barriers to healthcare throughout history, perceptions of physicians and their roles, barriers to healthcare, the structure of the American healthcare insurance system, and the impact of COVID-19. In exploring the Biblical foundations of the topic, the areas of 1) Biblical spirituality and healthcare, 2) the debate on the limits of help, and 3) modern perspectives will be addressed. Within these sections, some of the topics include both the Old and New Testament understandings of health, Jesus' example, Biblical suffering, and the great commission.

Description of Search Strategy

The search strategy was complex due to the limited research on the topic overall. The library databases of Liberty University, Wheaton University, and Moody Bible Institute were utilized for identifying previous research and literature. Search terminology included "spirituality and healthcare", "Biblical healthcare", "American healthcare insurance", "pastoral perspectives of healthcare", and "Christianity and healthcare". The

Biblical research was conducted by using word searches within the Biblical text, as well as Biblical commentaries to understand original Hebrew and Greek contexts.

Review of Literature

Spirituality and healthcare have a long, tumultuous history, although it has not always been this way (Oberholzer, 2019). Spirituality and health have been intertwined due to inconsistent knowledge of disease throughout time (Collier et al., 2020; Oberholzer, 2019). In fact, the first hospitals were established out of religious motivations as early as the end of the fourth century (Mitchell, 2012). Within the current American medical climate, 90% of healthcare patients report believing in a higher power, even though conversations about spirituality are not as common in healthcare settings today as they once were (Collier et al., 2020). Collier et al. (2020) discuss religion and spirituality as the last taboo within medical spaces, likening it to sexual health as once to be kept private but now recognizing its importance in overall health and well-being. More and more people in the medical field are seeing the benefits of including discussions of spirituality within medical practices (Borovecki, 2020). Perhaps the connection between spirituality and health is not so strange after all.

To fully grasp the topic of the Biblical responsibility of healthcare, there are many considerations. First, it is vital to explore the beginnings of healthcare, including 1) its foundational philosophy, 2) how it functioned throughout the world, and 3) the role of faith traditions, including Christianity. Secondly, a thorough understanding of the current American healthcare system is necessary, which includes 1) the political divide of the right to healthcare, 2) healthcare provider roles, 3) barriers to healthcare, 4) government

interventions throughout American history, 5) healthcare insurance in a free-market system, and 6) the impact of the COVID-19 worldwide pandemic. Lastly, the role of the American Church in recent years is explored with considerations of 1) denomination differences, 2) racial divides, 3) worldwide impact and the allocation of resources, and 4) pastoral perspectives and influence. This information together portrays an understanding of current research on the topic of Biblical interpretations of healthcare within the context of the historical underpinning of the connection of faith traditions and healthcare throughout history.

Healthcare Throughout History

Ancient View of Health

Healing traditions are commonly seen within all cultures throughout history (Aquilina, 2017; Bassareo et al., 2020; Bruner, 2018). Tribes during ancient times often had a primary individual who adopted the role of a healer, knowing the most about herbs, nature, medicine, magic, spirits, and other remedies both known and unknown to this day (Aquilina, 2017). A well-documented account comes from ancient Egypt, where certain healers specialized in the use of natural laxatives to purge the body of whatever affliction was ailing a person (Aquilina, 2017). Throughout other parts of the ancient world, systems of medicine developed similarly, using a combination of natural remedies and spiritual rituals to heal the sick (Aquilina, 2017; Mitchell, 2012; van Minnen, 2006). Before hospitals, there were temples dedicated to the gods of healing within the Egyptian, Greek, and Roman cultures (Bassareo et al., 2020; Mitchell, 2012; van Minnen, 2006). These healing spaces were a place of worship to the gods as well as human action of cleaning wounds and pain management with plants and herbs (Bassareo et al., 2020).

As cities formed and populations grew, illness did too, causing many to become sick more often than when life was lived farther from one another (Aquilina, 2017). This led humans to need more healing resources, to understand diseases more thoroughly, and to work towards prevention (Aquilina, 2017). Ancient Greece spearheaded this task, developing a scientific medicine that helped answer questions as to illness formation and ways to stop it (Aquilina, 2017; Bassareo et al., 2020). Within Greek mythology there is a clear storyline of the beginnings of medicine, starting with the many gods of healing, creating a direct line to Hippocrates (Bassareo et al., 2020). The Hippocratic Oath, still used in medicine today, focuses on the ethical duty of a healthcare provider to do no harm (Aquilina, 2017; Bassareo et al., 2020). The oath originated from the time of Hippocrates in 460 B.C. and specifically includes a part detailing the physician's responsibility to know the limits of their treatment, tasking clinicians to refuse to treat a patient if they do not believe it is possible (Aquilina, 2017).

When someone became ill in Ancient Greece, they would often try to heal from the smallest to the largest scale (Aquilina, 2017). For example, if a family member had a natural remedy or solution, that would be the first option explored (Aquilina, 2017). However, if that did not work, a sick person had to seek out a neighbor, a witch, or if one could afford it, a physician (Aquilina, 2017). Physicians in ancient Rome were discovered to have used many different methods of healing including diet changing, cautery, clay pills filled with medication for their patients, or surgery (Aquilina, 2017). The fifth or sixth centuries is when this practice of medicine takes the form from house calls and temples and turned it into a skill for learning the practice of healing (Bassareo et

al., 2020). Although these practices would not involve as many resources, healthcare in ancient times, if accessible, may have looked closer to the modern day than expected.

This goes far beyond Christian understandings of health and healing, as many different faith traditions have their own ways of understanding what health is and how to value and protect it (Marty & Vaux, 1982). Religion has been largely at the center of medicine and healing; it is only within the last hundred or so years that the two concepts have split and become more secular in the minds of the standard public (Swartley, 2012). Caribbean cultures practice healing within religious ceremonies (Marty & Vaux, 1982). African cultures value health within communities and have a *Nganga* who is known as an herbalist or spiritual healer (Marty & Vaux, 1982). Jehovah's Witness have physical rules and practices that pertain to spiritual requirements (Marty & Vaux, 1982). Mormons, likewise, have regulations within their faith tradition to abstain from caffeine or tobacco intake to preserve health standards while Seventh-Day Adventists are additionally vegetarian (Marty & Vaux, 1982). The scientific achievement that highlights the development of medicine is important within Christian Science (Marty & Vaux, 1982). Throughout history, Protestant Christianity has demonstrated both advancements in the healthcare field, while also assuming other cultural traditions are less effective (Marty & Vaux, 1982). From the perspective of cultures outside of the Western majority, modernization is not always the right answer (Marty & Vaux, 1982). Identifying how the system has shifted in unhelpful ways allows for leadership within faith traditions to guide congregations toward the original connection of health and faith as demonstrated in ancient texts.

Health as a Virtue

Being ill was physically and socially unpleasant, as an illness was often thought of as a punishment from the gods (Aquilina, 2017). Birth defects and long-term illnesses were a burden during that time period, often leading to isolation for those afflicted due to conditions being untreatable at the time or simply not understood (Aquilina, 2017). Aside from the virtuous pursuit of health, it can be argued that due to its many flaws, medicine foundationally rearranges diseases throughout humankind but does not get rid of them in significant ways (Payne, 1985). This argument is backed throughout history by the ever-changing nature of the medical field and healthcare overall (Payne, 1985). Even in modern times, some believe that the Bible shows that sickness is directly related to immoral choices such as sexual immorality, substance use, and not caring for the body as the Bible instructs and that lifestyle changes and prayer offer well-being (Bolger et al., 2018; Payne, 1993). Virtuous living, therefore, was and continues to be conflated with well-being in certain populations or belief systems. However, Biblical ethics are rooted in the concept of love as a foundation; therefore, health as a Biblical virtue also uses love as its foundation (Payne, 1985). The debate surrounding the virtue of health sparks conversation around human ecology as an important consideration surrounding healthcare throughout the ages (Marty & Vaux, 1982). Human ecology is the holistic care of humans, including their relationships with God, the self, family, and society (Marty & Vaux, 1982). There is still an understanding to be had in modern perspectives of the holistic connection between virtue and health from a Biblical perspective.

The Priest, The Physician

Historically it is clear that healers throughout time were also spiritual people within many cultural contexts (Marty & Vaux, 1982; Sansom, 2019). Information in

general is passed down through traditions. Traditions include knowledge of all things, including medicine and religion (Marty & Vaux, 1982). The two are intertwined because they both involve the whole person, and if a provider cares for a group that has a particular faith tradition, he must learn about it in order to offer good medical care (Marty & Vaux, 1982). Many Christian physicians that have been identified within the first eight centuries of history have practiced within the homes of church members, making the connection between physical healing, occupation, and personal spirituality much more connected than perhaps we often give credit (Collier et al., 2020; Oberholzer, 2019). As early as the 4th century there are examples of compounds responding to natural disasters including infirmaries alongside churches to aid in the holistic restoration of the hurting people (Jarlsberg, 2014). Before the microbiological revolution that sparked new knowledge about the origins of disease, physicians relied heavily on their belief in a higher power (Collier et al., 2020). While it might be easy to say that science, due to many of the beliefs linked and attributed to it, is what originally resulted in the distancing from Christianity, that may not be a fair assumption (Oberholzer, 2019). As religion usually holds to a strict moral compass, the connection between religion and health became complicated due to the potential of there being more than one way to get to health and wellness (Meador, 2021). Regardless of faith tradition, healers were known as such due to their spiritual connection or deeper understanding of the world (Marty & Vaux, 1982).

Barriers to Care in the World, Then & Now

Within conversations about healthcare throughout history, barriers to accessing care have consistently been a significant consideration in creating and maintaining

healthcare systems. Ancient barriers to health included 1) finances, 2) physician shortages, and 3) physical space. Finances became a barrier to healthcare as populations increased rapidly in denser populations, and although physicians did house calls, affording one was a significant financial burden (Aquilina, 2017). A shortage of physicians was another significant barrier to accessing healthcare services, as getting someone with healing expertise to respond in time to an ailment was a serious concern (Aquilina, 2017). Additionally, there was no public physical place for healing (Aquilina, 2017). The closest thing to a citizen receiving help for an ailment without financial or spiritual resources in the ancient world was if they were a soldier or a slave (Aquilina, 2017). There were infirmary-like places for these groups of people, but both groups of people were seen more as property than people. This resulted in healthcare that was focused on getting the tool that happened to be a human back to functionality for the use of the state instead of a genuine focus on healthcare access to humankind (Aquilina, 2017).

In today's world, barriers to healthcare are numerous and more identified than in ancient times. Some of these barriers include 1) diverse populations, 2) financial burdens, and 3) government resources. Access to healthcare varies from country to country because every social system allocates its resources differently (Okereke et al., 2021). Even still, diversity is increasing, and with it, the need for culturally competent healthcare throughout the modern world (Handtke et al., 2019). Despite amazing developments in some countries' healthcare systems, many still struggle with providing adequate care (Okereke et al., 2021; Osman & Bennett, 2018). Gross national income is a factor that affects the ability to provide access to quality healthcare for residents of a given country

(Okereke et al., 2021). Brazil, for example, has first-hand experience with economic recession severely impacting its healthcare system (Russo et al., 2020). Countries like Bangladesh that, similar to the United States, have a mix of private and publish healthcare coverage but have 66% of their population in rural low-income areas, have costs of healthcare that are astronomical (Osman & Bennett, 2018). For people there that are able to access public health services that do exist, coverage of costs is only about 50%, leaving most health services unaffordable and therefore not accessible to the general population (Osman & Bennett, 2018).

Christian Foundations of Hospitalization

Christianity's healthcare system is credited as a major reason for the religious widespread growth during its early centuries (Swartley, 2012). Hospitals have become primarily secular, even though their origins were rooted in faith communities (Mitchell, 2012). The current structure of hospitals has a rich history in the monastic traditions of the Christians in Egypt (Aquilina, 2017). Pachomius contributed significantly to the development of monasteries in Egypt in the fourth century that aided in caring for the ill (van Minnen, 2006). Christianity in the Western world developed hospitals through the use of monasteries as the Roman Empire began adopting Christianity (Bassareo et al., 2020). Christian monks saw a deficit in how the underprivileged sick had limited access to healthcare (Aquilina, 2017). With their foundation and focus on sharing resources for the success of all based on their Biblical convictions, the monks established an infirmary open to the public (Aquilina, 2017). Saint Basil (329 AD – 379 AD), a Christian monk who revolutionized the monastic tradition with his messages on the social responsibility of Christians, was the first Christian leader to write about the Churches calling to

healthcare responsibility (Basil & Schroeder, 2009). Basil was passionate about Jesus' teachings surrounding caring for the sick and needy, prioritizing limiting wealth resources in an anti-capitalistic way and instead sharing society (Basil & Schroeder, 2009). He advocated that social consideration, which he described as *sustainability*, was the baseline of ethics, and keeping anything for oneself beyond basic needs was taking resources that could benefit another (Basil & Schroeder, 2009). Although born into wealth himself, he advocated for restructuring systems that reinforce cycles of poverty and predatory behavior on the needy for capital gain (Basil & Schroeder, 2009). Overconsumption and hyper-competition were, to Basil, anti-Christian at their core and directly against the teaching of Jesus about how to care for the sick and in need (Basil & Schroeder, 2009). Basil accomplished this in real-time, during a famine in 369 A.D. by establishing a monastery that housed holistic health and wellness resources called the *Basiliad*, which included healthcare resources for anyone in need (Basil & Schroeder, 2009). St. Basil founded the first hospital in 369, establishing a tradition that grew to include 37,000 Benedictine monasteries caring for the ill by the mid-1500s (Elmore, 2022; Mitchell, 2012; van Minnen, 2006). Although started by Christian monks, Arab Muslims contributed to the development of hospital systems four centuries after St. Basil (Mitchell, 2012).

As hospitals' effectiveness began to be recognized, emperors and other governmental officials took an interest in expanding the services beyond the church, shifting healing away from being owned by religious communities (Bassareo et al., 2020). Public hospitals became overcrowded and problematic in the 1700s, remedied by the work of Florence Nightingale and the development of nursing (Bassareo et al., 2020).

As with many other unfortunate moments of history, religious institutions were influenced by resources, offering better treatment to those who financially contributed (Bassareo et al., 2020). The very first payment-based hospital was opened in London in 1842, with only single-bed rooms (Bassareo et al., 2020). As civilizations grew, so did the development of healthcare systems. Governments continued to get involved, and models of healthcare began to form in the late 1800s that were various combinations of charity, payment-based, privately operated, government-run, and employer-funded (Bassareo et al., 2020).

Throughout history, holistic healthcare that includes care for the body, mind, spirit, and ecology is the only kind of healthcare that is Biblical (Payne, 1985). The resources that were developed by monks and the early church were focused on meeting holistic needs for this reason (Basil & Schroeder, 2009). John Wesley was another advocate in the church's history for this kind of holistic care (Payne, 1985). When striving to understand how Christians perceive health, healthcare, and healthcare reform in the United States today, it is important to consider the broad understandings and limitations of research and discussions surrounding the topic currently. More specifically, much debate surrounds how Christians should engage with health sciences in current political climates (Hall et. al, 2010). The first hospital's roots in Christianity is an important consideration when discussing the current healthcare crisis due to its example of radical human equality, altered understandings of repayment, and establishing the foundational need for hospital institutions (Elmore, 2022).

The Current American Healthcare Climate

According to the Global Health Index (2022), the United States is one of the only countries in the world that uses a combination of free-market and government-sponsored healthcare to create a system that universally covers all, although it is not universally free. Many other countries offer universal free healthcare, and still, others have payment-centered healthcare where they do not offer anything for free (STC Health Index, 2022). Ghana and the United States stand alone in this combination healthcare system (STC Health Index, 2022). Understandably, then, healthcare in the United States is confusing for most. Unlike the system's counterpart in Ghana, the United States also operates on a state-to-state level, adding another layer of complication. Clearly, the current American healthcare system is complex, but understanding it more clearly paints a picture of its' intention versus reality. Within the exploration of this system, it is important to understand 1) the right to medical care, 2) the role of the physician, 3) barriers to healthcare, 4) government interventions, 5) American healthcare insurance, 6) concerns about healthcare, and 7) the impact of COVID-19.

The Right to Medical Care

Medical care as a basic human right is not agreed upon by everyone. Some believe that for something to be considered a right, it must be enforceable by a governmental authority (Payne, 1993). This argument would mean that if healthcare was a basic human right, it should be enforced by whatever means needed, therefore, because law enforcement does not get involved with healthcare, it would not be a right (Payne, 1993). However, there are still others that consider medical care a right due to the philosophical ethics of doing no harm and preventing harm for humankind on an innate level (Culhane-Pera et al., 2021; Meier et al., 2018). Healthcare from this worldview is a

foundational need for survival, second only to food and shelter (Cernadas & Fernández, 2021). Because of the severity of the need for healthcare from this perspective, it is important to overcome social imbalances to provide access to healthcare services to all populations (Cernadas & Fernández, 2021). For Christians, this view of the right to medical care rests in both an understanding of man being created in God's image as well as Jesus' example of healing the sick without discrimination (Basil & Schroeder, 2009; Bolger et al., 2018; Gross et all., 2018; Jo et al., 2010).

American Christians have tried to disengage from Eastern traditions with which health virtues were founded on their desire to de-traditionalize, evidenced by Americans insisting they have no tradition (Marty & Vaux, 1982). The political economy of the U.S., likely due to individualism and capitalist values imposed since its separation from Britain, has prevented health care from becoming socialized (Osman & Bennett, 2018). These truths result in a complex conundrum for the American Church and their perspective on a person's right to healthcare access.

The Role of the Physician

Determining quality healthcare must include the consideration of physicians' roles, including their duties and their acceptance of the insurance plans people are purchasing (Polsky et al., 2018). As of averages calculated in 2018, physicians accepted 100% of employee-sponsored healthcare plans, 91% of physicians were in-network for marketplace health insurance and 75% were in-network for Medicaid (Polsky et al., 2018). One-third of physicians do not accept new Medicaid patients (Polsky et al., 2018). The lower acceptance of Medicaid is linked to provider reimbursement being less than marketplace healthcare plans (Polsky et al., 2018). Although this lesser percentage paid

out to physicians helps to reduce healthcare costs for the government, it intrinsically limits access for those with Medicaid to see doctors they potentially need or want to see (Polsky et al., 2018). Appointment availability on average in 2018 for a physician was 83.3 percent for employee-sponsored insurance, 72.7 percent for Marketplace plans, and 63.3 percent for Medicaid patients (Polsky et al., 2018).

Generally, a physician's duties include diagnosing, assisting, relieving suffering, prognosticating, and potentially rehabilitating a patient (Payne, 1993). Providers are responsible for communicating to one another about shared patients (Coombs et al., 2022). Additionally, a physician aims to prevent illness and sometimes performs continued research (Payne, 1993). The communication between providers is vital for the success of the healthcare system (Coombs et al., 2022). Additionally, providers need to communicate effectively with their patients (Coombs et al., 2022). Without effective communication between providers and patients, the healthcare system cannot be effective (Coombs et al., 2022).

This is not always the perspective of the public on the duty of a physician. Many consider physicians to be healers, and as discussed earlier, physicians throughout history were often also spiritual people. Perhaps a more fitting role for physicians is one of a reliever rather than idealizing them as healers (Payne, 1985). Not too long ago, iatrogenic diseases resulted from about 9% of surgical outcomes (Payne, 1985). These physician-caused complications go directly against the Hippocratic oath, a concern not to be taken lightly in the medical field (Payne, 1985). This paints a cautionary tale for the pressure that is put on physicians and their role in the healthcare system.

America is obsessed with the glorification of the youthful body, which often elevates physicians beyond their capacities (Payne, 1985). This mindset pushes the agenda that healthcare is designed to overcome death and aging, promoting resentment about sickness and finitude from anything aside from youth (Payne, 1985). Physicians within a profit-based healthcare system are also frequently linked with higher-ups in hospitals and healthcare systems that are focused on making money, not necessarily making decisions that benefit the healthcare consumer first (Coombs et al., 2022). The hypocritic oath is a reminder that physicians are also limited in their power, although their responsibility to do no harm goes far beyond the physical. This is important to consider within the discussion of the healthcare system.

Barriers to Healthcare

Healthcare barriers have been consistently debated within the American cultural climate for decades. The healthcare market is constantly changing and evolving, making it even more challenging to navigate for consumers, resulting in unequal access to care (Choi et al., 2020; Coombs et al., 2022; Russo et al., 2020; Snowden et al., 2023). The debate regarding the ethics of for-profit healthcare systems runs rampant within American healthcare discussions (Coombs et al., 2022). Geography, racial and cultural concerns, insurance availability, and ableism are some of the most consistent issues contributing to American healthcare access (Choi et al., 2020; Coombs et al., 2022; Matin et al., 2021; Rachoin et al., 2021). Access to healthcare can be understood within the five dimensions of 1) approachability, 2) acceptability, 3) availability, 4) accommodation, and 5) affordability and appropriateness (Levesque et al., 2013). Within these dimensions are conversations surrounding transportation complications for communities to physically

access services, communication difficulties between patient and provider, healthcare costs, and lack of healthcare education for various populations (Coombs et. al, 2022; Matin et. al, 2021). The American identity of rugged individualism also can become a barrier to healthcare being accessible for all, as this influences a capitalistic, free-market healthcare system rather than one that is universal (Coombs et al., 2022; Osman & Bennett, 2018). Capitalist societies with market-driven healthcare systems like the United States become increasingly unsustainable, which ultimately leads to a healthcare crisis (Swartley, 2012). Improving some of these barriers includes providing more access physically, mentally, and emotionally using things like patient education, physical transportation services, holistic care clinics, and extended hours of services (Culhane-Pera et al., 2021). Examining the previous barriers within American healthcare under the light of Levesque et al. (2013) provides a framework for understanding these obstacles, however, it is important to acknowledge them in detail.

Cost

Gross national income affects the ability of countries to provide access to quality healthcare for residents of that country (Okereke et al., 2021). Most Americans can only afford suboptimal care, even though the United States invests highly in its healthcare system (Osman & Bennett, 2018). Unmet healthcare needs are more common for high economic inequality populations (Tumin et al., 2018). The identification of high healthcare costs and limits to access have been prevalent for a very long time (Payne, 1993). Jacobs et al. (2021) estimate that in 2019 these combined healthcare costs would account for at least a quarter of a middle-class family's income. This is more than the family average spending on food or transportation costs (Jacobs & Hill, 2021). The

family cost that has the potential to be higher than combined healthcare costs in 2019 would be a housing cost, averaging 21.5-30.8 percent of income (Jacobs & Hill, 2021). Incomes increased at a rate of close to 5% between 2015 and 2019, however, Marketplace healthcare premiums rose at rates of at least 49% (Jacobs & Hill, 2021).

The cost of health services for those without health insurance is unaffordable for many different populations (Adekeye et al., 2018; Hamilton et al., 2022). Preventative health is often out of the question for those who would need to pay out of pocket due to the costs of services being too expensive or even not communicated before services are rendered (Adekeye et al., 2018). Healthcare costs have to be weighed against other basic needs like food and shelter for these populations (Choi et al., 2020).

Adults ages 50-64 without health insurance are 7 times more likely to neglect regular healthcare appointments (Choi et al., 2020). Only 15% of uninsured adults in this age range sought out preventative healthcare services (Choi et al., 2020). Because Medicare does not begin until someone reaches age 65, older adults that do not qualify for disability services are left uncovered for healthcare and therefore are left in states of poverty (Choi et al., 2020). Health advantages go to people with more income, education, and employment as they more often have better access to healthcare resources (Tumin et al., 2018). Rachoin et al. (2021) found that patients with Medicare, Medicaid, or self-pay did not receive the same treatment for health conditions as those with private insurance.

Another consideration cost rests in the capitalist economy foundation of medical practices (Payne, 1985). Medication is formulated and advertised to physicians, costing drug companies money. However, this has not been known to significantly increase physician use of the medication, resulting in wasted funding resources (Payne, 1985).

Additionally, medications are advertised on television and in other ways as free-market strategies, costing money, and therefore increasing consumer cost and access. The chronically and terminally ill are marketed to by drug companies in order to gain profit (Swartley, 2012). Even those that can financially afford healthcare insurance still find themselves struggling financially to afford services (Tumin et al., 2018). Although there have been some recent attempts to decrease medication barriers, it can still be a significant barrier for people in need (Gellad & Hernandez, 2022).

Rurality & Misplaced Populations

The geography of a person's location is also a concern for accessing basic healthcare for many families living in less populated areas or where healthcare services are not nearby (Rachoin et al., 2021; J. Smith et al., 2019; Tumin et al., 2018). The more rural someone lives, the more likely the challenges for accessing care (Culhane-Pera et al., 2021; Rachoin et al., 2021; J. Smith et al., 2019). Rurality makes it especially hard for those with disabilities to access care and receive care that is high quality (Hamilton et al., 2022). Community economic inequality also impacts access to healthcare since lower levels of social capital influence result in lower financial investment in public services that include healthcare resources (Tumin et al., 2018). Although lack of physical access is a clear concern within rural healthcare systems, providers within these communities do consider the more intimate setting and reduced patient volume as benefits to the quality of care (Kueny et al., 2020). Coombs et al. (2022) present research from a provider perspective from rural populations, highlighting that providers in these populations have very limited time for in-depth care of patients due to the number of patients per provider in rural areas. Understanding provider needs in rural populations conflate barriers to

healthcare access for the communities (Kueny et al., 2020). Resources are also scarcer in rural populations, something that was exacerbated during the COVID-19 pandemic as hospitals become the place of primary healthcare for rural communities (Coombs et al., 2022; Kueny et al., 2020; Nataliansyah et al., 2022; J. Smith et al., 2019).

Homelessness or being a member of a misplaced population is another barrier for healthcare. Throughout many parts of the world, unhoused populations do not always have documentation for their identities which can limit them to receiving care (Cernadas & Fernández, 2021). In many parts of the world, vulnerable populations in urban areas live in slums where there is little, if any, access to healthcare (Teixeira de Siqueira-Filha et al., 2021). While many countries in developing Asia have made remarkable progress in expanding access to public services in recent decades, there remain large disparities in access across the region, and when care is available, the quality of services is generally very poor (Osman & Bennett, 2018). Even within systems with universal free healthcare, the unhoused and misplaced populations are not always included (Cernadas & Fernández, 2021). Homelessness is culturally viewed in different ways and comes with certain stigmas, often leading to fewer resources for homeless populations and less willingness to be involved with community members (Cernadas & Fernández, 2021). Beyond healthcare needs, unhoused populations require basic needs of shelter and food arguably before health can even be addressed (Adame et al., 2020). In an effort to address some of the specific holistic needs of this population in America, a program called Housing First was developed in the State of Washington that aims to provide access to healthcare for homeless populations by providing safe and stable housing followed by other met needs, and its success has been widely admired (Adame et al., 2020). Research shows programs

like this create more than just temporary solutions by also promoting lasting community and connection for vulnerable populations, laying a foundation for moving forward with healthcare needs from a different angle than public healthcare alone (Adame et al., 2020).

Employment Status & Age

Occupational stress can lead to many health-related short and long-term physical and mental problems (Sinclair et al., 2020). Although some jobs come with healthcare benefit access, certain professions such as family farms or other self-employment jobs have limited access to healthcare through their workplace (Berkowitz et al., 2021; Silver et al., 2022). As of 2021, 10% of the U.S. labor workforce was self-employed, with numbers consistently increasing, requiring most if not all of that population to find healthcare access outside of their employment (Berkowitz et al., 2021). While many employed people are offered healthcare plans through their jobs, self-employed people often do not have the same resources (Berkowitz et al., 2021). For example, farm households have higher health-related financial risks than the general population due to the percentage of uninsured farming families (Miller et al., 2023). Most farming households have a spouse employed away from the farm to create healthcare options given that most farms are self-employed (Miller et al., 2023). As demonstrated within the farming community, bigger self-employed businesses with profit margins in the mid 6 figure range are much more likely to acquire healthcare for those involved with the business as there are generally other employees involved (Miller et al., 2023). Without a big enough business structure, however, nuclear families often split for one partner to work a job elsewhere that offered health insurance the whole family can be listed under. Farmers who have one operator or spouse doing off-farm work are 4% more likely to

report employer-sponsored health care coverage (Miller et al., 2023). Some self-employed people, however, do not have the option for another family member to work where family health insurance is offered (Berkowitz et al., 2021). Berkowitz et al. (2021) found that self-employed people are more likely to prolong medical care due to being uninsured, which can have a long-term impact on higher medical costs later in life (Berkowitz et al., 2021). Self-employed people, therefore, often have to have other resources outside of their jobs to provide healthcare insurance. Single individuals over the age of 26 with self-employed business or other workplaces that do not offer healthcare access are even more limited in this way as they have aged out of their family of origin's healthcare plan and do not have a legal partnership of their own to rely on for healthcare coverage.

Older adults that lose their job struggle to find employment again, often leaving those that do not qualify for Medicare or disability struggling to afford healthcare access (Choi et al., 2020). Unemployment has been linked to adverse health outcomes, especially for populations that were unable to work (Silver et al., 2022). Short-term unemployment is associated with difficulty with healthcare access because it often lands people in a gap of qualifying for public services while no longer being covered by private employment-based insurance (Silver et al., 2022). Virtual healthcare tools have been utilized with populations that experience barriers such as employment given that they reduce costs for providers (Abdel-Rahman, 2021). However, it has been shown that the older the patient, the less likely they are to utilize virtual services (Abdel-Rahman, 2021). When unemployed people struggle to maintain their health and well-being, it can be challenging for them to stay healthy enough to find a new job, often creating a cycle of

unemployment (Silver et al., 2022). The Consolidated Omnibus Budget Reconciliation Act (COBRA) exists for those that become unemployed while having benefits through work for up to 18 months past employment (Silver et al., 2022). However, it does not follow the same pay structure as coverage would have when working, therefore, the loss of income from the loss of a job often complicates access to COBRA for the unemployed as many cannot afford the price tag (Silver et al., 2022). Similarly, when an unemployed person qualifies and is utilizing Medicaid services and then get a job, it sometimes hinders healthcare access again if the job does not offer employer-sponsored healthcare, creating a disincentive to work for many that might be capable of working (Silver et al., 2022).

Racial Barriers

Unfortunately, endemic racism within American culture has demonstrated previously that cultural differences do play a foundational role in access to healthcare (Coombs et al., 2022; Yearby, 2018). Unequal treatment between minority and majority patients has been presented in the literature for many years (Rachoin et al., 2021; Yearby, 2018). This discussion includes minorities of many different kinds; however, different minorities face a variety of concerns with barriers to healthcare (Rachoin et al., 2021). For example, among Latinx undocumented people, barriers in accessing healthcare include 1) difficulty in making the decision whether or not to seek care, 2) identifying location and transportation to healthcare locations, and 3) receiving appropriate and quality healthcare from providers (Doshi et al., 2020). Overall, there is little research conducted with first-generation immigrant populations, resulting in biased healthcare for sub-racial groups (Adekeye et al., 2018). There is a fear of past horrors and injustices

within certain populations and the healthcare industry, including the risk of deportation of undocumented people and historical medical experimentation on other minority groups including Black Americans (Culhane-Pera et al., 2021; Doshi et al., 2020; Snowden et al., 2023). Disparities due to the Jim Crow laws, the lack of support during the 1918 Spanish Flu pandemic, and being used as guinea pigs during syphilis scares have made many within the Black community distrustful of medicine (Louis-Jean et al., 2020; Snowden et al., 2023).

Racial trauma contributes to the lack of trust in the system even in attaining healthcare through the marketplace (Culhane-Pera et al., 2021; Snowden et al., 2023; Yearby, 2018). Gathering race information from Marketplace users is challenging as many consumers choose not to disclose that information (Sorbero et al., 2022). From the data that has been collected, there has been a significant disparity in White versus Black Americans' use of the Healthcare Marketplace (Snowden et al., 2022). Since the ACA, African American enrollment in the healthcare marketplace rose 8.2 percent, significantly decreasing the gap in coverage acknowledged between these groups (Snowden et al., 2022). This increase has been increased by the ARPA due to the expansion of tax subsidies for various income groups (Snowden et al., 2022). The accessibility for Black versus White Americans has consistently been an issue throughout American history (Yearby, 2018). Past research has shown, however, that there are important health differences between African-born Black immigrants and African Americans, although these populations often get blended into one group during research and healthcare interventions (Adekeye et al., 2018). Nevertheless, Black minorities have been funneled into particular neighborhoods using racist home lending procedures since the Jim Crow

era (Yearby, 2018). Segregation within neighborhoods results in healthcare systems that are also segregated and underfunded, rippling into the closing of resources funded by tax dollars if those tax dollars are less, which is seen in minority communities (Yearby, 2018). These unequal structures continue to exist, perpetuating the racial barriers for minorities to access healthcare services within the healthcare system (Yearby, 2018).

Cultural differences are drastically important to respect as a provider, something that some providers have more experience in than others (Coombs et al., 2022). Thaddeus & Maine (1994) summarize the racial barriers present regarding healthcare as 1) the political climate and therefore the impact of seeking care given cultural factors, 2) the accessibility of services impacts identifying and reaching appropriate services that are needed, and 3) the quality of care differs within cultural barriers. Providers' perspectives have seen racial barriers include fear of enforcers of the law especially when considering undocumented patients, costs, presents of local police, transportation, language and cultural barriers, facility cultural norms and environment, and cultural normalcy to seek care. Yearby (2018) makes it clear that racism within the health system is shown in literature repeatedly on systematic and local levels, and without addressing larger-scale racism, the barriers to healthcare that are race-induced will continue on.

Healthcare Literacy & Disabilities

There are different levels of skills in navigating the healthcare system (Haggerty et al., 2020). One of the skills needed for the navigation of the healthcare system is health literacy. Health insurance literacy is a huge concern surrounding issues of American health care because of the consistent changes in policy as well as the vast number of options for consumers to choose (Chen & Page, 2020; Culhane-Pera et al., 2021). Health

literacy is especially low in rural and undereducated communities (Kueny et al., 2020). Many Americans do not understand the differences between deductibles, premiums, or other healthcare insurance-related terminology (Chen & Page, 2020). Those with high health literacy skills will be able to navigate the system, while those with low skills might struggle and therefore have less access (Haggerty et al., 2020). Socially vulnerable people might struggle to have enough skill to navigate the healthcare systems (Haggerty et al., 2020). 50% of uninsured people who qualify for insurance report unfamiliarity with how insurance policies or structures work, influencing their ability to attain insurance accurately (Snowden et al., 2023). Therefore, it is important that clinics are as transparent as possible with how their system works, the explanation of healthcare procedures and operations, and diagnoses management (Culhane-Pera et al., 2021).

Disabilities, or differing abilities, is another factor to consider. There are three themes when considering barriers to healthcare for people with disabilities including 1) lack of patient-centered quality care, 2) bad communication that marginalizes patients, and 3) accessibility issues both physically and systematically for navigation of the healthcare system (Hamilton et al., 2022). 25.6% of adults in the United States have a disability (Hamilton et al., 2022), while 15% of the world's population lives with a disability (Matin et al., 2021). Almost half of those with disabilities in the United States rate their health as fair or poor as compared to less than 10% of nondisabled adults (Hamilton et al., 2022). The common issues for access to healthcare for women with disabilities include sociocultural issues, financial issues, and structural issues (Matin et al., 2021). Some patients in this population need more time with doctors to understand or communicate their health needs (Hamilton et al., 2022). Communication difficulties are

common as are gaps in follow-up and preventative care and a lack of collaboration in care between doctors or specialties (Hamilton et al., 2022; Matin et al., 2021). The physical body language of patients is important for doctors to consider as it may look different from abled-body patents, and the lack of explanation or clarity of communication from doctors can also pose a problem for patients if they misunderstand information about their health (Hamilton et al., 2022).

Women with disabilities are particularly more vulnerable to difficulties with access to quality healthcare. 60% of those with a disability worldwide are women (Matin et al., 2021). Even as the majority, women with disabilities are more likely to have unmet healthcare needs, low income, poor education, and low-quality healthcare, leading to overall poor health (Matin et al., 2021). The education gap for professionals is vast, especially around sexual health concerns, for women with disabilities across physical, mental, and psychological disabilities (Matin et al., 2021). Income and limited health literacy are huge barriers for this population to access proper resources (Matin et al., 2021). The knowledge of health issues and concerns for women with disabilities often comes from family and friends instead of healthcare professionals because providers do not always take, or perhaps even have the time to educate patients with disabilities (Matin et al., 2021). There is a call for the improvement of infrastructure around healthcare to facilitate access for this population, including the inclusion of women with disabilities within policy change discussions (Matin et al., 2021).

Overall, biases are plausible and present for many of the aforementioned barriers of cost, rurality and misplaced populations, employment status and age, race, and healthcare literacy and disabilities as they connect with different people groups or life

situations (Cernadas & Fernández, 2021). Dehumanization and judgment get in the way of populations in need receiving healthcare services (Cernadas & Fernández, 2021). These barriers, although some more than others, are well-documented reasons there are consistent changes in the healthcare industry, as needs are consistently aiming to be met.

Community & Government Interventions

Surveys suggest the U.S. resourcing of healthcare lags behind other developed nations in quality, nationwide access, and government intervention (Osman & Bennett, 2018). The U.S. has one of the highest financial investments in healthcare compared to many countries and is capable of top-quality care, and yet, healthcare satisfaction is not equivalent to other countries (Osman & Bennett, 2018). This difference can be seen as an injustice, as public health is understood more and more to be an issue of social justice (M. Smith et al., 2019). The World Health Organization (WHO) established three core features needed for health services that include 1) accessibility, 2) acceptability, and 3) appropriateness (Rickwood et al., 2019). Countries around the world have applied these features in different ways (Rickwood et al., 2019). For example, Australia has developed a youth-oriented mental health service that utilizes both in person and online services which has grown and developed since 2007 (Rickwood et al., 2019). In Bangladesh, the government utilizes health complexes in rural communities in efforts to increase accessibility (Osman & Bennett, 2018). Health fairs and community health workers are additional resources countries throughout the world to meet the core features outlined by WHO (Ballard et al., 2022). These kinds of services offered vary worldwide, pointing to the need for these systems to be acknowledged within their cultural contexts and that WHO's features might look different within different contexts (Rickwood et al., 2019).

Success with community outreach that includes all populations requires collaboration with existing community resources, including homeless shelters and other organizations that serve vulnerable populations (Cernadas & Fernández, 2021). As an example, past research has found effective community interventions involving health fairs (Adekeye et al., 2018). These health fairs were hosted at medical centers and included over 800 health screenings, including cholesterol, blood pressure, blood glucose, and Body Mass Index (Adekeye et al., 2018). Health fairs can be successful for providing access to communities that have barriers to health services (Adekeye et al., 2018). Another resource being utilized through the the world in countries including Togo, Mali, Kenya, Malawi, Uganda, Kenya, Guatemala, Nepal, and Pakistan is Community Health Workers (Ballard et al., 2022). Community Health Workers (CHWs) are people within the communities that strive to build rapport in order to be a resource of health education and bridge some of the gaps of basic healthcare needs in communities that are in need (Ballard et al., 2022; Javanparast et. al, 2018). CHWs, as they have been helpful throughout the world (Ballard et al., 2022), are a potential resource for increasing access to healthcare in higher-income countries that still have gaps in healthcare accessibility but require collaboration with providers for success in healthcare interventions (Javanparast et al., 2018).

Within the United States, The Affordable Care Act (ACA) helped households with incomes of 100-400 percent of the federal poverty level without employee-sponsored medical insurance and who do not qualify for Medicaid by offering tax subsidies via the marketplace healthcare insurance plans (Osman & Bennett, 2018; Polsky et al., 2018; Snowden et al., 2022). The ACA ensured that companies with 50 or

more employees were mandated to offer healthcare coverage options through employee-sponsored healthcare plans (Snowden et al., 2022). Cost sharing reductions were also used to help with out-of-pocket expenses for Marketplace consumers with incomes up to 250 percent of the federal poverty level (Snowden et al., 2022). The ACA has been increasingly helpful in continuing to build a foundation for policy changes that make a difference, however, there is much still to do as many people are still uninsured (Buehler et al., 2018; Snowden et al., 2022). More recently, tax credits have become available to households who qualify, which help to make insurance premiums more affordable and provide more overall access (Larson et al., 2020). However, marketplace insurance members still struggle to predict copays and deductibles making the system challenging to navigate and plan appropriately for (Larson et al., 2020).

Community health centers (CHCs) in the United States have provided care to underserved communities since 1965 (Larson et al., 2020). These underserved communities often include people who have income below the federal poverty level (Larson et al., 2020). The system can be effective when hospitals and community health workers work together (Suran, 2022). CHWs can also see people in their homes and environments and provide important problem-solving skills that hospitals and doctor visits cannot (Suran, 2022). The Affordable Care Act expanded CHC's in some states including a decrease in uninsured individuals by more than 40% (Larson et al., 2020). CHC's rely on revenue from Medicaid and grant funding; more specifically, in states with lower funding CHE are more funded by grants (Larson et al., 2020). A public board exists to govern federal centers; however, most of these boards are staffed with

politicians and health professionals, reducing the public interest in favor of siding with the centers (Osman & Bennett, 2018).

On March 11th, 2021, President Biden signed the American Rescue Plan act into law, which aided Americans with financial burdens during the COVID-19 pandemic (Jacobs & Hill, 2021; Snowden et al., 2023). For healthcare, the act added tax credits to silver insurance plans for the years of 2021 and 2022, helping reduce the costs of insurance premiums (Jacobs & Hill, 2021; Snowden et al., 2023). Insurance premiums for the middle-class of Americans purchasing healthcare from the marketplace in 2019 were at least 11.3 percent of family income, increasing based on factors of age and healthcare needs up to over 20 percent of income (Jacobs & Hill, 2021). In order to understand how these government and community interventions function within the greater healthcare system, it is vital to discuss the various health insurance options that Americans and other living in the United States have access to.

American Healthcare Insurance

The American healthcare insurance system is complex, involving many different individual, company-sponsored, provider-sponsored, and government-sponsored plans (Payne, 1993). Within each healthcare plan offered, there are countless combinations of premium payments, deductibles, co-insurance, co-pays, or out-of-pocket experiences for the insured person or people. Some insurance options include private insurance, Medicaid, Medicare, Veteran options using a Veteran's hospital or Tricare, or health-sharing services, but many of these services have specific qualifications that need to be met to access them (Choi et al., 2020). Other healthcare resources involve non-profit organizations, cost-sharing options, or private pay. In 2021 over 15.3 million Americans

used the free-market system called the healthcare marketplace to purchase healthcare insurance (Cai et al., 2022). The healthcare marketplace is used when people do not have access to healthcare insurance through their place of work, nor do they qualify for government programming directly. Due to high deductibles and out-of-pocket costs, many people are still unable to afford healthcare even amidst the various insurance options (Tumin et al., 2018). Understanding the structure of how people pay for healthcare resources is an important element of understanding the nuances of the American healthcare system as a whole.

Terms of a Healthcare Plan

Although there are many variables to the dynamics of a health insurance plan, it is helpful to understand the common terms that describe areas of payment for the consumer to exemplify its complexity. A *deductible* is a cost for services an individual will pay before insurance pays the percent agreed upon. This cost is above and beyond the monthly fees for insurance called an insurance *premium*. Once a deductible is met, an insured person would financially still be responsible for their monthly premium as well as whatever co-pay or co-insurance was decided in the chosen plan. A *co-pay* is a flat rate, while a *co-insurance* is a percentage of the service. So, for example, if a person has a plan with a co-pay of ten dollars for their primary care doctor, they will generally pay this amount when they visit. If they had a 20% co-insurance, they would owe 20% of whatever amount the provider is receiving for the visit overall. The exceptions to this would be if the person has not paid their deductible in full, they would owe the full amount of the visit if they were using a service that is an exception to their deductible, or if they have reached their out-of-pocket maximum payment. Obviously, as demonstrated

here, it is understandable how the system requires a certain level of health literacy and guesswork to truly know how much a healthcare service will cost a patient.

Average deductibles for health insurance plans have increased consistently since 2010 (Chen & Page, 2020). Higher deductibles and higher healthcare costs from the insurance plan perspective are aimed at reducing the use of unnecessary healthcare spending (Chen & Page, 2020). Although this can promote a decrease in truly unnecessary spending, high deductibles discourage preventative or necessary care which might contribute to long-term health issues and health disparities related to income resources (Chen & Page, 2020). High deductible health care plans may result in less acceptability from providers as payment for services that are higher risk services (Chen & Page, 2020). High-deductible plans typically have lower monthly premiums for healthcare insurance (Chen & Page, 2020). In previous studies, high deductibles were found to increase unmet needs, which over time increased overall hospitalizations (Chen & Page, 2020). High-deductible healthcare plans disproportionately affect low-income and chronically ill patients (Chen & Page, 2020).

Lower premiums connected to higher deductible plans often result from tax credits and/or cost-sharing (Chen & Page, 2020). Healthcare premiums are only the beginning of healthcare costs, however, as insurances have co-pays, co-insurance, and deductibles (Jacobs & Hill, 2021). Individuals from the highest deductible group were less likely to have consistent and preventative care, consistency with their general doctors, and assurance that their insurance would be accepted (Chen & Page, 2020). High-deductible healthcare plans and marketplace healthcare insurance were connected to the likelihood of unmet healthcare needs and difficulties financing medical bills (Chen

& Page, 2020). Higher deductible plans were strongly associated with a lower likelihood of satisfaction when users were surveyed in 2016 (Chen & Page, 2020). With a general understanding of the complex payment structure of healthcare plans, it is important to explore the various types of insurance options within the United States.

Types of Insurance

Throughout many of the options referenced below, it is important to note that there are different kinds of insurance plans within the type of insurance. The two major organizational types of insurance plans offered are *Preferred Provider Organization,* or *PPO,* and *Health Maintenance Organization,* or *HMO* (Cai et al., 2022). Generally, if someone has PPO insurance, they can make an appointment directly with a specialist doctor without seeing their general doctor first. Alternatively, someone with HMO insurance usually needs a referral from their general doctor in order to see a specialist. These organizational types of healthcare bridge some categories of healthcare described below and reference the referral structure of an insurance plan.

Company-Sponsored Insurance

Company-sponsored health insurance is known to be health insurance gained as a benefit of working for a particular company that offers it as an option to their employees. The company is vertically integrated with insurance companies and chooses particular plans to "sponsor", or pay a percentage of the cost, so that employees are paying less than they would elsewhere (Cai et al., 2022). In practice, this looks like an employee working for a certain amount of time with a company, and then receiving a benefits package through their company with the insurance company options and plans for the employee to pick from. Some popular companies are Blue Cross Blue Shield, Aetna, United, and

Cigna, although employers will choose which companies to sponsor and therefore actual offerings to employees is often more limited. Alternatively, some companies will have employees fund their insurance through another means such as the marketplace or a private company that acts as a middleman for insurance companies and small businesses, but the employer will reimburse the employee for a percentage of the cost.

Provider-Sponsored Insurance

Provider-sponsored insurance plans are plans that are offered within a specific provider network (Cai et al., 2022). A clinical entity, such as a hospital, physician group, or health system, collectively offers services and manages the insurance organization. One of the well-known provider-sponsored healthcare insurance is Kaiser Permanente. Their insurance is offered within their own network with their specific team of doctors. The benefits of this kind of insurance include financial agreements between providers, ease of access to shared medical records, and higher levels of collaboration between providers.

Marketplace Insurance

Numbers of enrollment in the Healthcare Marketplace greatly vary from state to state from 20 percent to 70 percent of all eligible people (Snowden et al., 2022). Some of the variations comes from the state government's acceptance and marketing of the Marketplace healthcare options (Snowden et al., 2022). In 2016, almost 90% of marketplace enrollees had a high deductible healthcare plan (Chen & Page, 2020). Marketplace healthcare insurance consumers are more likely to have problems finding a doctor, getting an appointment, or having their insurance accepted (Chen & Page, 2020). The Marketplace has had previous criticism about the lack of minority-awareness,

considering and involving various stakeholders and community resources in decision-making for Marketplace healthcare offerings in order to succeed (Snowden et al., 2022).

Government-Sponsored Insurance

There are many different types of government-sponsored healthcare options throughout the country, many differing based on location, socioeconomic status, military service, or ability. Options within this umbrella would include services like Medicare, Medicaid, State-Funded (i.e., Medical in California), Veteran Association (VA), disability insurance, and Tri-Care. The Medicare system pays for 1 in 5 healthcare dollars (Suran, 2022). Medicare partners with 6,000 hospitals and has many different levels within it, described as parts (Suran, 2022). Each part of Medicare relates to different coverage options (Suran, 2022). The current goals of Medicare are to 1) advance health equity which would allow socioeconomic status and identity to not prevent people from accessing quality care, 2) organization capacity, 3) rural community focus by increasing residencies in rural communities as it allows for doctors to learn about these communities and populations and therefore be an asset where there is need, 4) permanent payment for telehealth and audio only health increases access for vulnerable populations, and 5) prioritize holistic health models (Suran, 2022). For the existing public healthcare, governing boards are full of politicians and health professionals, creating gaps and distance between lofty ideals of public healthcare and practical application, leaving plenty of room for continued restructuring of the system (Osman & Bennett, 2018).

Non-Profit Involvement

There are some non-profit or grant-funded healthcare centers that do not require health insurance for people to receive services. The goal of nonprofit hospitals centers on

the idea of providing care to the needy with either free or discounted services (Burani, 2021). There is debate surrounding how grounded in charity some of the nonprofits around the US actually are, and therefore needed research to determine nonprofit hospital effectiveness (Burani, 2021). Nonprofit healthcare organizations make up about half of the US total healthcare employment, however, previous research has showed a significant gap in how much charity services are actually being offered (Burani, 2021). Nonprofit hospitals are eligible for a tax-exempt status, but without a specific definition for how much charity is required, there is room for inconsistency in charitable effectiveness.

Nonprofit health services often are associated with higher patient satisfaction and quality of care (Cai et al., 2022). Examples of these places would include grant-funded non-profit healthcare centers such as Open Door Community Health Centers on the East Coast, and Lawndale Christian Health Center in Chicago. These organizations are often on a local scale. Burani (2021) developed a model that demonstrates the complicated relationships between nonprofit effectiveness, charity distribution, and worker compensation. Overall, it was found that organizations with a labor force that focuses on a mission-orientation to their work were able to give the most charity services possible, as those workers accepted a lower wage to fulfill the organizational mission (Burani, 2021). There is still much needed in-depth exploration of the effectiveness of nonprofit healthcare organizations in the present day, as the gap in Americans getting healthcare continues to exist even with nonprofit resources.

Other Alternatives

Since health insurance is not mandatory as a citizen of the United States, some people choose not to enroll in any health insurance, instead paying individually as private

pay patients. Additionally, there are some groups of people who have established cost-sharing programs that are privately operated. Examples of these would be CrowdHealth or Medi-Share. These options work as private pay within appointments, however, a patient can submit medical bills to the organization or group and they reimburse based on their agreed-upon rules for reimbursement.

Healthcare Insurances Concerns

Even with all of the options previously mentioned, health insurance is unpredictable in its nature (Payne, 1993). Healthcare insurance is unique from other kinds of insurance due to its subjectivity, reliance on the doctor's discretion of treatment modality as well as the patient's report of ailments (Payne, 1993). It can be almost impossible to predict the cost of procedures, if the insurance plan with cover the procedures, and if they do, what percentage will be left for the patient to pay (Payne, 1993). Understanding the vast amount of healthcare coverage options that change can change with every president is complicated for the average citizen, much less for those a part of populations that are particularly vulnerable (Choi et al., 2020). There is a large gap between people with healthcare insurance and those without in terms of their healthcare needs being met (Choi et al., 2020). Technology can be helpful, but patient-centered telehealth care does not always include patients with disabilities or other populations that face barriers (Hamilton et al., 2022).

The Impact of COVID-19

Discussion of the impact of the COVID-19 pandemic is foundational to understanding both triumphs and pitfalls within the American Healthcare system. However, it is important to remember that the COVID-19 pandemic is still being

understood, and its long-term impact is still unclear. Developments are continuing day by day. Therefore, this discussion will be understandably limited and will focus on how it has impacted the healthcare system overall and within the church between the years of 2020 and 2022.

To this point, there have been 103,672,529 COVID-19 cases and 1,119,762 deaths in the United States alone (CDC, 2023). Dying from a COVID-19 infection is consistently higher if a person lives in a non-metropolitan or rural area, are a member of a highly vulnerable community, are uninsured, or have a lower socioeconomic status (CDC, 2023; Louis-Jean et al., 2020; Teixeira de Siqueira-Filha et al., 2021). At the beginning of the COVID-19 pandemic, most people were in agreement between political parties about how communities should respond to the spread of the virus. As time went on, there became a bigger political divide with how people responded. Providers offered low-quality care in the past because they have not been incentivized to do otherwise (Bhatia et al., 2021). The pandemic challenged this as any medical treatment raised potential risk of exposure, allowing for a new cost/benefit analysis for providers in giving care versus exposing themselves (Bhatia et al., 2021; Hellman, 2022).

Face masks were found to be an important way to slow the spread of the virus, but production was not keeping up with demand. Likewise, hand sanitizer and cleaning supplies were scarce, leaving medical staff under-resourced, much less people at the community level (Bhatia et al., 2021). Those who needed care could not always get it, and during the worst of the infections, many people were being turned away or left in hospital hallways as no space was available in rooms. The risk of getting covid-19 with physical contact has allowed for many people to only seek care when absolutely required

(Bhatia et al., 2021). Understandably with the reduction in the socialization of people, ambulatory care visits decreased by 40% during the COVID-19 pandemic (Bhatia et al., 2021).

Populations that faced barriers to accessibility of healthcare insurance were increasingly highlighted during the COVID-19 pandemic (Coombs et al., 2022; Hsu et al., 2022; Okereke et al., 2021; Teixeira de Siqueira-Filha et al., 2021). In fact, due to the severe amount of job loss surrounding the pandemic, many more people faced barriers to accessing healthcare than was recorded previously (Coombs et al., 2022). Larger percentages of African Americans work in retail, home healthcare, mass transit, factories, or jails where social distancing is significantly more difficult, resulting in higher rates of infection as well as deaths from COVID-19 (Louis-Jean et al., 2020). Throughout the world, vulnerable populations with little access to healthcare services before the pandemic were even more underserved, leading to some of the highest fatality rates in the world (Okereke et al., 2021; Teixeira de Siqueira-Filha et al., 2021).

In efforts to reduce the spread of the virus for those with insurance, active use of online platforms for healthcare services became increasingly recommended or in some cases, exclusively offered (Bhatia et al., 2021; Hsu et al., 2022; Perrin et al., 2020). Insurance companies were suddenly faced with the dilemma of covering telehealth services, as many previously opted out of covering virtual healthcare services (Bhatia et al., 2021; Perrin et al., 2020). Virtual healthcare has been in existence since the 1970s, although it was not used widely until the pandemic despite the significant increase in technology (Bhatia et al., 2021). Some of the pre-covid barriers to virtual care were medical licensure concerns, payment options, and physician hesitation (Bhatia et al.,

2021). Insurance companies made short-term exemptions to the non-coverage of telemedicine visits, although many did not communicate if or when that coverage would end post-pandemic (Perrin et al., 2020). This has caused confusion in the current healthcare climate as some plans cover telehealth and some have stopped this coverage. Although telehealth services provide resources to people without the risk of spreading infectious diseases, there are risks for providers of overmedication or missing other important aspects of care that would be only noticed in person, thus allowing for different risks with virtual care (Bhatia et al., 2021).

The barriers that are consistently seen within the COVID-19 data, even three years after it first broke out in the United States, clearly resemble known barriers to healthcare in the country as a whole. Although these barriers have been consistent for many years, COVID-19 quickly highlighted these gaps in healthcare and left many people longing for drastic change to the entire system. It is clear that these barriers have not drastically been altered, and although infections and deaths from COVID-19 have decreased, trends in the gaps of the healthcare system's response in America remain.

The American Church and Health

Protestant Christianity pushes back significantly on the natural connection between health and faith traditions across cultures and time (Marty & Vaux, 1982). Protestant Christianity in Western cultures prioritizes individualism, a construct that creates conflict between faith and health (Hotz & Matthews, 2012). With over 200 different denominations of Christians, it is easy to conclude conflicts on various issues arise including faith and health (Marty & Vaux, 1982). Two of these divisions happened between the mindset of Martin Luther and John Calvin, which paved the way for two

drastically different understandings that result in Western individualistic Christianity (Marty & Vaux, 1982). Although there are some various beliefs, most agree that spiritual care is important for holistic healthcare (McDowell & South, 2017). Lack of spiritual care was seen specifically identified by patients who are also healthcare practitioners (McDowell & South, 2017). Holistic healthcare incorporates body, mind, and spirit (McDowell & South, 2017). Being healthy means on all of these levels (McDowell & South, 2017).

As with many elements of the topic at hand, however, there are conflicting views. For the purpose of this study, it is beneficial to explore 1) educational perspectives of the Church's role in health, 2) the relationship between the government and the church, 3) racial differences between American churches in addressing health, and 4) church leadership perspectives across racial and cultural church contexts. Pastors are central leaders in local communities, especially when considering minority and under-resourced communities (Gross et al., 2018), therefore, understanding pastoral perspectives is vital for assessing church involvement in the healthcare system.

Educational Understandings of Faith and Health

Roberts (2012), although specifically referencing the world of Psychology in relation to Christianity, communicates the need for separation between the practice of health sciences and theology. Although there is acknowledgment that humanity has a natural curiosity for self-knowledge and development, especially within American culture, Roberts (2012) warns that leaning into the psychology of that curiosity too much might cause idols of false truth that would lead us astray from the Bible. Instead of putting importance on the health sciences, there are Christians who hold that the church

should be aimed at nurturing character and allowing for health to remain a separate discussion (Roberts, 2012).

One of the most intriguing places to understand how Christians engage with science and healthcare as a whole is within Christian public health institutions that train the next generation of Christians entering the public health field (Paltzer, 2018). Paltzer (2018) found that these institutions strove at their core to demonstrate how culture, religion and spirituality, and health, integrate and collaborate with one another to result in the goals of Christian public health. In other words, Paltzer (2018) found that these institutions were aiming to explore and teach how the Christian worldview connects with the secular worldview surrounding public health concerns such as accessibility, vulnerable population outreach, holistic healthcare goals, human dignity, and collaboration with community resources. Ultimately students were guided to focus on how their Christian faith defined serving God and others using the image of God as a foundational perspective to navigate and collaborate with secular public health (Paltzer, 2018).

Government Involvement

As much as there is a continuous debate among politicians and other leaders around healthcare expectations in the United States for consumers, there is much disagreement in regard to where the Bible places the expectation of healthcare provision (Levin et al., 2022). As demonstrated, it is clear to see gaps in the American healthcare system. The two sides of this debate to breach the healthcare gap within Christian circles can be understood as siding with the solution of 1) charity or 2) government provision (Payne, 1993). Although there is much disagreement in how to accomplish the goal, most

discussions surrounding the Bible's perspective hold to a similar foundation that the Bible has, which places the responsibility in the hands of voluntary charity of followers of Jesus (Payne, 1993). Alternatively, because government involvement in charitable contributions to the needy is not prohibited, some hold that today's society can use government programs to accomplish the same tasks (Payne, 1993). Christians as a whole remain mixed in how the Bible presents the role of the Church in bridging healthcare gaps completely, especially as the gaps are different depending on racial presentation.

The Division of Races

Minority Communities

In 2006 it was found that between a scale of 0 to 500 with 500 being ideal health literacy, Caucasians scored 256, Asian and Pacific Islanders scored 255, American Indian or Alaskan natives scored 227, African Americans scored 216, and Hispanic populations scored 197 according to the National Center for Education Statistics (Rowland & Isaac-Savage, 2014). Health literacy then is clearly lacking throughout all communities, however, some have significantly less health literacy than others, which contributes to access to healthcare services (Rowland & Isaac-Savage, 2014). In the last few years alone, the impact of healthcare differences for ethnic minorities difference in relation to the COVID-19 pandemic has been clear (Louis-Jean et. al, 2020). Throughout history, however, minority communities consistently have challenges including discrimination, suffering, experimentation, and decreased access that has increased their reliance on their local church communities (Bolger et al., 2018).

For example, the median family income for African American households is 59 percent as compared to White families (Snowden et al., 2022). Similarly, Latinos are

three times more likely to lack healthcare insurance compared to white individuals, therefore, their faith communities have had to increase resources (Bolger et al., 2018). As stated previously, there is much racial trauma that contributes to the lack of trust of government resources, and these communities often have increased trust in the church (Bolger et al., 2018; Culhane-Pera et al., 2021; Gross, 2011). Black congregations have increased health risks and disparities, especially when considering the Black women in the church (Gross, 2011). Churches have historically met the physical needs of the black community to aid in bridging the known gaps, while some church organizations have even employed healthcare practitioners to be on staff at the church location to meet the congregation and community needs (Rowland & Isaac-Savage, 2014).

Korean individuals, especially first-generation immigrants, rely on their faith and faith communities as a safe space for trust (Cheon et al., 2016; Jo et al., 2010). This is because immigrants struggle to navigate the differences in American health care compared to the countries that they come from, while churches are familiar institutions and therefore, they find comfort in finding resources within church walls (Jo et al., 2010). This means the church is a foundational resource for Korean individuals or families in need of holistic services, including healthcare (Cheon et al., 2016). Korean populations are known to wait many years before often seeking treatment (Cheon et al., 2016). They also have a high regular attendance in church rate, with an on average regular church attendance rate of 65% (Cheon et al., 2016). People attending Korean churches reported preferring health services, information, and education at church rather than trying to access it outside of the church (Jo et al., 2010).

Across all minority cultures, people living in lower-income communities need access to healthier food choices due to food deserts, hospitals are sometimes the only option for healthcare, and mental health treatment goes under-resourced (Williams & Cousin, 2021 et al., 2021). Aging, chronic conditions, obesity, and access to care are all concerns seen within church congregations of all kinds (Baruth et al., 2015). Radical changes to the healthcare system are vital to meeting the ever-changing needs of humanity as minority communities continue to slip through the cracks of quality care (Culhane-Pera et. al, 2021; Stansfield et. al, 2020).

Majority Communities

The White majority culture is under-researched in this area. Although some research does examine majority white culture, because most of the health resources that exist in the church are within minority communities, it is not as common of a conversation elsewhere. When conversations around health are discussed within White culture, the focus is often on Worldwide efforts and missions happening in other countries or communities. A possible reason for this is due to White Christians' focus on the Great Commission in the book of Matthew in the Bible, as it instructs believers to go out into all of the world healing the sick and ministering for Jesus' sake (*English Standard Version,* 2001). There are mixed responses to missionaries focused on healthcare services worldwide (Bruner, 2018). White Christians have, sometimes unintentionally, utilized the practice of medicine to colonize and strip people of their cultural practices of healing to move them into Western medicine traditions (Bruner, 2018). It is important to remember that there are Christians within various cultures and that European Christianity is not more divinely inspired than others (Bruner, 2018).

Therefore, when considering how Christianity and healthcare combine, exploration of worldwide cultures would be beneficial, although outside the scope of the current study. The focus of the American Christian church on individualism also might contribute to these problematic beliefs, as many might be unaware of the healthcare gaps in the U.S. unless they have friends or family struggling with receiving adequate healthcare.

Worldwide Faith-Based Organizations

Faith-based healthcare organizations are used as alternatives to publicly funded healthcare organizations in different parts of the world (Porter & Bresick, 2017), however, there is little research on their use and effectiveness here in the United States (Abbey & Keogh George, 2020). Faith-based organizations worldwide offer holistic healthcare services to their local communities, often funded and aided by short-term mission group teams (DeHaven et al., 2004; Jarlsberg, 2014). Porter & Bresick (2017) have shown the effectiveness of Faith-based organization (FBOs) healthcare systems in Africa. When surveyed, patients were more likely to choose FBOs than other healthcare centers due to positive experiences building relationships with staff, better healthcare costs, and physical accessibility to the location for patrons. Around the world we have seen community outreach within healthcare as an effective strategy, however, using community resources to inspire systematic change could be revolutionary for healthcare reform (Stansfield et. al, 2020).

Christian Leadership on Health and the Churches Role

Research that has focused on pastoral perspectives of church health interventions and the reasoning behind them is limited. However, health ministries and programming are reported to exist at various churches throughout the country, primarily within

minority communities (Baruth et al., 2015; Jo, 2009; Senteio, 2019). Churches are helpful spaces practically for these resources for many reasons, including their various meeting rooms, kitchens, auditoriums, and other building space (Baruth et al., 2015). Some of the various programs reported to be offered across denominations and cultures are 1) education of church leadership and congregations on the community impact of medical concerns such as HIV, heart disease, high blood pressure, diabetes, cancer, and discussion of prevention methods (Rowland & Isaac-Savage, 2014; Senteio, 2019; Williams & Cousin, 2021), 2) health workshops (Williams & Cousin, 2021), 3) meal preparation classes (Williams & Cousin, 2021), 4) health screenings (Rowland & Isaac-Savage, 2014), 5) substance use programs (Rowland & Isaac-Savage, 2014), 6) health fairs, 7) parenting seminars, 8) legal workshops (Jo, 2009). Rowland & Isaac-Savage (2014) identified the increased likelihood that if pastors reported health concerns within their congregations, they were more involved in health resources and advocating for offering them. An example of these programs is Your Blessed Health, which focuses on the education of faith leaders within faith-based organizations (Senteio, 2019). Another example is the L.A.D.I.E.S. project that focused on the needs of African American women's needs (Gross et al., 2018). Interestingly, some pastoral leadership communicated the insight that poor health within the community directly resulted in poor health in the church overall, often relating directly to the action their church was taking to offer healthcare resources (Gross et al., 2018).

Health education is reported to be a main source of health resourcing the church is capable of as it helps bridge the gap in health literacy and lack of medical information in medically underserved communities (Senteio, 2019). Additionally, health education is

important for faith leaders as they often report seeing themselves as role models for their congregations, modeling both health behaviors as well as routine doctor visits for preventative care (Gross et al., 2018; Jo, 2009; Williams & Cousin, 2021). Becoming a role model of health for the congregation is an important pillar for many pastors (Jo, 2009). The important aspects of holistic health according to pastors are good sleep, coping with stress, exercise, healthy eating, and abstaining from substance use (Gross et al., 2018).

One of the barriers expressed from the pastoral perspective is congregation involvement in health resources (Williams & Cousin, 2021). Although one study found 75% of pastors reported health services, they also reported an unwillingness within their congregation to participate in programming (Williams & Cousin, 2021). Additionally, some pastors indicate the congregation members responsibility to inform church leadership of their health needs (Williams & Cousin, 2021). Most pastors reported that people in their congregation get extremely ill before interventions are done, whether that is by fear of the medical system, lack of access, or pride (Gross et al., 2018). Pastors and church leaders also have to be aware of their time and energy limits, as the role of the pastor comes with many responsibilities (Williams & Cousin, 2021). Compassion fatigue is a huge concern when considering the added stress healthcare responsibility would be on pastoral populations (Cheon et al., 2016). Some pastors reported feeling overwhelmed with the time investment of holistic care of their congregation or frustrated with a lack of knowledge of how to help (Jo, 2010). Funding is also a huge barrier for churches to offer health programming (Rowland & Isaac-Savage, 2014). Political affiliation differences

within the congregations sometimes impede healthcare services outside of the church's immediate congregation (Rowland & Isaac-Savage, 2014).

During one of the last major pandemics to rock the world, H1N1 in 2010, churches and other faith-based organizations partnered with the government to act against the slowing of the spread, including providing resources to the communities, which included vaccines (Levin et al., 2022). This was in line with the long history the United States has had with using churches as action houses for healthcare emergencies. When COVID-19 began to spread at alarming rates, the government again looked to churches to represent healthcare change (Levin et al., 2022). However, the healthcare system did not have enough resources available for this to happen, resulting in a drastic number of underserved populations with healthcare needs (Levin et al., 2022). Although the COVID-19 pandemic demonstrated many deficits in the collaboration of government resources and church communities, church leadership does have a history with believing in the provision of medical resources in various areas of the country for certain populations.

Some church leaders struggle to identify the Biblical roots of the connection of faith and health, while others have clear opinions. Many Christian leaders, although able to communicate health as a priority for their faith system and their church congregation, have a difficult time defining health and supporting their definition with Biblical text (Abbey & Keogh George, 2020). Abbey & Keogh George (2020) surveyed Christian leaders to explore the concept of the theology of health more closely. Their findings indicated stark cultural differences in the church's success of being a place of healing for congregations. Many members of pastoral leadership justified their value of health and

its' relation to their faith as rooted in Biblical themes, church statements of faith or doctrine, or the personal interest of the pastor (Abbey & Keogh George, 2020). Jo (2009) found that pastors cited need-based ministries as a way to identify and meet spiritual needs through meeting physical ones. When defining an understanding of holistic health, participants usually described it in terms of a combination of the body, mind, and soul, but struggled to answer questions surrounding the *why* around this answer (Abbey & Keogh George, 2020; Senteio, 2019). When leaders were able to provide Biblical references, the references included most often 1 Corinthians 6:19-20 which describes the body as the temple of the Holy Spirt, followed by a calling to honor God with the physical body (Abbey & Keogh George, 2020). Some other Biblical references mentioned included 1 Timothy 4:8, 1 Corinthians 10:31, Mark 12:29-31, Matthew 22:37-40, and Philippians 4:8, to name a few, while also highlighting themes within the Bible of creation, Jesus' own life, being a living sacrifice, and minding the wisdom traditions from Proverbs (Abbey & Keogh George, 2020).

Leadership is another theme mentioned by pastoral leadership in relation to the church's role in healthcare (Williams & Cousin, 2021). When discussing modeling health behaviors for their congregations as a role the church has in health education, many pastors relate this Biblically to the idea of the pastor's role of being a shepherd to their flock, as described in 1 Peter 5:2-3 (Jo, 2009; Williams & Cousin, 2021). It is highlighted that the sheep have holistic needs including their safety, health, basic needs, and community engagement, all things the church is therefore responsible for (Williams & Cousin, 2021). Pastors communicated Jesus' example for healing as he spent more time healing than preaching (Jo, 2009).

Although little research has been done comparing minority community pastoral perspectives with each other, there have been observed differences in how the leadership sees the connection of faith, health, and their role in it within various cultural and racial communities. For example, when these populations are compared on views of faith and health, the most significant difference hinges on their understanding of what defines faith (Bolger et al., 2018). For African American and Latino populations, pastoral leadership highlights God as Healer, working through resources like medicine when needed, however, God can and does heal without it (Bolger et al., 2018). Black pastors also consider their involvement in healthcare resources for their congregation a foundational part of their roles (Yearby, 2018). Alternatively, for Korean populations, medicine is the primary focus of healing, and faith refers to the community of believers that offer support and sometimes medicine to aid in healing (Bolger et al., 2018). Within White pastoral perspectives, many reports they view themselves as having little to no impact on the health of their congregation, seeing it as the responsibility of associate or youth pastors in the church, if not directly the job of congregation leadership (Baruth et al., 2015). Some White pastors refer to themselves living a healthy lifestyle as a role model and/or occasional messages from the pulpit about health their contribution to promoting health within the church.

Some pastoral leadership highlighted how women in leadership at church are dying more often and at a younger age than the men with similar leadership roles in their church, questioning if church plays a role in chronic stress and health concerns (Gross et al., 2018). Although very few female pastors have been surveyed in past research, one female pastor describes women's overextension of effort to contribute to church and

family (Gross et al., 2018). She communicated her belief that women die faster because they neglect themselves to prioritize the church, leaving room for health interventions as a way to empower women to increase self-care and in doing so, health outcomes (Gross et al., 2018). Prioritizing women's health is an investment in family health (Gross et al., 2018).

Clearly, a framework surrounding a theological understanding of health is difficult for many Christian leaders across racial and gender differences to describe. Overall, studies found that pastors were eager to be involved and partner with organizations interested in increasing access to care, even if the knowledge of how to do that was still unclear (Gross et al., 2018; Jo, 2009). Pastoral leadership reports a desire for more connection to healthcare resources such as education with tangible health interventions (i.e. defibrillators, etc.), as many understand health issues within their congregations are often preventable if the right interventions are used (Cheon et al., 2016; Gross et al., 2018; Jo, 2009; Rowland & Isaac-Savage, 2014; Williams & Cousin, 2021). Training of church leadership to assess level of care needed would empower the connection of the church and community resources, providing safety in insuring the proper level of care for people (Cheon et al., 2016). Further research is called for often, as there is a gap in understanding detailed perspectives across cultures, denominations, and the like (Rowland & Isaac-Savage, 2014). Health seminars and health workshops are desired by leadership but do not always have resources unless there are physicians within the congregation that volunteer their services (Bolger, 2018; Jo, 2009). Training of church leadership in medical knowledge and interventions is also desired among pastoral leadership (Jo, 2009). The younger generation is more health conscious so there is some

movement towards health awareness but the disconnection between faith and health needs to be addressed (Gross et al., 2018). Increasing collaboration using physicians to help train and teach health education is vital to the success of health programs within church walls (Bolger, 2018).

Biblical Foundations of the Study

From a Biblical worldview, the WHO definition of health is too broad (Swartley, 2012). The Biblical definition of health includes an understanding that health is life, blessedness, holiness, and maturity (Wilkinson, 1998). Health and wellness include an understanding of holistic wellness that demonstrates met physical and spiritual needs (Gaiser, 2010; Swartley, 2012; Wilkinson, 1998). God's role and the church's action within the healthcare system are often suppressed in modern healthcare (Swartley, 2012). Luke 10:25-37 describes the story of The Good Samaritan (*English Standard Bible,* 2001). The story describes an Israelite that was beaten and robbed on a road, essentially left for dead (*English Standard Bible,* 2001). Many passersby chose not to stop, some including people that were well respected in the church as leaders (*English Standard Bible,* 2001). Instead of those that were known to be other followers of the Bible, it was a Samaritan that stopped to help the man (*English Standard Bible,* 2001). He spent much time and resources getting the man to a place he would be safe, paying in advance others to care for him (*English Standard Bible,* 2001). The significance demonstrated by Jesus in telling this story is that caring for someone who is hurting requires risk, sacrifice, and discomfort (*English Standard Bible,* 2001). Samaritan and Israelites were known racial rivals, highlighting the extreme level of risk and compassion

that was taken to help another human be restored to health, without asking questions nor demanding anything in return (*English Standard Bible,* 2001). This parable lays the foundation for rethinking health and the purpose of healthcare as a matter of shalom and justice for all, with hospitality to the marginalized (Swartley, 2012). It is a reminder that the people of God could have stopped to help, but something got in their way. The current study strives to explore what still gets in the way of the church getting involved unconditionally in the restorative health of others. To gain a full understanding of the Biblical foundations of the study presented, topics of 1) Biblical spirituality and healthcare, 2) curing versus healing, and 3) modern perspectives must be explored.

Biblical Spirituality & Healthcare

Spirituality and healthcare have a long tradition (McDowell & South, 2017; Swartley, 2012). Christians in ancient history believed that illness was a direct cause of God's wrath, which linked spirituality and health together in a negative way (Amundsen, 1982; Swartley, 2012). Even when some Christians were not convinced that illness was punishment, others still held that it was God's way to keep them humble, leaving confusion about how to pray for illnesses (Amundsen, 1982; Swartley, 2012). Jesus spoke against this viewpoint in many parts of the Bible (*English Standard Bible,* 2001), however, it is helpful to dive deeper into the Biblical understanding of health. Swartley (2012) presents the five Biblical themes of understanding health as 1) the connection between health and shalom, 2) justice and healing, 3) Jesus' example, 4) the calling to provision of material goods, and 5) early Christian church provision of health care regardless of personal risk. These five themes will be further explored within a Biblical

context, as well as an in-depth exploration of Old and New Testament descriptions of health.

Old Testament Understandings of Health

Ancient Israel was not immune to illness or disease- in fact, Adam and Eve would have been the first to experience the body becoming ill (Aquilina, 2017). The Israelites and the Old Testament considered God as a physical and spiritual healer while physicians were sometimes viewed negatively as in 2 Chronicles 16:12, Job 13:4, and Jeremiah 8:22 (English Standard Bible, 2001). Alternatively, the book of Sirac, which is not part of the Christian Bible but is considered a Holy text to some, describes physicians as a gift from God and a resource to use when ill (Swartley, 2012). Although there are accounts of physicians throughout the Old Testament in various ways, there is not a focus on identifying much of their personal worth beyond the importance that Yahweh always takes priority as healer (Gaiser, 2010). However, presenting physicians as unwanted or something to avoid is not common compared to how much they are mentioned overall (Gaiser, 2010). In the early Old Testament, health and wellness standards are given to the Israelites (Aquilina, 2017). These were strict standards, argued in the present day for the semantics of their meaning (Aquilina, 2017). However, these guidelines were meant to reduce illness and harm to God's people, as their medicine had not developed enough for alternative methods of preventing illness (Aquilina, 2017). Priests in Biblical times were designed to enforce the Old Testament's sanitation rules (Aquilina, 2017).

Exodus 15:26 says that God is the Lord that heals his people, while many of the Psalms also describe the Lord as one who heals (English Standard Bible, 2001; Gaiser, 2010). In fact, there are about 30 Psalms in total that describe healing and deliverance

including Psalms 6, 13, 16:9-11, 25:16-18, 30, 32:3, 35, 38- 41, 51, 88, 102, 103:3, 107:17, 116, and 147:3 (Swartley, 2012). In the healing Psalms, sickness is viewed as an interruption of God's Shalom over the order of creation. However, there is much debate on whether God's identification of himself as a healer is intended as God defining himself as the *only* healer (Gaiser, 2010). The use of medical practices similar to other ancient traditions of balms or remedies is referenced briefly in the Book of Jeremiah 8:22 and 51:8 (Aquilina, 2017). Although these references are considered a sarcastic response to how tangible medicine cannot heal everything, it adds to the knowledge that the Israelites were indeed using some of these resources when appropriate (Aquilina, 2017). In Isaiah 38:10-20, Hezekiah prays for healing, an example of healing involving the power and authority of God. Although some early understandings of health linked illness to sin, Swartly (2012) identifies that sin does not directly cause illness as that is too simple of an understanding of creation and the relationship of humanity to God Almighty.

Health & Shalom

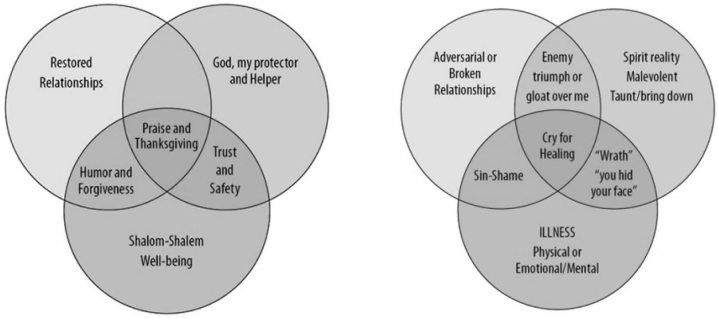
Shalom is a Hebrew word for peace used around 250 times in the Old Testament and can dimensionally mean wholeness, well-being, peace, salvation, and justice (Swartley, 2012). Throughout the Bible, it often means well-being and demonstrates God's will and desire for all people (Swartley, 2012). God originally created us for shalom, but sin goes against those intentions and separates us from it (Swartley, 2012). When Adam and Eve committed the first sin and became aware of their nakedness in Genesis (*English Standard Bible,* 2001), the reality of illness entered the world as the protection covenant was broken. Where there is illness, there is fractured shalom; where there is unrest, there is illness (Swartley, 2012). Swartley (2012) identifies Genesis 29:6,

Genesis 37:14, Genesis 43:27, Exodus 18:7, 1 Samuel 10:4, 1 Samuel 17:18, 1 Samuel 22, 1 Samuel 25:5, and 1 Samuel 30:21 as various examples of the holistic well-being using the Hebrew terminology of shalom and healing. Shalom and healing are connected in the Israelites wandering in the desert in Exodus 15:26 because God's commandments allowed the Israelites to be close to him, and when they were close to him and relationship, they were not sick (Swartley, 2012).

There are a few more specific examples of the connection between shalom and healing in the book of Jeremiah (Swartley, 2012). Jeremiah 8:15 and 14:19 describe shalom and healing as something that is sought after together in times of war (*English Standard Bible,* 2001; Swartley, 2012). Jeremiah 8 tells of lamenting cries from leadership towards the healing of the nation as they connect to the restoration of peace between peoples and nations (Swartley, 2012). Isaiah 42:1-4 and Isaiah 53:5-12 indicate that suffering for the cause of justice leads to shalom and healing, demonstrating that suffering acts as a vessel to move towards peace and healing in the face of brokenness (Swartley, 2012). Swartley (2012) uses these diagrams to describe the connection between shalom and sickness (Figure 1), demonstrating how within the Biblical context shalom, restoration of community, healing, and illness are all interconnected.

Figure 1

The Relationship of Shalom & Sickness



When there is concern about physical illness or relational distance either with God or with others, shalom and healing are not attainable (Swartley, 2012). The passages described in the Old Testament demonstrate that peace and wellness have been intertwined throughout generations, and if wellness is something humans desire, peace must play a role. One of the most challenging elements of this concept when applied to the modern day, however, is that the United States is notorious for residents who disagree on how to accomplish both peace and wellness.

Individualism is a threat to community health and the cultivation of shalom as God intended it (Swartley, 2012). Individually choosing what we want has the potential to damage communal shalom (Swartley, 2012). Swartley (2012) likens the damage of communal shalom to the economic downfall during 2008-2011, something society is experiencing again in a post-COVID world. Health is a spiritual issue too, as the less people care for health the less God is involved in the understanding of shalom (Swartley, 2012). Therefore, it can be argued that Biblical healthcare requires the advocacy of peace demonstrated and modeled by a healthy relationship with God.

Justice & Healing

In connecting shalom and peace, Scripture emphasizes justice, which is in step with shalom (Swartley, 2012). The Hebrew word for justice is not about equality, instead, it focuses on the needs of the poor, widows, orphans, and resident aliens (Swartley, 2012). Biblical justice alters from the traditional understanding within the United States of justice for all in that it focuses on people who are outside of traditional access to resources, it is not focused on insuring equality (Swartley, 2012). Psalms 72:4, 12-14, 146:7-9, and Isaiah 10:1-2 all demonstrate justice as a principle for compassion that

increases community peace, leading to shalom, which leads to healing (Swartley, 2012). Micah 6:8 states that the Lord requires his people to commit justice while actively loving kindness (*English Standard Bible,* 2001). In the New Testament, James 2 directly links the demonstration of partiality as a transgression of the law (*English Standard Bible,* 2001). Understanding Biblical justice requires an additional exploration of Biblical healing with the Old Testament.

The Hebrew word *Rapha* translates to the English word heal and it occurs 86 times within the Hebrew Scriptures (Swartley, 2012). Martin Luther describes this Hebrew word as the Lord identifying himself as the ultimate physician. In Exodus 15:26, God is identified as "Rapha" and describes Yahweh healing those who are ill. This passage in the Bible comes right after the Israelites were saved from Egypt and saw the plagues that the Egyptians went through. They were told that they were to keep God's commandments so he will not bring any of the diseases that the Egyptians faced upon them because he is Yahweh the healer. The 10 Commandments were established alongside these expectations as a way to protect God's people and breaking them jeopardized the health of the whole community, not just the individual who broke the commandment. God's promise to protect the Israelites from disease was conditional on them following the 10 Commandments. There are other areas of the Old Testament that discuss *Rapha.* Psalms 6:2 30:2 41:4 60:2 107:20 147:2 all include this word, and describe healing in many contexts including celebration, suffering, justice, and prayer (English Standard Bible, 2001). Deuteronomy 30-39 and Isaiah 45:7 present that the Lord is to be obeyed and worshiped, and the Lord both wounds and heals. Other passages

discuss God's promises to heal those that keep his covenants such as Ezekiel 37:24-26, Proverbs 4:4, and 4:22 (English Standard Bible, 2001).

There is a religious pluralism here highlighting that God demands loyalty and in return offers the role of healer, however, there is no promise of complete protection against suffering and illness (Swartley, 2012). The Old Testament passages seem to point instead to the idea that a relationship with him will bring an understanding of the connection between overall humanity's choices throughout history and the impact on the health and well-being of everyone. Malachi 2:1-10 discusses that maintaining the covenant with God ensures life and peace (English Standard Bible, 2001), which aligns closely with the concept of health and justice. By following God's commandments there is justice, by living in justice there is healing. When applying these concepts to modern day, healthcare then needs to be accessible to all in the United States, as access to healing directly relates to ensuring justice for underserved populations within the context of Biblical morality (Swartley, 2012).

New Testament Understandings of Health

The classical Greek word for health is *Higieia* and is not included in the New Testament (Wilkinson, 1998). This frames health in the New Testament as something other than a traditional viewpoint. In the English translation when the word health is used, the original Greek referenced one of the five other words (Swartley, 2012; Wilkinson, 1998). These Greek words all speak to a more holistic understanding of health and well-being and therefore do not translate well to the English word of health in the English translation (Swartley, 2012; Wilkinson, 1998). Instead, they more closely translate into the English word hygiene and actually describes a holistic health, including

the health of the body, mind and spirit (Swartley, 2012). These five Greek words are 1) hugies, 2) eirene, 3) zoe, 4) teleios, and 5) soteria (Wilkinson, 1998). There's also a Greek word used in 1 Corinthians 12:9, 28, & 30 that points to the gift of healing that God gives to others which is a different Greek word than those used to describe Jesus's healing (Swartley, 2012). These holistic healing words are used both in Jesus' healings as well as throughout the New Testament when referencing healing.

In John chapter 9, Jesus heals a man that was born blind (English Standard Bible, 2001). The story goes against expectations that were set in the Old Testament of the connection between illness and sin in a cause-and-effect direct relationship (Swartley, 2012). Sickness is then rooted ultimately in the fact that all of humanity is fallen into sin, instead of it relating to the direct action of individuals, since this man was born blind and did not become blind after committing a sin. Faith, therefore, is not a precondition for Jesus healing the man, and yet healing is a part of Jesus' gospel (Swartley, 2012). Diseases were not well understood during ancient times, therefore, consideration of Jesus' abilities to heal the sick meant a lot to early Christians (Crossway, 2022; Oberholzer, 2019).

Luke, the assumed author of the New Testament books of Luke and Acts in the Bible, has been identified as a physician (Oberholzer, 2019). In both Luke and Matthew chapter 10 describe physicians as playing important roles in the early church (Swartley, 2012). Luke prioritizes healing people before proclaiming the gospel, while Matthew proclaimed the gospel first, and then heals (Swartley, 2012). Luke traveled with Paul, and although Luke was not an eyewitness to the teachings of Jesus, he wanted to share how the gospel traveled to the Gentiles and demonstrate what living a life devoted to God

looked like from a Gentile perspective (Crossway, 2022). This information sheds light on why Luke detailed Jesus' healing miracles the way that he did because as a physician, health would be something understood between cultures (Crossway, 2022; Oberholzer, 2019). In Luke 8:1-3 and 9:1-4, healing and compassion produce a new community of diversity between Gentile and Jew.

Swartley (2012) highlights several key points about Jesus' perspective of healing throughout his ministry in the New Testament. First, Jesus' compassion is what shines through his healing ministry as shown in Matthew 9:35-38. Compassion is what makes Jesus' healing a ministry rather than simply acts of magic, disregarding his ego, and instead, focusing on the restoration of humanity to a relationship with God. Second, Jesus has anger towards the realities of disease, illness, and death in John 11:33, showing anger at the wailing for Lazarus. Mark 3:5 also identifies Jesus' anger with the pushback he received from the Pharisees for one of his healings. In these examples, his anger is present in the midst of observing suffering, and even in healing. Thirdly, Jesus' healings are not restricted to Israelite men and include women, social outcasts, and non-Israelites, which will be discussed further. Fourth, the word faith is seen in 17 of the 41 cases of healing, demonstrating the connection that sometimes is highlighted between faith and healing.

When considering what the New Testament has to say about health beyond Jesus' works and words, there are some specific passages that come to mind. 1 Corinthians 6:19-20 says that physical bodies are a representation of the Temple, a holy place where God dwells (Crossway, 2022; *English Standard Bible,* 2001). Crossway (2022) suggests this verse is aiming toward the stewardship of the physical which includes holistic health.

1 Timothy 4:8 discusses how physical attention to the body is a part of the lifestyle of a follower of Jesus (Crossway, 2022; *English Standard Bible,* 2001). The Bible teaches in 1 Corinthians 10:31 that everything a human does has the potential to glorify God (Crossway, 2022; *English Standard Bible,* 2001). Matthew 22:37-40 which says to love the Lord with all of your heart, mind, and soul is of particular significance when discussing health expectations as it is a commandment from the Old Testament that the Jewish people would have been extremely familiar with as they would have been reciting it daily (Crossway, 2022; *English Standard Bible,* 2001). Collectively, these verses explore that health and wellness play a significant role in the life of a human.

Jesus' Example

Jesus' healings were a direct manifestation of God's reign and power promoting the restoration of the relationship between man and God. About 1/5 of the entire gospels is devoted to Jesus' healings in the physical realm (Swartley, 2012). There are eighteen documented healings in Mark, nineteen in Matthew, twenty in Luke, and four in John. Counting the duplicate records of Jesus' healings, the number of healings in the gospels is 72. In this vast amount of healing throughout Jesus' ministry, he demonstrates what faith looks like. Mark 3:13-16 and Mark 6:6-13 is where Jesus calls his disciples to follow in his life example, which would include the expectation to produce healing. The lessons learned from Jesus in relation to healing include 1) healing requires compassion instead of curiosity and action instead of conversation, 2) physical healing always has spiritual meaning demonstrating the holistic nature that healing entails at its foundation, and 3) requires that healing be connected to an admission of human fragility and weakness, acknowledging who God is (Wilkinson, 1998).

Jesus performed many healings throughout his ministry and therefore provides an example of how healing functions in the Bible. Swartley (2012) describes Jesus as a healer-savior, providing an example of a life of thriving amidst suffering. Matthew 8:16-17 briefly describes some of the healings done by Jesus, identifying them as a fulfillment of the prophecy in Isaiah in which the Messiah would heal infirmities and diseases. Jesus sometimes connects disease with sin as in Mark 2:1-12, while elsewhere separating the two as in John 9 and Luke 13:1-5. In addition to the connection with sin, Jesus' healings often are tied to faith as seen in Mark 2:5. However, healing is not always reliant on faith as exemplified by John 9 and Luke 7:11-17. Oftentimes in Jesus's examples of healing, there is a focus on demonstrating the glory of God instead of identifying the cause of the illness (Wilkinson, 1998). Wilkinson (1998) posits the reason for this is that causes of illnesses do not find cures, God's grace finds cures. St Basil, who spearheaded change in the area of healthcare within the early church, founded his approach based on Jesus' words from Matthew 25:31-46 (Basil & Schroeder, 2009). This passage is known for verses 35-45, in which Jesus describes that those who feed and clothe the needy are doing so for Jesus himself. Within the whole passage, Jesus addresses the end times, where judgment will happen. During that time, the blessed will be those that cared for those who were needy while those cursed to eternal punishment will be the ones who ignored the needs of others. In his own descriptions, then, Jesus advocates for his followers to care for those in need with the tangible items of food, clothing, and quality time when sick or in prison.

These offerings were not just for those who were deserving or simply of God's people. Luke 4:18-19 describes Jesus as a healer of the oppression, sickness, and

brokenness of the world in order to make it whole. Jesus modeled healthcare inclusion of the poor and marginalized, challenging unjust societal structures and advocating for foundational change in Mark 11;15-19, Matthew 9:35, Luke 7:18-23, and Luke 19:42. Jesus demonstrated healing at the community level whenever and wherever he encountered those who were in need of healing (Wilkinson, 1998). In fact, one-third of his healings were women and another third were social outcasts due to the nature of their diseases or conditions (Swartley, 2012) such as gentiles in Mark 7:24-30, Matthew 18:5-13, and John 4:46-54, those with leprosy in Luke 17:11-19 and Matthew 8:1-4, the blind in Mark 8, Matthew 9:27, John 9:1, and Luke 18:35, and the women with long-term bleeding in Matthew 9:20. Additionally, Jesus demonstrated in his ministry completion of the healings against the traditions or expectations of religious leaders such as in Mark 3:1-6 when Jesus healed a man on the Sabbath day. Women receiving care and Biblical times looked vastly different, and Jesus is example of healing towards the women equally as to the men offers the example for equitable healthcare in today's day and age championed by the church (Gaiser, 2010). Ultimately, Jesus demonstrates with who and how he heals that all deserve to be made well and that it is his followers who are called to continue after his resurrection with the power of the Holy Spirit.

The Great Commission

In Matthew 10:1 and Luke 10:9, Jesus calls his followers to go out and heal the sick. In Matthew 28:19-20 is a passage known as The Great Commission in which Jesus commands his followers to make more disciples throughout the world, teaching everything that Jesus has taught (English Standard Bible, 2001). According to Gaiser (2010), the great commission was Jesus sending his disciples out to heal as, for Jesus,

going out into the world and proclaiming the good news directly requires actions of healing. Matthew 10:1 says that Jesus gives the disciples authority to cure every disease and illness, as well as casting out spirits (Swartley, 2012). Luke 9:1-2 also states that Jesus gave followers the power and authority to cure diseases, cast out demons, and sent them out to advance the kingdom, while Luke 10 highlights the church's mission as a whole to prioritize healing and deliverance as a way of advancing the kingdom (Swartley, 2012). Jesus' ministry included meeting the needs of people both physically and spiritually, and the church is continued into that calling in the early years as well as the present day (Gaiser, 2010). After Jesus' resurrection, the Holy Spirit descends and begins a work of healing and restoration within Jesus' followers and beyond, promising future holistic healing for all who believe (Swartley, 2012).

Acts 8, 13, and 16 describe how the gospel was spread into different parts of the world using both deliverance and demonstrations of healing. In Acts 10:34-38, Peter preaches to the Gentiles about Jesus being anointed with the Holy Spirit, leading to acts of healing. Through the Holy Spirit, Peter, John, and Paul all demonstrate healings of their own such as the examples in Acts 3:1-10 and Acts 20:7-12. In the epistle of 1 Corinthians, healing is described as a spiritual gift, given to believers and usable for the glory of God. From these examples, it is clear that the church is called to be God's hand of healing in the world using the power of the Holy Spirit and the exercising of faith, in the early church and beyond. Sharing material resources is a foundational calling for the New Testament church, including healthcare resources (Swartley, 2012).

The Early Church's Example

Christian churches in the early centuries provided health care for their members and local communities even though it was dangerous (Swartley, 2012). For close to two thousand years churches of Christianity have offered programs to support the poor, widowed, and needy, as early Christians nursed the sick to emulate the healing power of Christ and express their faith in him (Swartley, 2012). In the Bible, Paul emphasizes that all followers of Christianity are to contribute to their communities with no exceptions (Swartley, 2012). In the book of acts, the early church continued this practice by prioritizing healing as part of outreach in the community (Wilkinson, 1998). In fact, early Christian letters make more references to sickness than early pagan letters implying the understanding that the Christian God cares far more about human illness and suffering than pagan ones (Swartley, 2012). The growth of the early Christian church depended heavily on its healthcare component, both from and for its members.

Biblically, James 5:14-15 is the most frequently used New Testament text for healing as a ministry as it instructs those who are sick to call for the elders of the church and by prayed over, anointing them with oil in the name of the Lord. It goes on to say that the prayer of faith will bring the Lord's healing. This verse is often considered to be a foundation for the church today to continually practice a healing ministry (Swartley, 2012). Swartley (2012) points to early advocates of healing as an action of the true church including Irenaeus, Gregory Thaumaturgus, St. Basil, Gregory of Nyssa, and Martin of Tours. Later in history, Methodist John Wesley promoted healing of the sick as a command of Christ, and therefore, a roll the church should take. He advocated for this by opening a Health clinic and writing a manual about what good health looked like. As denominations have evolved over time, more diverse understandings of the connection

between health and church responsibility have as well (Swartley, 2012). Reasons for this include colonial expansions, racism, and political debates throughout history leading to more division within the church. As colonialism emerged, healing rituals brought by colonials directly opposed native traditions, therefore creating damaged relationships. In more recent times, Pentecostal traditions emphasize the power of the Holy Spirit and the connection of the Holy Spirit and healing, while other denominations focus on meeting healing needs in countries overseas. Medical missions became a popular thing for protestant churches during the 1800s due to the fact that missionaries with medical training could frequently gain access to individuals and communities that a pastor could not (Swartley, 2012). Understanding current views of various cultures and denominations is an under-researched area, something that demonstrates the need to explore how the American healthcare system has gaps given the Biblical importance of healing and healthcare. The foundational belief leaned from the early church is that God's people are vital to the holistic healing of those in need (Wilkinson, 1998).

Made in God's Image

The Bible clearly describes humans as being made in the image of God in Genesis 1:27 (English Standard Bible, 2001). Humans are created in the image of God, charged with cultivating and sustaining creation, including themselves since the fall (Payne, 1993). Defining what is meant by the image of God can be understood to include both material and immaterial dimensions of the universe and mankind (Payne, 1993). Part of this image is the ability to have ethics and morality, formulated from God's revelation through Scripture, history, and doctrine (Payne, 1993). After Adam and Eve had sinned, they were told caring for themselves would be hard work, a groaning alongside creation,

as sin damaged the original intention for health and wellness (English Standard Bible, 2001).

In the Hebrew Bible, humans are *Adam* which means of the earth, *nephesh* which means needy person, and *basar* which means vulnerable person found in various scripture references describing humanity in Genesis and the Psalms (Payne, 1993). In the New Testament, however, Paul simplified the Old Testament understanding of humanity in the presentation of the essential role of love for the believer in thriving (Payne, 1993). It becomes clear in the New Testament that health goes far beyond basic needs and requires an acknowledgment of mortality, the power of God, and the new covenant freedom to be in a relationship with God which brings restoration. The New Testament allows for the redefinition of what it means to be made in the image of God to include partnering with him in expanding the kingdom through holistically healing the hurting.

Modern Debates

Although there is much to identify within historical understandings of the Biblical perspective of healthcare and healing, it is also important to address some of the modern debates around the topic. The following is not an extensive list, however, it gives insight to some of the current differences in perspectives that can be expected in church environments around the topic. Those discussed here are the debates of, 1) limits of help, 2) curing versus healing, 3) Biblical suffering, and 4) some paradoxes.

Limits of Help

Although the concept of unending sacrifice for the glory of God might sound clear, there is a great debate surrounding the understanding of the Biblical limits of charity. For example, some hold the belief that Christians should help people as long as

there are certain boundaries, such as help with healthcare costs as long as the requirement to refrain from alcohol consumption and maintain an active lifestyle is present for those in need (Payne, 1993). This argument originates from the Apostle Paul's instructions in Thessalonians that one must work in order to eat, as well as Timothy's instruction to not help younger widows as they are meant to remarry (Payne, 1993). The interpretations of these passages can be argued against Jesus' treatment of the sick equally regardless of status, as seen in his healing miracles being offered to the poor and rich alike (*English Standard Bible,* 2001). Understanding the perspectives of church leadership on the limits to healing Biblically requires further research.

Curing Versus Healing

According to Swartley (2012), it is important to differentiate between curing and healing. Many would identify the differences as curing is focused on a medical outcome while healing is a holistic action done through God. In this definition, someone can be cured of a disease and yet not healed of the traumas that the disease resulted from. Theologically, we are only fully healed upon the restoration of humanity to God in the end times, and in that time, of our physical bodies as described in John 6:39-40, 44, and 54. Medical advances allow for progress towards a cure for illness caused by sin and therefore progress in healing, but it cannot complete it. When a person prays for healing, they also hope for a cure.

Biblical Suffering

The Bible acknowledges the complicated dynamic of suffering and God's plan, something that is still discussed in light of illness often. Some of the things that are made clear throughout the Bible about suffering are that God has the capacity to suffer,

suffering is not good, and God can transform and bring good out of suffering (Swartley, 2012). Suffering brings humans closer to God as scripture points to the active role God takes during human suffering. In the Old Testament, Job accepts that both God and Satan have roles in suffering, however, he refuses the idea that all suffering is directly earned, which God confirms in Job 31:35-37. Job is an example of how sometimes human suffering is not understandable due to the human condition and yet it still glorifies God and moves forward God's purpose. Psalms 56:8 links suffering to sickness specifically by describing tears of a sick person, while Psalms 90 and 103 acknowledge the frailty and brief length of human life. 1 Thessalonians 1:6-7 describes the Christian identity connected to suffering and identifies moving through suffering as a way to imitate Jesus. Through the discussion of suffering and sickness, the Bible references that suffering is not the absence of God, but instead is his presence in love. Therefore, there is room to further discuss in modern times how the church might take an active role in human suffering in illness and beyond.

Some Paradoxes

One of the most challenging aspects of the topic of health in the Bible is the many paradoxes that become challenging for the human mind to unravel. Perhaps the most complex element of the paradoxes is that the Scriptures do not often offer a *how* to move through them. For example, Swartly (2012) describes humans as both frail and finite while also being made in the divine image of God and exist as co-creators with God. This paradox relates directly to human fragility and reality of illness while also speaking to the human capacity to work towards healing brokenness. Although this paper has reflected

on the various examples of Biblical healing, it also has identified the ways humanity has desperately failed in actually moving towards the latter part of the paradox.

Another uncomfortable paradox is that God is good while also allowing bad things to happen. The human experience involves pain, suffering, and anguish while also the power and love of God as a triune healer demonstrated by Jesus' life and ministry in healing. God is all-knowing and powerful, and yet does not stop illness from occurring. Even more so, God does not always ensure healing happens when it is needed. God's omnipotence is not about control, its about the demonstration of love (Swartley, 2012). Sometimes people are healed, while others are not, but either way God and his goodness stays true according to his word.

Discernment

Discernment is a challenging topic debated as it asks the question of balance between relying on medical healing of illness and divine intervention. As mentioned previously, views of the physicians' role in Biblical health and healing are vastly mixed throughout historical and cultural contexts. Who holds the power to make the decision around the authority of another to help someone who is sick? Some hold the view that physicians are vessels for God to bestow healing and health, while others hold that if healing does not happen in a supernatural way it was not intended to happen. Cultural differences in dealing with illness are clear between more individualistic and collectivistic cultures. Both in the Old and New Testament, sick people are helped by friends to receive care as demonstrated in 2 Kings 5:1-19, Mark 2:1-12, and John 9:1-2. Ultimately, discernment around the Biblical responsibility of healthcare is one of the foundational debates surrounding this current study.

Summary

As identified thus far, the relationship between healthcare and the Bible has vacillated throughout time, needs, history, and cultures. What has been made clear is that American healthcare still has many gaps and that although the Bible points to the Christian responsibility in taking an active role in healing and helping those in need, it does not provide a clear path forward. Although the Church has existed for centuries, it has struggled both internally and externally to fully follow in Jesus' footsteps in his healing ministry, especially in present day.

While it is clear from research completed thus far that faith-based healthcare has been able to result in positive contributions to healthcare as a whole, fostering more collaboration and connection to secular healthcare is severely under researched (Paltzer, 2018). This can be seen as closely related to the significant lack of understanding of how the Christian community understand and define health and healthcare as a whole, including what their role is in connection to it (Abbey & Keogh George, 2020).

Seeing that community resources for healthcare can be effective when they are focused on community insight, established and trustworthy relationships between providers and patients, a priority on specific community needs, thriving volunteer systems, long-term strategies for community engagement, and striving to treat needs beyond healthcare of housing, poverty, employment, environment, and crime and safety (Stansfield et. al, 2020) is foundational for understanding why Christian perspectives would play a role in the development of accessible and effective healthcare reform in the United States. Depending on Christian perspectives within specific areas of the country surrounding health and healthcare services, there may be opportunities for creative

reform that uses the rapport, location, and access the church already has established within its communities to aid in mending that gap.

CHAPTER 3: RESEARCH METHOD

Overview

This chapter will explore the research questions, research design, participants, study procedures, research design, instrumentation and measurement, data analyses, and the delimitations, assumptions, and limitations of the study. Understanding the structure of the study will allow for a strategic exploration of how knowledge of the Biblical responsibility of healthcare will aid in the betterment of the American healthcare system.

Research Questions

RQ1: What is the Biblical responsibility of healthcare?

RQ 2: How does culture influence the role of the Church in healthcare?

RQ 3: What current programming in Churches support the Biblical responsibility of healthcare?

Research Design

Given significant gaps of research exploring multicultural pastoral perspectives of the Biblical responsibility of healthcare, this study aimed to increase understanding cross-culturally of the current understanding of church involvement in the U.S. healthcare system. To accomplish this, the research design is qualitative in nature. As previous studies have demonstrated, a one-on-one interview method with pastoral leadership is effective in exploring an understanding of the research topic (Abbey & Keogh George, 2020; Bolger et al., 2018; Cheon et al., 2016; Gross et al., 2017; Jo et al., 2010).

Likewise, as this study is focused on gathering information from pastoral leadership, a one-on-one interview qualitative research method has been chosen.

Participants

Ten pastoral leaders from various churches throughout the United States were selected for this study using a convenience sample. The sample size was chosen after exploring previous research sample sizes for similar studies, finding 10 participants as within the norm (Abbey & Keogh George, 2020; Bolger et al., 2018; Cheon et al., 2016; Gross et al., 2017; Jo et al., 2010). Ensuring these pastoral leaders are from various churches allowed for more diversity in perspectives, while remaining small enough to explore in more detail nuances of pastoral beliefs around the topic. Pastors were contacted via emails found on their church websites, given through social media, or from responses from the interest screening form posted to the public online to discuss the opportunity to be involved with the study and to ensure that inclusion and exclusion criteria are met. The inclusion and exclusion criteria were established to ensure those interviewed were appropriate for research questions involving Biblical understandings. The selection criteria included 1) the pastoral leader must identify as a "Bible-believing Christian", and 2) the pastoral leader must identify themselves as a pastor or Biblical leader of the church congregation and may or may not be on the church elder board, council, or other leadership structure. Exclusion criteria were 1) pastoral leaders who identify more than the Bible as a divinely inspired resource for their faith and 2) pastors that do not hold a current role at a church. Recruitment continued until saturation. If interested in the study, potential participants were sent a link to complete a screening

form, which ensured that the inclusion/exclusion criteria were met. After confirming a participant met the criteria, they were contacted to schedule an interview date and time via email. All participants were given a human subjects consent-to-participate form and were briefed on any personal and social risks involved with the study through email as well. All participants signed and returned the consent form before their scheduled interview.

Study Procedures

Participants were sent an email prior to the interview explaining that the questions will be asked about their theology of health, while intentionally not including the questions themselves, as previous studies have shown some church leadership unprepared for Biblical examples without some preparation (Abbey & Keogh George, 2020). Semi-structured interviews were 26-57 minutes each and were conducted by the researcher. Each interview was completed virtually using the secure video chat platform Doxy.me. Interviews were recorded using audio technology with the participant's consent. The researcher took physical notes to document things such as body language, tone, and vocal inflection. All documentation including audio and physical was duplicated and stored both digitally and physically (digital files stored physically via the use of external hard drives) in two different locations.

Instrumentation and Measurement

The semi-structured interview included 7 questions about how Christian beliefs (social justice, servanthood, generosity, help of the less fortunate) are connected to the

Biblical responsibility of healthcare. The 7 structured questions from the interview were 1) “How are Christians supposed to engage with healthcare according to the Bible?”, 2) “What role do Christians have in the provision of healthcare in the United States?”, 3) “If healthcare in the United States could look like anything, what do you think it should look like based on Biblical responsibility?”, 4) “How does culture relate to your Biblical understanding of healthcare?”, 5) “What do you know about faith-based healthcare organizations in the United States or abroad?”. 6) “What scriptural references guide your theology and knowledge of health?”, and lastly, 7) “What programs do you support that model your definition of the Biblical responsibility of healthcare?”. Questions were not asked in the same order for each interview, and given the semi-structured nature, more unstructured questions were included based on the individual interview conversations.

Data Analysis

The researcher who completed the interviews will also complete all data analysis and presentation of data. In-vivo coding, as well as thematic coding, were used for data analysis by the researcher. The physical notes by the interviewer included written keywords, themes, voice inflections, and body language communication from the interview itself and this information was documented. Directly after each interview, the audio recording was uploaded to the digital OneDrive for storage as well as the program Transkriptor to be transcribed. The researcher verified that the transcriptions were correct, making any needed changes to ensure accuracy. The transcriptions of each interview were then analyzed, identifying keywords and phrases in the participant’s responses. The themes that emerged from all levels of data analysis were compiled into a

final list for the presentation of data. This data analysis process is a combination of previously used methodology from similar studies (Abbey & Keogh George, 2020; Bolger et al., 2018; Cheon et al., 2016; Gross et al., 2017; Jo et al., 2010).

Delimitations, Assumptions, and Limitations

Delimitations

Choosing to include pastoral leaders from churches throughout the United States was a deliberate decision to include perspectives throughout various communities. There are many Christian churches that have various focuses within different communities including prioritizing racial groups, sexual identities, ages, or citizenship status. Choosing a convenience sample allows for the exploration of multiple perspectives on the Biblical responsibility of healthcare, offering insights beyond previous research that explored more focused communities alone.

Assumptions

Given that this study is conducted using one-on-one interviews, there is the assumption that the pastoral leadership being interviewed have answered the questions honestly. Additionally, it is assumed that the participants have identified their Biblical beliefs accurately. There is no measurement to assess their knowledge or familiarity with the Biblical texts, therefore, it is assumed that pastoral leadership has enough of a Biblical understanding to competently represent their opinions on the subject of Biblical healthcare.

Limitations

Because this is a one-on-one interview qualitative case study, the biggest limitation is generalizability. Although this study has gathered the pastoral perspectives from these specific 10 pastoral leaders, it cannot be assumed to be the perspectives of all pastors, Biblical teachers, or Christian leadership. However, this data gives us insight to how to continue the dialog within the broader Christian church around its involvement with healthcare. Similarly, this study does not determine causality. Deduction of why the pastors have the perspectives that they have is not something this study focuses on. Therefore, this data will not be useful for prediction of how pastors will consider these issues in the future.

Additionally, there is a potential limitation of social desirability. As pastors are leaders within the community, their reputation matters. Perhaps pastoral leadership have presented alternative answers to questions based on fears of potential repercussions from their congregations. Although pastors signed an informed consent document that establishes anonymity, pastors could be concerned with how the researcher might perceive them socially given their answers.

Summary

This research examines pastoral perspectives on the Biblical responsibility of healthcare in the current American healthcare climate. The purpose of this research is to broaden resources to underserved communities, increase governmental and church collaboration, and demonstrate the Biblical calling to healthcare as understood from the

research. By conducting semi-structured interviews, participants had the flexibility to explore the topic while also being given specific questions.

The research questions for the study include 1) what the Biblical responsibility of healthcare is, 2) how culture influences the role of the Church in healthcare, and 3) what current programming in Churches support the Biblical responsibility of healthcare. The participants of this study were ten pastoral leaders from various churches throughout the United States. Semi-structured interviews lasted between 26-57 minutes and were audio recorded, transcribed, and processed using in-vivo and thematic coding. Results were documented and described to aid in the reconstruction of the American healthcare system to breach gaps of care.

CHAPTER 4: RESULTS

Overview

The purpose of this study is to explore pastoral perspectives of the Biblical responsibility of healthcare, with the intention to provide information that will assist in bridging current gaps of the American healthcare system. This study is a case study, which utilized interviews with ten pastors throughout various parts of the United States. The research questions for the study include 1) what is the Biblical responsibility of healthcare, 2) how culture influences the role of the Church in healthcare, and 3) what current programming in Churches support the Biblical responsibility of healthcare. To help answer these research questions, some of the questions asked throughout each interview in no particular order:

- "How are Christians supposed to engage with healthcare according to the Bible?"
- "What role do Christians have in the provision of healthcare in the United States?"
- "If healthcare in the United States could look like anything, what do you think it should look like based on Biblical responsibility?"
- "How does culture relate to your Biblical understanding of healthcare?"
- "What do you know about faith-based healthcare organizations in the United States or abroad?"
- "What scriptural references guide your theology and knowledge of health?"
- "What programs do you support that model your definition of the Biblical responsibility of healthcare?"

Data was collected using audio recording technology, the audio file uploaded and

transcribed to a text document and analyzed for themes presented in this chapter.

Descriptive Results

This study included 8 male participants and 2 female participants. All participants identified as Pastors, and all were currently serving within a pastoring role within their church. Out of 10 participants, four have Master's degrees (three in theology and one in counseling), and all hold bachelor's degrees in various subjects. Most described their congregations as small, while one specified that the church has multiple campuses, making it a larger church. Participants, all of whom were given pseudonyms, are described in the following section.

Tony

Tony is an African American male who has been in formal ministry for 24 years. He received his education through Liberty University and Christian Bible Institute and Seminary, holding a master's degree in ministry. He is currently a Senior Pastor at a Non-Denominational church in a suburb of Chicago with a congregation of about 110 members, stepping into that role 7 years ago. He also holds a Leadership role where he oversees about 30 local pastors within the community offering supervision. Tony takes pride in his marriage of 26 years, is a father to five sons, and a grandfather to four.

Kenan

Kenan is a male pastor who has been serving in a pastoral role for 20 years. He holds a Masters of Divinity and was ABD on his PhD in systematic theology. He has been in his current role for 7 years as the Pastor of Adult Ministries at one of the 6

campus locations of his Evangelical Free Church. Kenan expressed that the church is very large and diverse located throughout the Chicagoland area.

Tanner

Tanner is a Caucasian male that has been in ministry since he was a freshman in high school, bringing his total time in ministry to 15 years. He received his Bachelors of Biblical and Theological Studies from Wheaton College. He has held his current role of Youth Pastor to an Assemblies of God church in Detroit, Michigan that has a congregation of around 200-300 for five years. He also serves as director of the food distribution outreach at the church, as well as overseeing the media team. Tanner specified another important contribution to his identity within the church is that his congregation is over 90% people of color, so he has learned a lot about serving as a white pastor in that context. He also specified that every pastor on the team is multi-vocational. Tanner has been married for a year and a half.

Ronald

Ronald is a Caucasian male that identified taking many roles within the church before stepping into ministry. After getting to know God more personally from his own study of the Bible, Ronald went to Western Baptist Seminary in 2003 and became an Associate pastor in 2005 at the same Baptist church that, as of 2018, he currently serves as the Senior Pastor. The church he currently holds the title of Senior Pastor at is in the Bay Area of California. Ronald is married and has one daughter and one son.

Cory

Cory is a Caucasian male that has been in ministry for 19 years, serving at 4 different churches during that time. He received his bachelor's degree in math, and

originally began to pursue higher education for marriage and family therapy, eventually landing on seminary instead through Western Seminary. He completed his graduate studies through Western Seminary in 2015. His current role is Pastor of Outreach and Director of Operations and has held those roles for 2 years. The church that he pastors identifies as Non-Denominational and is located in the Bay Area of California. Cory estimates the congregation is about 600-700 people. Cory is married, and together he and his wife have three children.

Edwin

Edwin is a Korean male who has been in ministry for 20 years as an ordained minister. Edwin started serving in church as a teenager and eventually became a youth pastor before becoming ordained and moving into a Lead Pastor role. Edwin holds a master's degree in counseling from Northwestern University and works full time in a private practice as a Licensed Clinical Professional Counselor in addition to being the Lead Pastor of his church. He describes his church in the suburbs of Chicago, IL as very small. Edwin is married and has two kids.

Catie

Catie is a Caucasian female that has been in ministry for about 10 years. She holds a bachelor's degree in public relations journalism with a minor in biblical studies from Biola University. Catie and her husband planted a church together in Portland, OR, describing the kind of church as a "funky house church network". Catie holds a position of Lead pastor, but describes that each house church has internal leaders and volunteers as well that play integral roles. The house churches gather for a big service altogether once a month. Catie describes her church as non-denominational, while acknowledging a

connection with the Christian Evangelistic Association. Catie and her husband have kids, with one more on the way.

Sara

Sara is a Caucasian female that has been involved with ministry throughout her life. Sara has held the role of Kids Pastor for 7 years total, and has been with her current Assemblies of God church in the Central Valley of California for 4 years. Sara is currently going through her education provided by the church through Global University to be a certified pastor. Although she currently works at an AOG church, Sara personally identifies as non-denominational. Sara also runs a homeschool co-op that includes her two sons, as well as volunteers at the youth center in town managing events and working with middle and high school students. Sara and her husband are backyard farmers and are hoping to adopt another child to continue growing their family soon.

Lucas

Lucas is a Caucasian male who grew up with a father who was a pastor, exposing him to ministry at an early age. Although he grew up serving in the church, Lucas decided to become pursue a history degree to become a middle school teacher. While in his profession, he continued volunteering with the youth group as his church, and eventually stepped into youth ministry as a youth pastor. Lucas served as a duel youth pastor and worship pastor for six and a half years, which led him and his wife to plant their own church near Salem, OR. Lucas has been the Head Pastor of his non-

denominational church for almost seven years. Lucas is married to his wife of many years and together they have three kids.

Mitch

Mitch is a Caucasian male who grew up with a father who did both youth ministry and street ministry in Chicago, IL. After becoming a Christian at the age of 21, Mitch dove directly into serving as a youth pastor, holding that role for 22 years. From there, Mitch has been an associate pastor for 11 years, currently holding the title of Spiritual Formation Pastor at his Baptist church in downtown Chicago. His educational background was trade school originally, receiving his degree in Bible and Theology from Moody Bible Institute in 2010. Mitch and his wife of 25 years have four kids, two biological and two adopted, as well as a dog, three cats, and a garden.

Study Findings

This study used thematic and in-vivo coding to analyze the 10 interviews from pastoral leaders. First, each interview was transcribed into a word document. Then, the interview transcription was evaluated and coded based on keywords, in-vivo wording, and general ideas. Next, these codes were combined into larger themes across the interviews and organized into themes relating to each research question. The themes are presented below.

RQ1: What is the Biblical responsibility of healthcare?

Multiple questions were asked to assess pastoral perspectives of the answer to this research question. According to the data from this study, the biblical responsibility of healthcare can be understood within two ideas 1) responsibility of caring for the self, and 2) responsibility of caring for others. Various themes emerged from the interviews

relating to this question including Defining Health, Ideal Actions of Health, and Example of Jesus. Within these themes, the topics of Holistic Health, Body as Temple, the Role of the Individual, and the Role of the Church are presented.

Defining Health

When asked about their theology of health based within biblical texts, there were multiple passages mentioned as guiding the biblical understanding of health. Some gave specific passages, while others discussed their theology of what health meant within a broader context. The themes identified include Holistic Health, Hierarchy of Needs, Body as Temple, and Other Biblical References.

Holistic Health

One of the first themes mentioned when asked about health was the idea of health including a holistic nature. Catie highlighted:

> Genesis really guides my view that we're really holistic people. You see God create [the] body very intentionally, creates us from the dust… When you see God create relationship, we're relational people and that's part of our health. You see God create psychological parts of us… we can interact, we can dialogue, we can have emotion and make decisions about things. And then you see obviously God create our spiritual beings. We specifically more than any other creature, have an ability to commune with God. And that's really specific.

Other pastors identified that a holistic understanding of health is something that included the physical and spiritual self and is good. Lucas described, “God wants us to be healthy, physically, mentally, spiritually, and emotionally… Health is important and good.” Mitch brought the holistic nature of health under the definition of Shalom, stating, “Shalom is a

holistic health, right. It's mind, body, spirit… it is peace in society, peace in relationships, health in your body. It's like a holistic wholeness." Tony identified a verse about prosperity being directly being to the holistic nature of health, sharing:

> … the etymology of that particular word prosper is talking about financial prosperity, then it says and be in health. So now we're talking about physical prosperity and then it says even as your soul prospers, now we're talking about spiritual prosperity… And when you talk about the soul prosperity, now you're talking about the mind and the spirit and things like that as well.

Unlike perhaps some of the other pastors, Ronald presented the focus on health being rooted in God's presence with his people instead of being concerned about the physical health as a primary concern by sharing:

> … so to me that's a stabilizing factor for just general health to know that you're not forgotten, you're not forsaken, you're not being abandoned… And it's one of those things to me that when things aren't going so well, it's like, okay, well, I know Jesus is with me, so all is well.

Pastors overall view holistic health as including the body, mind, and soul, highlighting the connection with God being foundational within health through Shalom and the worth and value that God brings to us in his promises.

Within this understanding of holistic health, however, many pastors ensured communication that illness is part of a sinful world and is not a direct punishment of ungodly action. Mitch shares, "… Jesus promises we're going to suffer. He promises that we're going to experience hardship in this world." Although suffering and illness is inevitable within a fallen world, illnesses do not directly happen as a result of sin. Lucas

shares, "… sickness is not a result of sin. I do not see that anywhere in scripture." Ronald also separates the acknowledgement of illness and God's direct action by sharing, "God didn't do it to me, and I didn't necessarily do it to myself. It's part of living in a fallen world."

Overall, then, non-health can be understood as a result of the fallenness of mankind after creation. Mitch communicates that, "… health is a condition we had before the fall and we're not going to have that again for a long time. We have echoes of that. We have facsimiles of that." Health then, although is seen holistic in nature, is presented theologically as something that is perhaps not attainable on earth due to the fallen nature of humanity.

Body as Temple, Made in His Image

Under the theme of holistic health, four pastors referenced the biblical passages describing the human body as a temple of the Holy Spirit, as well one making mention that humans were made in the image of God. Sara shared the direct verse and commented that for her, the verse provides the expectation for staying healthy as they did in Bible times:

> 1 Corinthians 6:19-20. Do you not know that your bodies are temples of the Holy Spirit who is in you? And you have received from God? You are not your own. You're bought at a price. Therefore, honor God with your bodies.

Slightly differing from Sara's interpretation, Cory mentions:

> … your body is a temple of the Holy Spirit you know. Now granted that passage in particular is talking about sexual promiscuity and is very targeted towards that. And so I don't hold with a, like, hard line of, you know, how dare you eat junk

> food or how dare you not work out or, you know, like whatever. Like, no, no, no, you know, but like, God has given us these beautiful bodies.

Kenan adds to his mention of the body as the temple the call to love others by saying, "…our bodies are a temple of the Holy Spirit…the idea of loving others [too]." Cory also mentions the intentionality of the created body as presented in Psalms 139 by sharing, "God has put together our bodies with care and so for us to take care of them while we're here." Pastors highlighting the passages biblically that talk about the body as the temple and being made in the likeness of God speak to their perspective that health requires the foundation of acknowledging the human identity as connected to holiness within the body and mind.

Ideal Actions of Health

After exploring the definitions of health, pastors spoke to the kinds of action that the biblical responsibility of health *should* warrant for the individual and the church. Pastors spoke to the ideals of biblical responsibility within these responses, not necessarily what tangible actions are being taken. The biblical responsibility highlights what the Bible calls for when thinking about health, separate from the current programming that will be explored later.

Role of the Individual

When asked questions related to the biblical responsibility of health, pastors often made mention of the responsibility to care for our own bodies, as well as caring for others. Bringing in text from Genesis 1:26, Mitch shared that even since the beginning of creation there has been a responsibility to be good stewards of our bodies. Some of the ideas of how to be a good steward of the body included Cory's mention of not using

substances that alter your state of control over your body, commenting, “God doesn't want us to allow our bodies to be controlled by anything other than by Him and His Spirit.” Sara commented how she sees many Christians not being good stewards of their bodies with choices they make, especially medically, and expressed that Christians should use resources God gives to do research about what it means to take care of our bodies naturally. Diet and exercise are two more areas of stewardship presented by pastors as examples for good stewardship of the body.

Diet and exercise are mentioned by four of the pastors as ways that they both demonstrate health as well as encourage their congregations to pursue health. Some Pastors mention programming they have within their church surrounding diet and exercise, while others speak about it as an individual journey and responsibility for a Christian. Catie expands on her own enjoyment of eating nourishing foods by saying, “… the creation account inspires me to make and eat good food that nourishes my body well…” Sara also shares about her process of focusing on diet based in her biblical understanding:

> [in Bible times] there was more wholesome nutrition and now we've gotten so used to what's quicker, what's easier. I'm a firm believer that if we went back to we're growing our gardens…walking daily… they fellowshipped and they tended to the land… it's another way of honoring and worshipping God, because we're

> taking care of our body… 1 Corinthians 10:31, it says so. Whether you eat or drink or whatever you do, do it all for the glory of God.

Tony adds to this understanding of diet and exercise, however, by drawing attention to the education gap around healthy eating, especially within certain communities.

> … the Bible says that this way my people perish for a lack of knowledge and a lot of people just simply weren't raised with the knowledge of the of the long term effects of the things that we eat, or the lack of physical activity that we engage in… so part of the challenge is breaking down the educational barrier and then learning how to change habits… in the African American culture… whatever they put on your plate, you had to eat the whole thing… learning the habit of overeating… When we started paying attention to it, I didn't know that the majority of the food that we eat is inorganic… I didn't know…

Diet and exercise are tangible ways that pastors expressed both their own choices regarding their own health as well as suggesting it as a call to action for Christians biblically as a whole. One pastor highlighting the education gap that exists within certain communities for these healthy decision-making impacts the expectations he may have for Christians being different than the other pastors advocating for healthy physical behaviors.

Community Focus

Another identified action of health is the fostering of community. Some pastors identified this as individuals being able to advocate and volunteer, while many used this idea of community focus when thinking about how the church engages with the biblical responsibility of healthcare. Tanner shared the passage of James 5, commenting on the

community mindedness surrounding a person who is ill. He shares, "… people should be present in your sickness … love that neighbor as yourself."

Beyond being present within community, many pastors spoke to the idea of the biblical responsibility of health including being a resource as a church, or as pastors. Pastoral perspectives about how the church fosters this idea of community within the biblical responsibility of healthcare differed. Two pastors identified how their churches foster this concept of community. Tony specified his passion for continuing using education within the church as a way to foster the biblical responsibility of community:

> I think that we should still be promoting a proper diet and exercise. I think that we should engage in the medical system of this country as much as possible as a matter of fact. The community gardens [his church is working on] will be good because that allows for the neighborhood to take ownership of something and to provide themselves with food as well. So obviously you're not only learning farming and growing food, but you're making sure that the food that is being provided to your neighborhood is healthy and free of pesticides and all those other things. Things like that could help, of course… churches can begin to kind of bring the issue of healthcare to top of mind [with health education].

Three pastors advocated for more church involvement in healthcare in various ways to promote this community, citing that the church could be a great resource for reconstruction of the broken healthcare system if they chose to be. Edwin commented:

> I think religious institutions can reform itself to be [a place for healthcare] whether it's just providing spaces for on the weekdays for treatments like mental health disease or intensive outpatient programs… I think our religious institutions

> can be reborn into that where the sense of community can be restored. So it's not just Christians going to church, but anybody that needs help that could, that needs the space can utilize those spaces when it is not being used as a religious facility in the weekdays. But I'm not sure if that is something that is happening many times.

Tanner shares the underlying reason for his belief in the involvement of the church in the healthcare system by being a resource of connection with the words:

> Philippians 2… we should care about folks' bodies and how they are being cared for, how they are being tended to… prayer is the thing that you do immediately… But there's also a ton of other actions that can get you know, supplemented with that per our availability of resources in a given situation.

Two pastors believed that the churches responsibility in healthcare on the community level is focused on offering spiritual peace and emotional support, rather than hands-on involvement. Ronald stated, "… being able to provide a pathway of healing and a pathway of just comfort, of peace, someone that they can talk to…" Cory resonates with Ronald's sentiment of the churches role being walking alongside those who are suffering with health ailments by saying **"**this is a challenge and we're going to walk with you…", however, he also highlighted the importance of encouraging members to have healthcare as it is a law in his state of California, referencing Romans 13. Although there are mixed perspectives on how the responsibility of health fosters community through the church's role as a whole, the tangible actions that pastors have taken to foster the biblical responsibility of healthcare will be addressed in the next research question.

Example of Jesus

Although not directly mentioned by every pastor, some gave references to Jesus as an example of the biblical responsibility of healthcare. Kenan comments:

> I know it's hyperbolic when Jesus says it, but if your eyes are looking at things that you shouldn't be, cut it out. And obviously he's not saying physically cut it out. But there is, there is a kind of a warning to help us understand that, man, our bodies are sacred. We're not to use it for sexual immorality. We're not to look at things that will harm our brains. We're not supposed to put things in it that will cause us to cause it to crumble and begin to die.

A few more pastors commented on Jesus' example of how he interacted with others being a helpful guide when thinking about biblical healthcare. Lucas says, "That is our mission from Jesus, to care for the weak." Tanner expands by commenting on Jesus' examples in his own healings and his parables that healthcare biblically is modeled:

> I think that the way that Jesus lived is a really important idea when it comes to healthcare…the miracles that he performed and the relationships he had. So much of his stories are done by just walking and talking with people and healing people's bodies and bodily functions and sicknesses and ailments and so if that was Jesus' mantra, like he cares about our physical existence and… if scripture says you are to be like Jesus you are to emulate Jesus [by doing the same]… Jesus had countless examples of and even mandates about, you know, giving folks the shirt off your back…Or you know, the Good Samaritan caring for this man and when he did, going above and beyond caring for his needs. It's not just a mandate.

Catie also shares her perspective of Jesus' example of finding importance in the physical body, "… we see Jesus caring for people's physical bodies [by] his miracles… to care for

people's physical bodies that he knows will someday continue to deteriorate. There's something to that I think we can't miss as church leaders…" Ewin also comments on Jesus' example of both physical healing and his relational interactions that prioritized no judgment, even cross-culturally, highlighting Jesus' goal to renew people. Mitch mentions Jesus' example of maintaining holiness while eating with prostitutes and tax collectors in the context of understanding the Christian engagement with the healthcare organizations that are not Christian:

> I want to walk in holiness, but Jesus ate with prostitutes and tax collectors and didn't compromise this holiness one bit. So I understand, you know, Blue Cross Blue Shield probably pays for a lot of abortions, but so do my tax dollars. You know, so I think at some level that is simply unavoidable.

In this way, we can still be walking within Jesus' example in the context of healthcare even if we are not using exclusively Christian organizations or resources. Societal resources as a whole, from this perspective, are not outside of Jesus' example.

RQ2: How does culture influence the role of the Church in healthcare?

Between the 10 pastors interviewed for this study, there were many differing perspectives on how American Christians should engage with healthcare, both individually and as church institutions. The perspectives presented by pastors about proper engagement with the healthcare system directly impact their perspectives of what ideal healthcare in the American culture looks like. When asked about cultural considerations for health and healthcare, many of the pastors shared their perspectives on the American culture, government involvement, and systematic concerns. Some pastors also mention racial, socioeconomic, and other personal cultural concerns. Multiple

questions were asked to assess pastoral perspectives of the answer to this research question. Various themes emerged from the interviews relating to this question of culture within the role of the church in healthcare including the Proper Engagement with Healthcare & Medicine, the Separation of Church and State, and Cost of Healthcare & Underserved Communities.

Proper Engagement with Healthcare & Medicine

Many of the pastors spoke about the tensions within the Christian culture surrounding the use of medicine and trusting doctors or the healthcare system. The main topics within this theme include the concept of Hierarchy of Needs, To Trust or Not to Trust Doctors, and Trusting God.

Hierarchy of Needs

The topic of hierarchy of needs is grounded in the various perspectives shared about whether health needs are met in the body or spirit first. Two pastors shared strong opinions that the physical well-being of people needed to be address in order to make way for the spiritual. Lucas commented:

> … if you're so worried [about physical health], then you're not able to think about how much you're loved... So if we can take care of the body and those immediate needs and we can move on to heart, soul, emotions, all that… we're spiritual beings, but you can't just heal the physical with spiritual.

Catie adds to this understanding of meeting physical needs of the body being separate from the spiritual ones by sharing, “we do have a psychological mental component… I will do things specifically to nurture that mental compartment of mine, like go on a walk or go to therapy…”

Alternatively, other pastors shared their perspective that the spiritual needs of a person need to be met before the physical ones, instead of thinking about things from the traditional hierarchy of needs perspective. Ronald states, “If your body is not whole, but your spirit is redeemed, the fact that your body isn't well or whole is totally beside the point.” Kenan also comments on how the goal is to help people find spiritual health first by saying, “…the church's primary responsibility is people to find healing and wholeness through Jesus first and then also their physical wellness as well…” Although there was disagreement about whether the physical or the spiritual needs of a person come first, pastors overall spoke to the idea that there is a separation in thinking between the physical and spiritual parts of health in medical practice.

To Trust or Not to Trust Doctors

Unlike other topics presented thus far, every single pastor had perspectives to share regarding the trust of doctors and medicine. Perhaps this plethora of commentary on this area is grounded in the large spectrum of beliefs about good healthcare practices overall, but Tony points to the long history of tension between science and faith as a major factor:

> I do believe that part of the issue that Christians have had with Healthcare is the science part of it. For some reason, we've looked at the idea of going to the doctor as a statement against our faith. And that's always been a mistake…. I do think that's been an issue that's developed and probably more so in modern Christianity as the as the Word of Faith doctrine and the prosperity doctrine began to kind of become more popular in Western culture anyway. I think that that was an issue… the idea that you know, God didn't create doctors…

This broad acknowledgement about the tensions found within the Christian perspective of using healthcare services and medicine is vital context for the varying perspectives of the pastors as the interviews continued. Tony continues on to mention that the Apostle Luke was a doctor. Mitch and Edwin also commented about Luke being a doctor as a reason for Christians to listen to medical professionals in the community.

When discussing the role of medicine for the Christian, five of the pastors mentioned the passage in 1 Timothy 5:23. Mitch states:

> But you know, the fact that Timothy was sick and Paul says, you know, use a little wine for your stomach's sake and because of your frequent illnesses, he's literally telling Timothy to medicate himself. You know, it didn't just say claim healing in the name of Jesus.

Lucas shares, "But you see Paul giving Timothy the advice to have some wine for his stomach. Right? So obviously, like medicine, totally fine…" Edwin, Tony, and Ronald all additionally mentioned this verse as a reason to utilize medicine, but Ronald highlighted that Paul is not saying medicine is more powerful than spiritual healing. Tony presented his perspective on the use of doctors and medicine by saying, "if he gives us the knowledge [of health] to use for our benefit, then why not use that knowledge?" Lucas expands on his understanding of medication use biblically by saying:

> I would say medicine and science is a gift from God. It's actually discovering how God has created our bodies, our universe, all of it. The more understanding we have of that, I would say the better and the greater and bigger God becomes…

Sara's perspective is one of caution around medication use and stressed the importance of remembering natural resources and remedies before manufactured ones specifically by

sharing, “There's all these natural elements that we have at our fingertips… grab some herbs… We don't need all of these chemicals and stuff.” Edwin mentions the possibility of healthcare utilizing whatever methods, natural or manufactured, as an act of God, also commenting on the amount of judgement laced between the communities who differ in opinions on the conversation when he shared, “I think when somebody is either pro or anti medicine, you're making huge judgments on things that are… judgmental at best…So just about everything that could bring health is good, whether it's Eastern medicine or Western medicine…it's all God.” Expressing concerns with the homeopathically driven Christian community, three pastors shared stories about people they knew who refused available medical treatment due to their beliefs about it being against their faith. Mitch shared, “… you can let yourself die like my friend Trevor did, but then you are leaving a widow and orphans and you have to answer to God for that.” Kenan and Ronald both shared personal experiences of healing without medical intervention, and like Sara, advocated for prioritizing natural remedies before seeking medical intervention. Edwin mentions that miracles can happen through medical interventions and are just as legitimate as other miracles.

As presented, all pastors commented on the use of medical systems being sometimes beneficial, although some preferred to use natural remedies either before or instead of pharmaceutical interventions. Regardless, no pastor said that use of the medical system was unbiblical, although some had less trust in doctors than others.

Trusting God

For the pastors who were wearier of medical interventions, the theme of trusting God for healing was presented as most important. Ronald shared:

> Everything else [with health] will begin falling in place as you seek Him first… we can trust that God will use it to accomplish good for his name… we need to trust him that he knows what he's doing and because of who he is…

Sara resonated with Ronald's importance of putting the will of God first by sharing, "Like, I'm a firm believer, like God's got it handled." Ronald and Sara are the two pastors that seemed to be in the minority with prioritizing trusting God for healing, although neither were anti-medicine when natural remedies failed. Within the topic of trusting God for healing, both Tony and Mitch shared stories about people they know that come from that perspective. Tony communicated:

> I have a friend, as a matter of fact, who had a stroke because he wouldn't take his medicine…he was pastor of a church, but he wouldn't take his medicine because 'I'm believing God to heal me of the high blood pressure.' OK, well, in the absence of that… he had a stroke… we saw a lot of that [kind of thinking] particularly during the 80s, 90s, and early 2000s where this doctrine was that if you just believe, that'll be enough. And it was just an unwise - I don't want to say demonic – but it was just an unwise doctrine… Caused a lot of pain for a lot of

> people. Unnecessarily born out of ignorance, sincere sincerity, but ignorance nonetheless.

Mitch contributed:

> I've seen God spontaneously heal people. A lady in our church got diagnosed with ovarian cancer, emergency surgery. Everybody's praying. They open her up. There's nothing in there. So he can do that. But I've seen that once or twice in my 57 years of life. Like, he doesn't promise those things….

When discussing the concerns around biblical engagement with medicine within the American culture, what is clear across perspectives of whether or not to trust the medical industry or go back to the roots of trusting God first, is the emotional passion presented by the pastors. Regardless of the way each leaned within their perspective, they all demonstrated personal interaction with the medical world in some way, offering experiences with both sides of the debate of biblical involvement. The data generally pointed to pastors using medicine, some considering it an avenue God uses for healing and miracles, while others in the minority suggest being wary of the medical world and instead focusing on the spiritual health first.

Separation of Church & State

The theme of the separation of church and state was identified in the data as many of the pastors discussed how politics has become so intertwined with the medical system and healthcare, especially since COVID-19. Topics within this theme include History of

Church Involvement, Individuality, The Church's Role, Yes or No to Government, and COVID.

History of Church Involvement

When understanding cultural influences of the role of the church within healthcare, eight of the pastors mentioned the church's role within the healthcare system throughout history, six of them expressing the church's involvement with healthcare in the ancient and biblical times. Kenan shared:

> … in ancient areas, cultures like Israel, like the early disciples, you know, they tend to go to the local [with healthcare]. They don't call them doctors then, but the people who knew how to deal with certain ailments at the time… if you look at the history of the church in general… I came from a Methodist tradition. And so you'll have John Wesley have books on how to deal with, you know, broken arms or whenever missionaries would go to certain places, they had different home remedies, if you will.

Lucas speaks to more of the history of the church's and Christians' involvement with healthcare by sharing:

> I do know, like the early, early Christians, they would bring in the sick. The babies that were abandoned on the side of the road, the Christians would adopt those. I know during the plagues of the Middle Ages, Christians would stay and help and minister. I think Martin Luther talks about it …I mean, Christians were the ones who started the first hospitals. They were caring for the sick and the poor and the wounded and the outcast. I just feel like it weaves throughout Christian history that we are the ones who care for [people], like [in] the abbeys and the

> monasteries… It's a horrible time period, but even in the crusades, there was an order called the Hospitlers who started out helping injured pilgrims and stuff, and they turned into a military order, killing for God, which is terrible, but their origins were here to serve.

When considering the current way church is interacting based on this history, there has been separation. Edwin shares, "…there's many reasons why these lines [of separation] were very much blurred [throughout history]. And for whatever reason that I cannot know, it has been separated." Catie, being located in the Pacific Northwest of the United States, comments that current faith-based health involvement is not familiar to her by sharing, "…the history of the United States… originally it was faith-based organizations that were pioneering healthcare and I think just throughout time like that maybe that's shifted, probably rightfully so." From various pastoral comments, it is clear that the early church played a much more significant role in healthcare than it does currently. Some pastors seem to identify this as a positive thing, referencing more advanced systems and professionals, while others seem to present that the loss of connection to the healthcare system seems unnecessary, some even advocating for a return to involvement.

Individuality

A major important cultural consideration for the church as discussed by the pastors is the foundation of American individualism. Individualism within healthcare came up throughout many of the interviews, as some shared the importance of their right to choose things for themselves, while others discussed it as a barrier to improving the healthcare system. Tanner speaks to how individual interactions with those who need

care are what comes to his mind when thinking about his role in healthcare, rather than a systematic one:

> I think when most pastors think about the idea of intersection of Bible and healthcare, I think that we think more in terms of what is the intersection between Bible and that person in my congregation who's sick. Or the person in my community that's sick, or the person in my community that I know has an ailment of some kind. I think that that's more of an intersection that we think about… I've never thought of the idea of healthcare in a large sense intersecting… I think more individually. I think that pastors [in general] would lean towards that personally.

Cory expands on this concept by his example of conversations he has with congregation members when he shares, "I'm very careful… there's room for your personal beliefs to be able to help dictate the decisions that you make, right?" Edwin discusses his own autonomy over his body, while still acknowledging respecting differing perspectives from his own. Tony expresses the importance of upholding the rights of others when considering healthcare interventions by saying, "… the best system that I can see is the one that we have that that doesn't infringe upon other people's rights." He continues on to discuss how advocating for individualized education can help meet and empower individuals' health needs within communities:

> ... the reality is that none of us can live it for anyone else. And so the best thing that we can do for you is to teach you how to live it and then give you the freedom, you know, to make your own choice."

The topic of individually then within the context of the American culture aids in understanding that pastors are often more focused on the individual relationships with people in their congregations rather than systems.

What Can the Church Do Now?

Focus on The Gospel.

When asked about church involvement in provision of healthcare within the United States, some pastors specifically highlighted that the church was meant to be a place to heal spiritually, not physically, and therefore their churches focused on preaching about the gospel itself. Some pastors mentioned that conversations around health, or the topic of healthcare related to the Bible is not an issue they are concerned about. When asked how he may talk with his congregation about issues of health, Cory responded, "We get 52 Sundays a year. So we're going to use those Sundays and point to Jesus and point to the gospel." Cory continues on to say that health is not directly discussed from the pulpit, but that topics within health sometimes come up when preaching the gospel message. When asked how Christians are supposed to engage with healthcare according to the Bible, Mitch shared, "Well. I don't think it matters that much." Ronald mentions that the church needs to focus on teaching spirituality and identity in Christ.

Alternatively, Edwin commented on how churches have historically failed at being involved with healthcare in a healthy way, while still advocating against separating the church from healthcare interventions. He shares, "I could understand why churches want to just avoid [healthcare services] altogether, but I think it is very important because [people] come to one place for [spiritual] healing and have to go to another for [physical] healing." Some pastoral perspectives are that the church is reserved for spiritual health,

preaching the gospel, and dealing with health topics within those contexts, while other perspectives are that the church has done more in the past and could again be involved with conversations around healthcare if they so choose, even though it would definitely involve political debates.

Limitations of Practice.

Multiple pastors acknowledged that they are in fact, not healthcare providers and do not strive to own that role. In fact, many of the pastors advocated for that to be a reason to keep healthcare resources outside of church walls, instead focusing on partnering with outside resources. Catie shared:

> I'm equipped to help guide people in their spirituality, which also connects like emotionally, socially, you know, to people's worlds. But yeah, I think there's like a moment where that ability stops… we have a scope of practice as pastors. It's not doctors. But we need doctors and we need to know about things like that in our area so that we can help essentially funnel people to the correct person to address the need they have. And part of our scope of practice might be providing clean water to, like a homeless shelter… there are elements of physical health that we can enter into. Then there's a moment where it's like, that's beyond my scope of practice and let's get you to a professional…

Lucas echoes Catie's sentiments by saying, "I try to stay in my lane…We have trained professionals now who know what they're doing, whereas if I'm like, oh, you broke your leg. I don't know [how to help with that]." Cory adds to this understanding of the limitations of practice by speaking to the pressures as a pastor of having all of the answers that people seek, including those outside of his scope of practice. He shares, "…

people try to use pastors as their psychologists. And so often I sit and I listen and I go, OK, time to stop. I'm going to refer you… because this is beyond my scope."

While the pastors who spoke to their limitations acknowledged their boundaries of knowledge, they also highlighted the importance of being well connected and knowing of resources to guide people towards when they are asked.

Church as a Resource for Collaboration.

Speaking specifically about the role as the pastor within the church, four pastors mentioned their connections with the community being vital to their role and how they connect people with other resources outside of their church walls. Tanner mentions, "…your church should not be the epicenter of your influence. You should be able to be an arrow [that points people in the direction of help]." Edwin adds to this idea of being a well-connected resource by highlighting that although the church does still have a role of teaching the Bible, churches, and specifically pastors, also have the role of guiding people toward the specialized support they may need. The resources that pastors mentioned can be for many things and meet many needs. Catie often talked about mental health advocacy, however, she also mentions physical needs as a whole being something she can learn more resources in her area for, even mentioning the concept of being involved in advocacy for better healthcare structures. Overall, being a resource to point to other serves is acknowledged as an important role for the church and for pastors.

Pulse on Community

In order to have the knowledge of resources in the area, 2 pastors specifically spoke to the importance of knowing the community itself well by having a pulse on the community. Tanner specified:

> I envisioned the perfect version of a church intersecting with Healthcare is having an unbelievably close pulse on their community that would know the exact resources that folks would need, could help them monetarily where they can, but even if I can't figure out how to pay for someone's [needs], I know [how] to get that someone a job or I know how to connect someone with someone that could. I know the doctors that I could connect them with…

Lucas explains in more detail his understanding of what a close pulse on community looks like by sharing:

> Well, I would say if we had churches, and ours is not great at this either… actually in the community, not just meeting in the building every once in a while, but had people who are connected to the church in the community working with all socioeconomic classes, all race classes, all of that. And then we're aware of needs… But if we're not in the community and we're just going to that building because that's our clubhouse, then we don't know those needs… it's important that we, as the church, keep our finger on the pulse of the community, but also have those relationships with people who are working with those classes and are crossing the lines whether they are calling themselves Christian or not.

By keeping a pulse on their direct communities, pastors communicated that they are able to both know of more needs as well as point people in the direction of resources within their communities that can help meet those needs.

Clinics at Churches.

Although only one pastor out of the 10 interviewed worked for a church with this kind of resource, three pastors mentioned their desire to see more clinic

programming, even if they have never seen it. Additionally, Tony mentioned his church partnering with local government resources to put on health fairs, which although different from a clinic, is still bringing direct health services within church walls. Although there may not be many examples of church healthcare clinics from this group of pastors, two pastors spoke to the possibility of it being an opportunity for the American church to play a role.

Barriers for Involvement.

Within the conversation of this potential involvement in healthcare for the church, pastors identified some barriers for involvement. One of the most commented barriers was the size of the church or the limitations of time and money. Catie shared "So [we're] a small church, we're not widely connected with a lot of like different resources or programs…". Similarly, Lucas commented, "I would love to do that, but I don't have the time to find all those needs in the community and do that. And I don't have any money to hire somebody to do that." Edwin added to the conversation with his thoughts about trying to use the church space for health resources even as a small church:

> Our church right now is not suitable for it [in size], but it'd be really, really wonderful where the space can be utilized just about every day instead of just being reserved for one thing and one thing only [church services] …Yeah, and money [is a barrier].

Sara shared her perspective on a big barrier for the churches involvement in things like healthcare is due to their focus on their Sunday services and image with other churches rather than focusing on the needs of the community:

> I think there's just so many churches nowadays that just, they're like ostriches. They just put their head in the sand and they just focus on their church and that's it. I know it's a huge problem in [our town] where we have like 5 churches in our town and it's a huge everyone's against each other, nobody's coming together and it's not at a lack of me trying…There's not that deep fellowship that connects to discipleship. I think there's a lot of areas that we could be stepping up in and we're not because we're too focused on how many people are coming on Sunday.

Similarly, Tanner commented on how churches often focus resources on programs that are more sharable within the church in a video highlight reel, something that daily local involvement or programs do not offer. Barriers for church involvement can be identified as broad as funding and small congregations, or as specific as upholding the image and marketability of serving opportunities.

The Government's Role

When asked about their ideal system of healthcare within the United States, perspectives were drastically divided. Every pastor mentioned the government in some way, most likely due to the combination of how it is a big part of current conversations around healthcare within American culture, but also many pastors mention either more or less government involvement being the way to better the system. Ronald, speaking to the latter perspective, shares, "…because of the evilness and corruptness of man, get government out of it… the government is never interested in health. They're only interested in control." By having less government involvement, Ronald proposed that there would be more freedom for doctors to perform their healthcare duties within their religious convictions, including praying for patients. Sara also shares a desire for the

system of healthcare to utilize family businesses more rather than government getting more involved, with the intension that doctors could have more manageable caseloads. Mitch speaks to the injustices of the political agendas of healthcare, acknowledging while it makes sense as believers people want to disengage from the government system, that it is part of living within the American system. Lucas acknowledges the tension of government involvement with healthcare also, communicating some mixed thoughts about how much he would want the government involved:

> Look, like anytime the church gets in bed with politics, it's messy… I don't want to use the political term, but universal health care [would be ideal]… but done well, which, who knows if that's even possible… [but] I don't know of a better way to do it… I would say keeping the church out of politics as much as possible would be very good. But also, I don't think politicians and our political system is bad.

Catie echoes Lucas' desire for free healthcare with her thoughts, "I would love if healthcare was like, frankly free. If not, like, just way more affordable." Similarly, Tony shares:

> I would love for healthcare to be universal and free. However, there's no such thing as free… Somebody's got to pay for it. And the reality is that, if it is universal, then the quality of it probably isn't going to be very good… However, that's the pipe dream. It would make a miracle to figure out how to make that system work.

Cory also expressed his desire for healthcare access for people, expressing government involvement as a potential option, giving more details of what that looks like by saying:

> I do desire that healthcare would be available to everyone. Now, who does everyone include? When we're talking about illegal immigrants and that whole thing? That's a whole like I don't know. I wrestle with that a lot… the rich get richer and the poor get poorer and it's not accessible to those that honestly need it the most. I think there are people that take advantage of it and so of course that's always something that you've got to be watching out for. But I think for the most part as far as I can tell, right, there's checks in place, you know, so that those things are taken care of.

Tanner shared that the idea of utilizing churches with government to change the healthcare system within the United States is not something he has thought much about:

> I've never thought of the idea of healthcare in a large sense intersecting… I think that's such a huge conglomerate idea and usually one that has a negative connotation as of late. [Church and government partnership] Could definitely be something that's added, especially where there's a gaping hole in the theoretical American system. You know, I don't know that I have a specific answer.

Although some pastors may be hesitant, like Tanner, to envision the church having an operational fix for healthcare, Sara thinks that churches should be more involved in a lot of systems, including healthcare when she shared. “I just think in general, not just in healthcare but in general, churches have gotten lazy… We need to get back to actually tending to God's children, our brothers and sisters in Christ…we're being lazy.” As presented, there are many different pastoral perspectives when considering the role of the

government in an ideal healthcare system. Some pastors are very against the expansion of government resources to aid in healthcare reform, while others are not opposed to it but do not have a positive outlook of the success of that plan. Considerations for other plans or interventions, however, were few and far between.

COVID

In today's healthcare climate, COVID-19 comes up often. Especially within conversations with pastors, as four pastors commented about difficulties managing conversations around the pandemic with their staff and congregation. The pandemic brought many of the topics mentioned so far to the forefront for pastors, who were having to make decisions about being open, staying closed, requiring masks, and other things that married the healthcare and political debate across platforms, church included. Many pastors spoke to how impossibly complicated it felt. Cory shared:

> I think that does speak to the challenge that we have as pastors… during COVID… I had everything on every side of it, right… And here we are in the middle, trying to minister to these people, right. And there, there wasn't the Thou shalt not get a COVID vaccine. You know, we don't have verses like that. And guess what? Didn't come up in seminary training, how to pastor during a pandemic… And so it was definitely a real wrestle.

When presented with questions or commentary by his congregation, Lucas shared his method of navigating those challenging times:

> Yeah, well, we lost 50% of our people in COVID because of the decisions we made… there were Christian, Jesus loving scientists that I trusted and Christian leaders saying, let's take this seriously. And so I said, great, let's do that…

> Because we're commanded to love… the challenge I gave people, is, during this pandemic, what does love look like?

Altogether, the data showed that the COVID pandemic created a lot of complications for some pastors, highlighting differences of opinions with the trust in the government, healthcare systems, health information, and trust in medicine. Pastors were asked a lot of questions during this time that they did not always have the answers to. The sentiment during the navigation of the pandemic was that it was confusing and complicated.

Costs of Healthcare & Underserved Communities

Healthcare Costs

Many of the pastors point to the expense of healthcare being a major consideration for Americans. Mitch shared his thoughts about the costs of healthcare being the main source of the healthcare problems within the American culture by saying:

> The problem is that it costs $14,000 to have a kid. If you go to socialized medicine and you never deal with why a birth costs $14,000, you haven't fixed the problem. Can we have a conversation about why is $14,000 to have a baby? … $14,000 doesn't guarantee nobody's dying… I don't care so much whether we have private insurance or public option. There's pros and cons either way. Why does it cost so much?

Catie, currently pregnant herself, also spoke to how challenging the cost of having a child is, sharing, "… my value of life would come into play… [can we] make birthing a human a free thing to do?" Three pastors mentioned the costs of emergency room care, highlighting that cost is a concern for many people. Six of the pastors expressed a desire for healthcare to be free for everyone, with some specifying that lower income

communities have a much harder time affording care. Lucas mentioned that he knows of megachurches that have done things like paid medical bills for people, and that he would want churches to help provide resources:

> I feel churches in however they can do it, should help provide for health care, whether that's using some of their funds to pay hospital bills, like I said, or somehow pushing for some type of universal health care… I probably wouldn't ever say that from the pulpit, but I think if we read scripture, just because you have the money doesn't mean you're the one who should be healed.

There were additional things mentioned that may contribute to the expense of healthcare. Ronald mentions pharmacies increasing medication costs, desiring to see a shift in mindset from those companies as a way to lower costs. Additionally, two pastors mentioned the expense of malpractice insurance that medical providers have to pay as being another contribution to the rising healthcare costs. Mitch shares, "… you're looking at this constellation of issues that all have problems and nobody has the political will to tackle them. And even going to a I think like a collective, biblically based approach [for healthcare] still doesn't address that issue." Kenan mentions the added complication that with healthcare systems that prioritize profits, they also usually are the resources that have the latest technology to address health concerns. There are clearly many factors related to costs that are presented as complications to American healthcare systems.

Underserved Communities

An important consideration when thinking about the way culture influences the role of the Church in healthcare is underserved communities. Although many pastors discussed the idea of culture within the context of American culture and government

systems, some highlighted the importance of specific cultural minorities needs. Even within this context, there was some disagreement between pastors of whether there are racial, ethnic, and socioeconomic differences with healthcare. Ronald shares that from his perspective, people need to be treated equally within the healthcare and government system, something that he sees as being currently unequal. He shares:

> … for the most part, your 'racial ethnic' ancestral background should have absolutely no play in anything dealing with medicine… [resources] will go into some of these, 'underserved communities'. But part of that equation as well is, okay, what is driving them being underserved?... you need to get the government to quit playing favorites… And part of that is also recognizing the reality of the situation because of the evil nature of man, is that, yes, there are going to be some people who will get 'better health care than others'. Well, welcome to a fallen world… the only way to shut down the assault, the racist assault on the country is to quit talking about it. Let's just talk about people.

The other pastors who spoke about minority communities shared perspectives surrounding the specific health needs of particular communities, and the differences in accessing resources. While still acknowledging the humanity that brings everyone together, Edwin shares a slightly different approach:

> [We] can be very sensitive towards those issues, I think. And I think people can be sensitive to the socio-economic issues, cultural issues or ethnic gender issues. We're all humans. We all want to be accepted and we sometimes forget that despite what we don't agree on, we agree on a whole lot of things…

The majority of pastors who mentioned cultural health considerations shared the perspectives that there are specific differences. Catie mentions this fact even with Jesus' ministry by sharing, "… Jesus prioritized people that were othered by society… that's racial minorities, lower income, and vulnerable families… Jesus interacting with people on the margins does directly prompt me to… specifically be working towards good healthcare solutions for [them]." Although the sample of pastors was mostly non-minorities, Edwin shared that his experience as a minority aids in his awareness of the differences with access to care, sharing, "… me being a person of color…told that I was an outsider… I know little bit at least how that feels and how hurtful that it can be for the person." Tony mentions that within the African American community there is a lot of misinformation about health and wellness, something that impacts that community differently from non-Black communities. Tanner spoke to his experiences of privilege as a white person by sharing, "I'm white. I'm extremely privileged… after being in a privileged position and then coming to a very underprivileged community, the number one thing that has taught me is that education is extreme power." Therefore, those who mentioned underserved minorities as needing particular resources advocated for healthcare resources as well as education to help empower those communities.

RQ3: What current programming in Churches support the Biblical responsibility of healthcare?

When asked what kinds of programming supports each pastor's perspective of healthcare, most of the answers related to programs that their churches partnered with. The themes of Medical Missions & Overseas Opportunities, Christian Health Resources,

Partnerships Externally, In-House Programming, and Pastor Education were identified in the data.

Medical Missions & Overseas Opportunities

Doctors Without Borders, missionaries that used their medical skills, medical missions trips, and general missions trips were all mentioned by various pastors as programs that churches are currently involved with on an international level. Six pastors mentioned when discussing international healthcare programs and opportunities that it is important to them that the programs are designed to empower local communities, not just visit, help, and then leave. Lucas shares:

> The amount of money we spend just sending our kids on this one-week little trip where they feel like they're closer to God… could be so much better used to actually help the people that they're visiting. I've never thought about this, but the way you posed the question, we send so much abroad to help people, yet then we're like, well, we shouldn't have universal health care here because we'll get crappy care for everybody… we seem to care more about the poor over there than the poor here because we think the poor here should pull themselves up, I guess.

Sharing a slightly different perspective, Tony highlights that some people do talk about helping people here before going overseas, not seeing why both cannot happen at the same time. He shares, "… does home have to be perfect before you can help anybody else or can we walk and chew gum? And I think we can do both. I just think it takes us to be deliberate." Tanner shared that from his perspective, some people are "internationally called" and some are not, offering perspective on why there may be some different opinions on how to engage with international care. When sharing about one of his friends

that does yearly missions trips to Nepal, he commented, "… I'm not called there, [so] it's really easy for me to just be like, I don't love it. I think there's plenty of things you could do here [instead]." He goes on to say the early church did not have access to the knowledge we have about worldwide suffering, adding to the complications of the conversation of whether overseas resources are the most helpful. He shares, "… your only parameter for what you could meet was in your community [in early church times] … starving children in Africa, that wasn't a knowledge base…" He, along with the other pastors that mention overseas opportunities and programs, spoke to the need for follow up and local resource building to make that kind of programming effective in the long term.

Christian Health Resources

Two pastors mentioned faith-based hospital systems are current programing and resources that supported their understanding of the biblical responsibility of healthcare, as they ideally prioritize people over profit. Additionally, four pastors mentioned the Christian healthcare insurance company, Medi-Share, as a possible program. Although all four reported being uncertain of its effectiveness and that, although they know people who utilize it, they themselves do not. Pastors overall seem to have mixed feelings about it, concerned about some gaps in care as well as the implication of separating Christians from non-Christians within healthcare spaces. Tanner shares:

> I'm conflicted on it because on one end, I think it's brilliant because it takes Acts 2 and it puts it into play… We're just going to help those who need help… But the place where I got really conflicted was the idea that they had the ability to yay or nay [covering healthcare bills] … it's a little scary..

Commenting on the Medi-share system that reimburses based on the agreed upon Christian values, Mitch shared, “we live in a pagan world though, you know, like I sent my kids to public school… if you're going to be a disciple maker, you got to be around unbelievers… I don't want to be too separatist.” Sara was not concerned about the separation from regular resources; but instead expressed that she did not yet trust that the medical needs of her family would be met, as there is no guarantee.

The last Christian health resource mentioned was clinics that some churches facilitate. Although only one of the pastors in our group had a healthcare clinic at their church, two other pastors mentioned churches that they know that do have those services as well. Tanner shared, “[A Church in] Columbus [Ohio]… They have a full time healthcare staff on the other side of their building… mental health, immigration lawyers, because Columbus is a huge Syrian refugee population” Kenan shared about the clinic at his church:

> … so at our church we have a volunteer ran health clinic by nurses and certified doctors, chiropractors, physical therapists, eye doctors… I think there's a place for that in modern American healthcare where they're doing it out of the love of people. … our nonprofit health clinic at the church is more of a just something for the community. But if it's the patients are dealing with something more extreme, we obviously refer them to hospitals… the general times are in the evenings when the doctors and nurses are out of their day jobs… they come in to volunteer. Sometimes people call in and we can't see them for a month, just because of availability… it's heavily, it's heavily used… it's like 20-40 dollars and that includes even medicine sometimes. We do blood work as well… at the end of the

> day it's still American based ways of doing healthcare, just presented in a way that's understandable from wherever they're coming from and how we can best accommodate and how we can help them feel safe…

Partnerships Externally

Five pastors reference external programs that they partner with in their communities as things that model their biblical understanding of the responsibility of healthcare. Catie mentioned an organization called Speak Out that helps train pastors on dealing with mental health crises, as well as an organization called The Glue that is a website for people who are in crisis and want to connect with a pastor to talk about whatever they are going through. She also mentioned her church's partnership with an organization that builds tiny homes for unhoused populations in the Portland, Oregon area that also provides basic health check-ups for those populations. Tony mentioned a partnership that his church has with Alive Faith Network, an organization that works with the local medical system to provide resources to community members. Tony also mentioned that his church co-sponsors the local African American Health Fair that provides services like blood pressure screenings to the African American community. Cory shared that his church partners with a pregnancy center nearby, offering free services and education to expecting mothers. He also mentioned being on the board that is developing a maternity home connected to the center, offering housing for expecting and new moms that may be unsafe otherwise. He also mentioned ties to an organization called Help One Child that centers around foster care services as well as one called Moms that gives single moms help with car repairs. All of these partnerships demonstrate

ties to various communities, painting a broad definition of what healthcare programs may entail from the pastoral perspective.

In-House Programming

When asked about in-house programming that their churches offered, many pastors spoke to programs focused on education, some around health specifically, and others around family. Tony discussed education as a major opportunity for churches to be involved, identifying, "we can do [education] in the area of healthcare, of education, of government, of finance, of relationships… and otherwise." Tony mentions that there is a local doctor who will come into his church and gives seminars about health education. He also shares that his church does weight loss competitions, as well as has an exercise ministry that does workouts and diet education, mentorship programs, financial literacy programs, marriage counseling, and grocery giveaways. At his church, Tanner shares that there is a local doctor that has a ministry called The Well where she comes into the church and offers health information to the congregation. He shares, "…she's big on autonomy and teaching people how to ask questions, how to elongate a doctor's visit, how to get the care that you need." Cory shares that his church focuses their educational programming for health at church on the family system and what defines marriage, bringing in various speakers to help education the congregation during classes about these concerns.

Pastor Education

Two pastors, Catie and Lucas, both mentioned that as pastors, they want to continue learning about ways they could be more knowledgeable about health and health concerns. Two other pastors mentioned that they were largely unfamiliar with the concept

of Christian approaches to healthcare. Catie mentions that the organization Speak Out has played a big role in fostering this goal of hers, as it has highlighted some of the limitations directly for meeting health needs of her congregation. Similarly, Lucas mentions how he would like to learn more about what his theology on health really is, as this interview is the first time it has been brought to his attention in this way. He shares:

> "… it would be cool if there was some resources for pastors about mental health… Mental health, physical health. You're asking if I have a theology on health…. I wish there was a book about the theology of health so then I could create one. And I'm sure there's something out there. I just don't have time to find it.

With four of the pastors expressing a lack of familiarity or a desire to know more, the data suggests that there may be more exploration for pastoral education on the topic of health in churches as well.

Summary

The data from 10 pastoral interviews showed various themes throughout all three research questions. Within RQ1, the themes of Defining Health, Ideal Actions of Health, and Example of Jesus were identified. The key findings within this RQ were that pastors understood the biblical responsibility of healthcare to include both caring for the self and caring for others, although the ways the pastors envisioned this care varied. Topics of Holistic Health, Body as Temple, Role of the Individual, and Community Focus were discussed within these findings. In RQ2, major themes included Proper Engagement with Healthcare and Medicine, the Separation of Church and State, and Cost of Healthcare & Underserved Communities. From this data, pastoral perspectives were very mixed on

how culture influences the role of the church in healthcare. Some advocated for the church getting more involved, while others held that their limitations of practice and knowledge would be more damaging than helpful. Across all interviews, however, pastors agreed that ideally, healthcare would be free and accessible to everyone that needs it. Topics of Hierarchy of Needs, Trust of Doctors, Trust of God, History of Church Involvement, Individuality, What Can the Church Do Now, The Government's Role, COVID, Healthcare Costs, and Underserved Communities were discussed. Under RQ3, the themes of Medical Missions & Overseas Opportunities, Christian Health Resources, Partnerships Externally, In-House Programming, and Pastor Education were identified. Pastors shared programming they were personally connected with or new about and supported.

CHAPTER 5: DISCUSSION

Overview

The purpose of this qualitative case study was to explore cross-cultural pastoral leadership's perspectives on what the role of the Christian is within healthcare. The qualitative interviews explored concepts such as resource investment, multicultural expectations, barriers to Church involvement, and Biblical understandings of caring for the sick. This chapter discusses findings in the study and implications of the themes assessed.

Summary of Findings

In the exploration of RQ1, *What is the Biblical responsibility of healthcare?* the themes of Defining Health, Ideal Actions of Health, and Example of Jesus were identified. The key findings within this RQ were that pastors understood the biblical responsibility of healthcare to include both caring for the self and caring for others, although the ways the pastors envisioned this care varied. In RQ2, *How does culture influence the role of the Church in healthcare?* major themes included Proper Engagement with Healthcare and Medicine, the Separation of Church and State, and Cost of Healthcare & Underserved Communities. From this data, pastoral perspectives were very mixed on how culture influences the role of the church in healthcare. Some advocated for the church getting more involved, while others held that their limitations of practice and knowledge would be more damaging than helpful. Across all interviews, however, pastors agreed that ideally, healthcare would be free and accessible to everyone that needs it. Under RQ3, *What current programming in Churches supports the Biblical*

responsibility of healthcare? the themes of Medical Missions & Overseas Opportunities, Christian Health Resources, Partnerships Externally, In-House Programming, and Pastor Education were identified. While most pastors did not report direct in-house healthcare resources, many spoke about external programs they support and direct congregants to. Education as a resource was also highlighted as something several of the churches are focusing on.

Discussion of Findings

The findings from this research point to some relative contributions to affirming previous research, while also drawing attention to some distinct differences. First, the discussion focused on the research questions will be presented, followed by a discussion of the data within the Biblical foundations.

Discussion Related to Research Questions

Like previous research, pastors in this study did discuss their own health as an important resource for modeling behavior, as well as some showing a similar distrust in government systems when asked about the biblical responsibility of healthcare overall as well as for the church (Baruth et al., 2015; Bolger et al., 2018; Cheon et al., 2016; Drovdahl & Jones, 2020; Gross et al., 2017). However, unlike previous findings, multiple pastors were comfortable with government healthcare involvement, some even highlighting that a socialistic universal healthcare, although the quality may not be ideal, would be the only way forward in provision of healthcare to all in need. This difference in data is important, as the most recent study examining pastoral perspectives at the time of this writing is Abbey & Keogh George (2020) which would have put the timeline of

the interviews before or during the COVID-19 pandemic. Perhaps this difference in the openness to government intervention from so many of the pastors is related to the impacts of the COVID-19 pandemic, both helpful and challenging. As discussed previously, some pastors mentioned COVID as a challenging time for their churches and ministries, being asked health questions they were often unsure how to answer. Perhaps this has added to pastoral understanding of the limitations of the practice, resulting in a willingness to consider governmental involvement. As shared in the data, many pastors commented on their limitations of practice, acknowledging they are not healthcare providers and do not wish to do harm by overstepping their roles of being spiritual leaders. An important note is that while many would think the support of government involvement was exclusively from pastors in traditionally liberal areas of the United States, the regions that pastors lived in appeared to have very little impact on their leaning of more or less governmental involvement in the healthcare system. The current findings seem to be in alignment with Payne's (1993) findings that while some hold that the government should remain uninvolved in healthcare solutions, the Bible's non-prohibition of good government systems may create space for the government to play a role in meeting healthcare needs. On the topic of the government, it is important to note that none of the pastors made mention of the faith-based healthcare executive order that the government has utilized since the presidency of George W. Bush that puts value on a partnership between the government and faith-based resources for healthcare intervention, potentially highlighting the lack of awareness of the governments direct support of faith-based healthcare interventions throughout the last many years.

The tensions between faith and science were evident within the data presented in this research. Many pastors spoke to the history of the church being involved with healthcare resources, but that the shift away from those resources had an unclear timeline and/or reason, or at least, the pastors were unsure of them. Many pastors discussed their experiences with people that had strong opinions on the use or non-use of medication, grounded in the ideals that God will heal naturally if it is meant to be. An interesting takeaway from the data in this particular study is the idea that by not taking medications that might be another way God is providing healing, you may leave a family behind in death, something that would be potentially heartbreaking to God. This idea is one that seems to be new from previous research, that God's judgment is possible by choosing not to engage with medicine if medicine is a way God is making room for healing. Generally, regardless of the amount of support, all of the pastors interviewed supported some kind of professional medical interventions, even if they shared stories of other pastors they knew with differing perspectives.

Although pastors all advocated for healthcare being accessible to all, none of them clarified it as a human right, or expressed the *why* it should be accessible to all. Catie's interpretation of the value of life impacting her view that having a child should be free is the closest representation of a why behind the value of healthcare for all, however, the pastors overall discussed everyone having access to healthcare as an ideal, not as a human right. When considering barriers to the accessing of healthcare, pastors in this study focused limitations of access on costs of healthcare, with only a few mentioning underserved populations. While some of the pastors mentioned minority communities and their challenges with access to care, multiple pastors also commented that there

should be no difference in healthcare resources based on identity qualifiers. Unlike these findings, previous research identified additional barriers to access of care including geography, ablism, and general access concerns (Choi et al., 2020; Coombs et al., 2022; Matin et al., 2021; Rachoin et al., 2021).

Previous research has been focused on minority community pastoral perspectives, often finding church resources available to local communities through those churches. Consistent with the previous research focused on the majority culture, pastors that worked within majority culture churches were more likely to not have direct church programming relating to healthcare. Although many highlighted their focus on knowing resources in their communities to refer congregants to, many struggled to directly name programs and healthcare resources for people within their communities. Aligned with previous research, pastors often discussed their opportunities for involvement within healthcare is limited to the referrals they can make and education they can give, connecting back to the individualistic understandings of the American culture.

Two out of the ten pastors reported having actual healthcare or health education services within their church walls. Two additional pastors mentioned their familiarity with two other churches that offers those services. Out of the pastors that did not offer healthcare services, three mentioned that they do not see those resources as important for the church, one mentioned the laziness of the church, and the other four reported their lack of financial resources as a major barrier. Pastors also mentioned their lack of time and lack of knowledge themselves as reasons for not offering health services or programming, consistent with barriers found in previous research (Cheon et al., 2016; Gross et al., 2018; Jo, 2010; Rowland & Isaac-Savage, 2014; Williams & Cousin, 2021).

As far as this researcher is aware, this is the first time a pastoral sample has been cross-cultural and multi-gendered, gathering pastors from various places on the West Coast and the Midwest. Although female pastors had some specific things to share about added challenges of advocacy for change as a female pastor, their familiarity with resources and perspectives around health were relatively similar to their male counterparts. The pastors who belonged to minority groups, however, or worked in churches that pastored minority communities, demonstrated different understandings than their white counterparts.

Biblical Foundations

Consistent with previous research, pastors struggled with questions focused on understanding their theology of health, and what they perceive the Bible instructs about health and healthcare as a whole. The most mentioned Bible passage that pastors reported was related to their understandings of health was 1 Timothy 5:23, using this as a guide to support the use of medication when needed for health. As found in previous studies, pastors struggled to identify specific answers as to *why* their belief about health was the way it was (Abbey & Keogh George, 2020; Senteio, 2019). Some of the pastors presented the creation story as their foundational *why* health included the holistic nature and calling externally. When asked about the definition of biblical health, one pastor mentioned the Hebrew word Shalom, but did not go into detail about how his understanding of Shalom influences the responsibility of healthcare, as he mentioned he does not see the church as having much of a role at all in the provision of healthcare. Only one pastor mentioned the story of The Good Samaritan and only five mentioned Jesus' healing ministry as a biblical example of healthcare. This lack of information

about the underlying convictions of health and healthcare, while consistent with previous research, continues to highlight the lack of education for pastors around the theology and biblical responsibility of health.

Aligned with previously discussed Biblical foundations, pastors did specify that sickness was not a direct result of sinful actions, although the passages supporting this found within Jesus' ministry were not directly mentioned. Luke being a doctor was mentioned by four pastors, a fact that contributed to why pastors were comfortable suggesting their congregation seek medical attention when needed. Only one pastor mentioned the Great Commission as being rooted in having a healing element to ministry. The body as a temple was mentioned by multiple pastors, being the second most popular passage when asked about specific passages that guide the understanding of health. The biblical foundations of health and healthcare from this research was focused overall on the fact that health is good, healthcare is needed, and the uncertainty of how to play a role in solution-finding beyond connections they have with their communities.

Implications

The biggest implication of this study is that more pastoral education is needed around the theology of health and healthcare within the Bible. Especially with pastors emphasizing their confusion and feelings of overwhelm during the pandemic, it seems clear that pastors are under-educated in the importance of and opportunities for healthcare reform in the United States. Perhaps if, as Catie suggested, more organizations focused on training pastors on how to deal with basic health concerns seen within their congregations, they would have more confidence with how to move through those

concerns. However, this kind of training does not deal with the important piece of the theology of what biblical healthcare is. If pastors were able to have more of an understanding of the theology of health and healthcare, perhaps they would be more compelled to use their church buildings for healthcare programming, or even just advocate for and educate their congregations about how to navigate the complex healthcare system.

Another important implication is the lack of awareness the majority culture pastors overall had for the documented needs of various minority communities. This lack of awareness may significantly impact pastors' abilities to be aware of diversity concerns and use their platform for helpful advocacy. As seen from the data, the two identified pastors of color spoke differently about the church's involvement within health education and programming, both speaking to their experiences being under resourced in healthcare themselves. Some pastors talked about wishing insurance was more affordable, however, there was not mention of people who cannot get work at jobs that offer healthcare but may not qualify for government resources. Again, this implication is grounded in the continued need for more education on the specific cultural differences and needs of minority communities and communities overall that have difficulties accessing healthcare.

The last highlighted implication is that some pastors specifically identified their desire to learn more, while others considered the topic unimportant. Not only then does this research comment on the need for more education, but it is supported by pastors specifically asking for more resources on the topic, something that previous research has

not spoken to. Perhaps pastoral education is the beginning of truly making waves in reinventing holistic healthcare within the American healthcare system.

Limitations

There are a few important limitations to acknowledge in this study. Firstly, because this is a one-on-one interview qualitative case study, the biggest limitation is generalizability. Although having a sample size of 10 pastors is well within previous research norms, it would not be possible for these 10 pastors to accurately represent all 500,000 in the United States. However, this data gives us insight to how to continue the dialog within the broader Christian church around its involvement with healthcare.

Similarly, this study does not determine causality. Deduction of why the pastors have the perspectives that they have is not something this study focuses on. Therefore, this data is not useful for prediction of how pastors will consider these issues in the future.

Social desirability is another potential limitation. Pastoral reputations matter, and three of the pastors specifically mentioned their hesitancy to admit some of their perspectives and that they would not admit those same perspectives from the pulpit. It is possible that some pastors presented alternative answers to questions based on fears of potential repercussions from their congregations or others. Although pastors signed an informed consent document that establishes anonymity, pastors could be concerned with how the researcher might perceive them socially or professionally given their answers.

The use of a convenience sample is always another important limitation to acknowledge. Although there was a grave attempt made to diversity the pastors

backgrounds, locations, ages, genders, and race and ethnicity recruited in the hopes of diversifying perspectives, the sample may not have accurately accomplished that. Pastors were recruited and scheduled on a first come, first serve basis, contributing to the further possibility of a less diverse sample base.

The last identified limitation would be that all interviews were conducted virtually. Although they were completed over a video chat, there is possibility that some nuances of conversation could have been missed. Some pastors had their phones by them, taking a call when needed, or checking notifications. Although this may not have impacted the interviews or data at all, nor is there a guarantee an in-person interview would have altered this, however, it is important to mark as a potential limitation.

Recommendations for Future Research

The first recommendation for future research based on this study is to interview more pastors from more areas of the country with more diverse backgrounds. Including more demographic diversity may result in differing perspectives, and since this is an area of research that is still lacking, there is plenty of opportunities to continue it. Additionally, within interviewing more pastors, the possibility of interview follow up may be helpful. Many pastors commented that if they would have seen the questions beforehand, they would have had "a whole sermon ready" about it. Although for this research it was intentional not to share the questions beforehand to capture genuine perspectives, perhaps a follow up interview would be beneficial to see if pastoral perspectives have changed, or perhaps their programming or resourcing changed since the previous interview.

Another key area of future research would be to explore how pastors would best respond to education programming about the theology of health. Some pastors acknowledged their lack of time as a concern, a common reason given from pastors that declined to be involved in the interviews at all, so understanding what resources would be most effective at equipping pastoral leadership with information about biblical health and healthcare could make the difference in their willingness to participate.

The last identified direction of future research could be about what kinds of programming churches are involved with, both in-house and off-site, are most effective in meeting healthcare needs. For churches and pastors that may desire to expand their influence in the healthcare industry, knowing the most effective way to accomplish that would be vital for overall success.

Summary

Understanding 10 different pastoral perspectives on the biblical responsibility of healthcare and their understandings of the role of church in healthcare resources is complex. Pastoral perspectives did not always align, but findings generally pointed to the agreement that health is important to God, and that healthcare resources need to ideally be available to all. Pastors overall struggled to express the theology behind health and healthcare, some pointing to the Old Testament laws or Jesus' healing ministry as resources. Although they did not all agree on the level of involvement the church should have in the provision of healthcare or what that provision should look like, pastors shared the perspective that if people are hurting, it is the biblical responsibility to do what is

possible to help. It was in the *how* that resulted in somewhat of a dead-end for six out of 10 pastors.

Overall, this study demonstrates that pastoral perspectives of health and healthcare are not united or clear, and that there may be opportunities for pastoral education to increase understandings of both the *why* and the *how* behind the role of the Christian, the church, and pastors in the biblical responsibility of healthcare. Pastors expressing a general openness to learning more about the topic speaks to an opportunity that may exist within the system to bring science and faith back together in a way that honors the foundations of the historical past while holding space for change and growth to provide professional resources within Church walls, and in doing so, reinventing holistic healthcare.

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APPENDIX A: SEMI-STRUCTURED INTERVIEW QUESTIONS

Semi-Structured Interview Questions

1) "How are Christians supposed to engage with healthcare according to the Bible?"
2) "What role do Christians have in the provision of healthcare in the United States?"
3) "If healthcare in the United States could look like anything, what do you think it should look like based on Biblical responsibility?"
4) "How does culture relate to your Biblical understanding of healthcare?"
5) "What do you know about faith-based healthcare organizations in the United States or abroad?"
6) "What scriptural references guide your theology and knowledge of health?"
7) "What programs do you support that model your definition of the Biblical responsibility of healthcare?"