

# Acknowledgements

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# Executive Summary

This project is concerned with affiliations between Catholic and non-Catholic health care providers and their impact on the availability of reproductive health services in communities. The project examines trends in affiliations involving Catholic health care organizations, key issues in the affiliation process, the role of reproductive health services in the affiliation process, the impact of affiliations on the availability of a range of reproductive health services, and approaches used to provide these services. The number and types of formal affiliations (including joint ventures, mergers, acquisitions, consolidations, and long-term lease agreements) involving Catholic health care organizations between 1990 and 1996 are described, and a comparative case study method is used to describe the affiliation process and its outcomes. The cases are intended as illustrative models of successfully negotiated affiliations between Catholic and non-Catholic organizations and of possible solutions to issues involving the availability of reproductive health services.

The study finds that the number of affiliations between Catholic and non-Catholic health care organizations has been increasing (as have affiliations in the health care industry as a whole) and that a range of strategies is used to accommodate the partners' different values and traditions. The case studies of four successfully negotiated affiliations between Catholic and non-Catholic health care organizations suggest that acknowledging the importance of ideological differences early in the affiliation process and developing explicit strategies to deal with controversial issues are critically important. Overall, the case studies reveal little change in the availability of reproductive health services as a result of affiliations. Surgical abortion was the service most likely to be curtailed post-affiliation, and obstetrical services were most likely to be expanded or improved.

Specific findings are highlighted below.

## Overall Context for Affiliations

- Catholic hospitals represent about 10% of U.S. acute-care hospitals and were involved in about 18% of the nation's hospital affiliations between 1990 and 1996.

- Between 1990 and 1996, 131 formal affiliations involving a Catholic hospital or health system were publicly reported, of which 78% were between Catholic and non-Catholic organizations.
- Between 1990 and 1996, 40% of known affiliations between Catholic and non-Catholic providers were mergers, and 39% were acquisitions.
- Key factors motivating affiliations between Catholic and non-Catholic organizations in four case studies were increased competition in local markets resulting from the growth of managed care and capitation, declining hospital census, and a desire to increase market share.

### **Factors Associated with Completed Affiliations (in Case Studies)**

- Ethical and religious concerns about reproductive health services were evident in all case studies, and the reproductive service most often at issue in the affiliation process was abortion.
- Successfully negotiated affiliations between Catholic and non-Catholic case study organizations were characterized by:
  - identifying a strategy to address differences in ethical and religious values and their impact on controversial services early in the affiliation process;
  - developing strategies to obtain necessary approvals from the Department of Justice and the Catholic Church;
  - developing a plan for managing the operational and cultural changes required to support an affiliation, including human resources issues;
  - developing a plan to motivate physicians' participation in the affiliation process; and
  - actively informing the community and soliciting community involvement in all phases of the affiliation process.
- Ongoing challenges for the affiliation partners included managing cultural integration, workforce reduction, and physician-hospital relationships.
- Benefits to the communities included avoiding closure of facilities, improved services, reduced health care costs, and expanded community-based health programs.

## **Outcomes with Regard to Availability of Reproductive Health Services (in Case Studies)**

- Outcomes for reproductive health services were influenced by several factors: the pre-affiliation range of services provided by the partnering organizations, the history of earlier affiliation attempts, community involvement in the affiliation process, and community traditions with regard to women's reproductive rights.
- Hospital-based surgical abortion services were discontinued in two cases and unchanged in two cases; policies proscribing abortion referrals were not observed.
- Obstetrical services were expanded in two cases and unchanged in two cases.
- Family planning/contraceptive services were regarded before and after affiliations as issues best considered within individual physician-patient relationships.
- Emergency contraception services were unchanged as a result of affiliations and were available either on-site or at local or regional rape crisis centers.
- Sterilization services were expanded in one case and continued to be provided in the other cases.
- Infertility services were unchanged in all cases.
- Emerging issues related to reproductive health services in the case study sites include provision of non-surgical abortion, providing core benefits, and defining and providing comprehensive women's health services.

A key policy implication of this project is that assessing the potential impact on a community of affiliations between Catholic and non-Catholic health care organizations is complex. There is no simple correspondence between the type of affiliation and the outcomes with regard to availability of reproductive health services. Community members and policymakers need to weigh the potential benefits of affiliations (such as preserving community providers or enhancement of services) against the potential costs of affiliations (such as loss of proscribed services or added burdens to consumers seeking care).



# I. Introduction

## A. Background and Context

The purpose of this project is to examine the affiliation process between Catholic and non-Catholic health care providers and to assess the outcomes of affiliations for the availability of reproductive health services in the community. In the changing health care environment, there are increasing market pressures on hospitals and other health care organizations to form affiliations of various kinds. Often these organizations have different value orientations that may affect both the type of affiliation formed and the range of services made available to sociodemographically diverse communities. Catholic-sponsored hospitals have been increasingly involved in formal affiliations in recent years, and because Catholic values proscribe or constrain provision of certain reproductive services, some of these affiliations have attracted the attention of the media and advocacy groups concerned about the public's access to these services. Because women are the major consumers of reproductive health services, women's groups have been particularly concerned about these affiliations. This project considers how affiliation agreements are reached between Catholic and other health care organizations, the role of reproductive health services in forming these agreements, and the impact of these affiliations on the availability of reproductive health services in communities.

Catholic hospitals comprise the largest component of religiously sponsored health care organizations in the United States. In 1995, there were approximately 600 Catholic hospitals (about 10% of all U.S. acute-care hospitals), accounting for approximately 14% of all acute-care hospital beds (Japsen 1995a). The 1995 American Hospital Association Guide reports 62 Catholic multihospital systems with 487 hospitals operating over 112,000 beds; these hospitals comprised 83% of all hospitals in church-related systems, 34% of all hospitals in not-for-profit systems, and 17% of all system hospitals nationwide. The largest non-Catholic religious systems include Adventist and Baptist systems.

Catholic health care facilities in the United States are guided by the Ethical and Religious Directives for Catholic Health Care Services (hereinafter referred to as the Directives), which were approved by the National Conference of Catholic Bishops (NCCB) in 1971 and revised in 1994 (NCCB 1995). The Directives address the social responsibility of Catholic health care services; the pastoral and spiritual responsibility of Catholic health care; the nature of the professional-patient relationship; issues in care for the beginning of life; issues in care for the

dying; forming new partnerships with health care organizations and providers; and principles governing cooperation with activities considered to be morally wrong. With regard to reproductive health services, the Directives proscribe abortion (see Glossary, Appendix A) and “direct sterilization...when its sole immediate effect is to prevent conception” (NCCB 1995:20). The Directives also state that “Catholic health institutions may not promote or condone contraceptive practices” (NCCB 1995:20). In addition to these proscriptions, the Directives state that “a Catholic health care institution should provide prenatal, obstetric, and postnatal services for mothers and their children in a manner consonant with its mission” (NCCB 1995:19).

Regarding affiliations, the Directives recognize that new partnerships with non-Catholic health care organizations provide both opportunities and challenges. On the one hand, Catholic institutions that partner with non-Catholic organizations have opportunities to continue to implement religious and ethical teachings; on the other hand, these partnerships may involve Catholic institutions in activities judged morally wrong and may pose challenges to the viability of the Catholic mission in health care. Because of the risk of scandal (see Glossary, Appendix A) when partnerships are formed between Catholic and non-Catholic providers, the Directives suggest that “increased collaboration among Catholic-sponsored health care institutions is essential and should be sought before other forms of partnerships” (NCCB 1995:26).

Directive #69 states that “when a Catholic health care institution is participating in a partnership that may be involved in activities judged morally wrong by the Church, the Catholic institution should limit its involvement in accord with the moral principles governing cooperation” (NCCB 1995:27). The Directives contain an appendix outlining the principles of cooperation, which are theological tools to assist individuals in reasoning about the circumstances under which one may justifiably be involved in activities that are considered to be morally wrong. (See Glossary, Appendix A.) According to the National Coalition on Catholic Health Care Ministry, the principle of material cooperation “reflects the fact that in order to accomplish good, some cooperation with wrongdoing may at times be unavoidable” (NCCHCM 1995:15). The principle might be invoked, for example, to justify a Catholic health care institution’s partnership with a provider offering services, other than abortion, that are proscribed by the church.

Issues related to the provision of reproductive health services are not the only threats to Catholic identity that may surface in affiliation attempts between Catholic and non-Catholic health care organizations. Also problematic from the perspective of Catholic values regarding the dignity of the human person is end-of-life decision making and the debate surrounding euthanasia. In addition, and on the basis of its mission to advance social justice, in 1995, the Catholic Health



Association banned for-profit hospitals from membership, thereby discouraging affiliations between Catholic and for-profit health care organizations (Japsen 1995b). Issues related to reproductive health services therefore are part of a larger context of Catholic health care organizations' strategic attempts to reconcile religious values and mission with affiliations to enhance viability and organizational survival.

Advocacy groups have been active in bringing to public attention some recent cases in which the provision of certain fertility-control services was threatened by attempted or actual affiliations between religiously controlled and non-sectarian hospitals. One issue of concern to advocacy groups is that consumers may not be aware either of the implications of proposed affiliations for service delivery or of the post-affiliation policies of the parties with respect to fertility-control services. In addition, the most vulnerable consumers--those who are uninsured, low-income, or do not have a personal physician--may have the fewest options for accessing these services at alternative sites. Accordingly, advocacy groups have sought to provide information to inform the public as well as to intervene in specific cases.

For example, Catholics for a Free Choice, based in Washington, D.C., published an overview of 57 affiliations between Catholic and non-Catholic hospitals in the early 1990s, based on information obtained from the Lexis/Nexis database (Catholics for a Free Choice 1995). It also published results of a 1995 survey of 800 women ages 18 to 50, in which 28% of Catholic women and 26% of non-Catholic women answered "yes" to the question, "Would belonging to a Catholic health plan mean that your access to medical procedures is restricted in any way?" and 31% answered that they did not know. In response to the question, "If your hospital merged with a Catholic hospital, do you think the services you receive should be restricted by the dictates of Catholic teachings?" 86% of women answered "no" (EDK Associates 1995).

The Reproductive Freedom Project of the American Civil Liberties Union, a national project that defends and advances reproductive rights, published a report on hospital mergers to alert activist communities and to highlight successful strategies that have been used to protect access to reproductive health services (ACLU 1995). The report cited three cases of proposed mergers and acquisitions between non-sectarian and Catholic hospitals in which state civil liberties groups participated in efforts to block the affiliations due to concerns about potential loss of reproductive health services.

Mergerwatch, a project of Family Planning Advocates, Inc., of New York State, which works closely with the Center for Reproductive Law and Policy in New York City, provides statewide monitoring of hospital mergers involving Catholic institutions, a resource clearinghouse, an activists' guide and technical assistance,

statewide action alerts, policy analysis, and lobbying (Family Planning Advocates 1996). Family Planning Advocates was party to a lawsuit filed to challenge state approval of a merger between a Catholic and a non-sectarian hospital to form a new Catholic system in Troy, New York; following the merger, family planning services and vasectomies were discontinued at the formerly non-Catholic hospital. The lawsuit was settled in 1996 when the system agreed to provide referral information and followup to patients seeking these services.

Thus affiliations between Catholic and non-Catholic health care organizations and public attention to issues pertaining to reproductive health services in these affiliations provide the context of this project.

## **B. Research Questions and Definitions**

The project addresses the following questions:

- What is the extent of affiliations involving Catholic health care organizations and what are the major types of affiliations?
- What are the key issues in the affiliation process, including motivating factors and operational challenges, as well as strategies to address these concerns?
- What role, if any, do issues involving reproductive health services play in the affiliation process between Catholic and non-Catholic health care organizations?
- What is the impact of affiliations between Catholic and non-Catholic health care organizations on the community, especially with regard to availability of reproductive health services?
- What are some approaches used by the partners in these affiliations to make specific reproductive health services available to the communities served?

For purposes of this project, “reproductive health services” is defined broadly to include pregnancy-related care (e.g. preconception care, prenatal care, prenatal genetic screening, obstetrics, alternative birthing services), services to curtail or enhance fertility (e.g. contraceptives, male and female sterilization, abortion, and infertility diagnosis and treatment), and routine gynecological care including screening and treatment for sexually transmitted diseases and for cancers of the female reproductive system (Delbanco and Smith 1995). This broad definition provides a basis for examining the impact of affiliations on both controversial and non-controversial reproductive health services. It also provides a basis for

considering an organization's provision of comprehensive health care for women.

For purposes of this study, "affiliations" are defined as formal arrangements involving a hospital and another hospital or health system, including joint ventures, mergers, acquisitions, consolidations, and long-term lease arrangements (see Glossary, Appendix A.) The project focuses on affiliations involving Catholic and non-Catholic partners, because these are the affiliations in which potential conflicts between Catholic religious values and the values and practices of non-Catholic providers may arise.

## **C. Methods**

The project uses both quantitative and qualitative methods. (See Appendix B for a detailed description of these methods.) To address the research question on the extent and types of affiliations involving Catholic health care organizations, a statistical profile was compiled of formal affiliations occurring between 1990 and 1996. Because there is no central repository of such information for the health care industry, data were obtained from several sources. It is important to note, however, that these data reflect only those affiliations that were publicly announced and reported by the organizations providing the source data. In addition, the data do not reflect attempted affiliations that failed or completed affiliations that subsequently dissolved (e.g. "demergers").

To address the other research questions, a multiple case study design was used. The case study method was appropriate because detailed information about the affiliation process and decisions with regard to provision of reproductive health services could not be obtained except from on-site, confidential interviews with participants. Four cases of affiliations involving Catholic and non-Catholic health care organizations between 1994 and 1996 were selected for study based on criteria developed from the statistical profile and information obtained from public sources and knowledgeable informants. (See Appendix B.) It is important to note that these cases do not necessarily represent all affiliations between Catholic and non-Catholic providers during this time period. Rather, the cases are intended as illustrative models of successfully negotiated affiliations and of possible solutions to issues involving availability of reproductive health services in communities.

## **D. Organization of the Report**

The remainder of this report is organized into four sections. Section II presents national findings on the numbers and types of affiliations involving Catholic health care organizations between 1990 and 1996, including information from public sources on alternative outcomes with regard to provision of reproductive health services. Section III presents findings from the four case studies with respect to the affiliation process, including factors motivating the affiliations; the role of reproductive health services in the affiliation process; factors in successfully negotiated affiliations; and post-affiliation challenges. (The case study reports are presented in Appendix C.) Section IV presents findings from the case studies with respect to the outcomes of the affiliations, including overall community impact; availability of specific reproductive health services (obstetrical, contraception, sterilization, infertility, and abortion services); and emerging issues involving non-surgical abortion, benefits packages, and comprehensive women's health services. Section V presents the study conclusions, lessons learned, and implications for policy.

## **II. Trends in Affiliations Involving Catholic Providers**

### **A. National Affiliation Trends**

Dynamic market forces are transforming the financing, organization, and delivery of health care services. One of the products of the new marketplace has been the integration of health care providers and health plans in alternative types of affiliations. Driven by the growth of managed care and increasing competition for patients, as well as by pressures to contain costs, health care organizations are seeking to realize the benefits of multi-organizational arrangements. These benefits include cost savings through economies of scale, operating and financial improvements, and the potential for organizational growth (Jaeger, Kaluzny, and Magruder-Habib 1992).

Different affiliation types have emerged, including relatively loose arrangements--such as joint undertakings of limited activities and shared services--as well as "merged identity" organizations--such as holding companies, mergers, acquisitions, and consolidations. Coalitions are forming and dissolving at an unprecedented pace and are often difficult to track, especially in the case of organizations that change ownership more than once during the same year. Overall, 997 health care mergers and acquisitions were reported in 1996, a 58% increase over 1995 (Haas-Wilson and Gaynor 1997). These figures reflect transactions in major segments of the health care industry, including hospitals, long-term care facilities, physician groups, and other providers.

Affiliations between various types of health care organizations have dramatically increased in recent years. Integrated delivery systems that include inpatient, outpatient, and long-term care facilities are proliferating. Physician-hospital organizations (PHOs) and management service organizations (MSOs) have emerged as new forms of joint activity between hospitals and physicians. Further, the divisions between the insurance and service delivery markets seem more permeable than before, as mergers and exclusive contracts between insurers and providers are developed and as providers begin to carry full insurance risk for the services they deliver.

Affiliations among the same type of health care organizations also are growing. Examples of recent activity among managed care organizations include the acquisition of U.S. Healthcare by Aetna Health Plans and the merger of

Foundation Health and Health Systems International, each of which created a health plan with several million enrollees in many states. Among physicians, the shift from solo to group practice and the growth of Independent Practice Associations (IPAs) and physician management firms illustrate fundamental changes. In 1996, more than one-third of all physicians were in group practices, and approximately 4,000 IPAs were in operation (Haas-Wilson and Gaynor 1997).

Record numbers of hospital affiliations involving corporate and individual hospital activity have been reported. In addition to the factors motivating health care organizations in general, hospital affiliations have also been driven by the declining financial performance of a large proportion of hospitals as a result of the shift to non-hospital care settings and prospective payment systems. Poor financial outcomes have been observed particularly among small, not-for-profit community hospitals. For example, a three-year study of the financial performance of 1,297 such hospitals found that one-fourth of all sampled facilities were in a “crisis or warning status” (Prince 1991).

Approximately 235 transactions (involving 768 hospitals) were announced or completed in 1996, compared with 230 transactions (involving 735 hospitals) in 1995 and 184 transactions (involving 650 hospitals) in 1994 (Japsen 1996). These figures indicate that almost 40% of the 5,200 nonfederal U.S. hospitals have been involved in some type of affiliation in the past three years. Corporate affiliations (i.e. between systems), numbered 11 in 1996, six in 1995, and eight in 1994, and accounted for many of the above transactions. Recent examples include the 1996 acquisition of OrNda HealthCorp by Tenet Healthcare to create the second largest hospital chain in the country (Japsen 1996) and the 1995 acquisition of Healthtrust (a 115-hospital chain) by the largest hospital chain, Columbia/HCA (Lutz 1995).

From the perspective of community hospitals, 1,018 community hospitals have been involved in affiliations with hospitals, health systems, or chains in the past three years via 581 affiliations (Japsen 1996; Lutz 1994). (This figure excludes academic medical centers or large teaching hospitals, specialty hospitals, and hospitals that were already owned by an investor-owned chain.) In 1996, 63 hospitals involved in affiliations changed ownership from not-for-profit to for-profit status, compared with 48 such cases in 1995 (Japsen 1996; Lutz 1995).

This recent growth in the number of affiliations in the health care industry can be attributed in part to the clarification of guidelines and the review process of the Department of Justice (DOJ). For more than a century, the United States has subjected proposed affiliations between organizations to close scrutiny under various antitrust laws. In response to the growing number of affiliations between health care providers, the DOJ and the Federal Trade Commission published six

policy statements in September, 1993, to provide guidance to hospitals, physicians, health systems, and other provider networks interested in mergers, joint ventures, and other types of affiliations. Included in the guidelines were outlines of “antitrust safety zones,” described as “the circumstances under which the Agencies will not challenge conduct under Antitrust laws,” and guidelines for providers falling outside the DOJ safety zone (U.S. Department of Justice and the Federal Trade Commission 1994). Additional DOJ guidance is expected as the agencies acquire more experience reviewing affiliations among health care providers (U.S. Department of Justice 1996).

## **B. Affiliations Involving Catholic Partners, 1990-1996**

Like other health care organizations, Catholic providers have participated in affiliations. After matching the American Hospital Association’s (AHA) and Modern Healthcare’s annual lists of hospital affiliations with the Official Catholic Directory (1995) and the AHA’s Guide to the Health Care Field (AHA 1990-1996), we identified 131 transactions involving one or more Catholic hospitals or health systems between 1990 and 1996. These transactions represented 18% of all hospital affiliations (N=718) reported by these sources for this seven-year period. (See Appendix B for a more detailed description of methodology.)

Reported affiliations involve significant organizational changes, namely, acquisitions, consolidations, mergers, joint ventures, and longterm lease agreements. They do not include looser arrangements, such as management contracts or cases where a hospital joins a network. In addition, these transactions focus on community hospitals that affiliated with other hospitals or health systems. They exclude corporate merger activity such as the 1996 merger of Sisters of Charity Health Care Systems, Catholic Health Corp., and Franciscan Health System to create Catholic Health Initiatives, a Denver-based system of 63 hospitals (Japsen 1996) or the 1995 merger of six-hospital Daughters of Charity National Health System-West into then 18-hospital Catholic Healthcare West, San Francisco (Lutz 1995).

Table 1 shows the 131 affiliations involving Catholic hospitals between 1990 and 1996 categorized by type of ownership of the partner. Nearly 80% of affiliations were between Catholic hospitals and a non-Catholic partner. Two-thirds of the affiliations were between Catholic hospitals and non-Catholic not-for-profit hospitals or systems. Twelve percent involved a Catholic hospital and a for-profit hospital or system. This distribution may reflect Catholic hospitals’ preference to affiliate with other not-for-profit providers with whom they share similar values, rather than with for-profit entities (Japsen 1995b,c).

Table 2 presents the 131 affiliations by type of organizational arrangement. Overall, mergers and acquisitions were the dominant types (40% and 37%, respectively), followed by joint venture/holding company arrangements (11%). Transactions between Catholic and other not-for-profit providers were more diverse with regard to affiliation type, compared with cases involving Catholic partners only or those between Catholic and for-profit organizations. For example, consolidations and lease agreements were only pursued between Catholic and other not-for-profit organizations. The majority of affiliations involving Catholic and for-profit partners were cases in which the for-profit partner acquired the Catholic hospital (56%). The most common type of affiliation involving Catholic and other not-for-profit organizations was merger (48%).

An evaluation of the financial performance of Catholic hospitals helps shed light on the factors motivating Catholic hospital affiliations. Financial stress in Catholic hospitals is thought to be related to their tendency to be located in underprivileged communities, to provide charity care, and to incur more bad debt than other hospitals. Kwon et al. (1988) examined the 1982 total population of Catholic hospitals and classified more than half as deficit hospitals (in which total operating cost exceeds patient revenue). The study found that compared to the surplus hospitals, the deficit hospitals were older, smaller, treated more Medicaid patients, had larger debt burdens, had longer length-of-stay and lower occupancy rates, and were less likely to belong to multihospital systems. Prince and Ramanan (1994) conducted a similar analysis of the operating performance of a sample of 235 Catholic community hospitals from 1986-89 and concluded that 30% of these facilities were in a “warning zone of fiscal stress” and threatened with a possible closure. Factors contributing to financial distress were similar to those in the Kwon et al. study.

A more recent study documented that the average 1992 Catholic community hospital was less profitable than the average matched not-for-profit community hospital (Prince 1994). The author argued that although more than 80% of Catholic hospitals were part of church-related health care systems, many were not realizing the benefits of system membership because the systems were geographically dispersed across regions, with no significant concentrations in local service areas. The study concluded that serious threats exist to the economic viability of Catholic hospitals and that closures will occur unless relationships with local providers are established.



### C. **Alternative Outcomes for Reproductive Health Services**

Affiliations involving Catholic health care organizations have produced varied outcomes with respect to the availability of reproductive health services. From public sources, affiliations can be identified in which reproductive health services have continued unchanged, have been provided in different organizational arrangements, or have been discontinued following affiliation. In addition, it has been observed that because of Catholic moral distinctions between abortion and other proscribed reproductive health services, affiliations may treat each of these services differently (Bayley 1995).

First, it is noteworthy that some proposed affiliations between Catholic and non-Catholic providers have been derailed by failure to agree on issues related to the provision of proscribed reproductive health services, particularly abortion. For example, a proposed merger between a Catholic and non-Catholic hospital in Poughkeepsie, New York, was canceled in 1995 when the non-Catholic hospital's governing board reversed its decision to discontinue abortion services following community objections. Instead of merging, the Catholic and non-Catholic hospitals announced plans to pursue looser forms of collaboration (Family Planning Advocates 1996). In another case in Portland, Maine, a Catholic hospital withdrew from merger negotiations with two non-sectarian providers after intense lobbying by reproductive rights activists. The non-Catholic hospitals proceeded with their merger plans (ACLU 1995). In Kalamazoo, Michigan, a proposed merger broke down when a Catholic medical center could not agree to the partner hospital's continued performance of late-term abortions of anencephalic fetuses. Such cases illustrate that abortion can be a "deal breaker" in affiliation attempts, but because these cases may not be publicly disclosed, it is not known how often this occurs.

Cases are known in which controversial reproductive health services have continued unchanged at the non-Catholic hospital following affiliations with Catholic partners. Typically, these are cases that do not involve merging assets or the acquisition of non-Catholic assets by the Catholic partner. Instead, they tend to be transactions involving a lease agreement, a joint venture, the formation of a holding company, a virtual merger, or the acquisition of Catholic assets by the non-Catholic partner. For example, reproductive services continued at a city-owned hospital in Texas after the facility was leased to Seton Medical Center, a Catholic provider, in 1995. Catholic officials explained that although Seton would govern and fully manage the public hospital, it could continue to provide reproductive services since the city retained ownership of the facility. Similarly, infertility and sterilization services continued at hospitals in Cincinnati, Ohio, following their 1995 virtual merger with a Catholic hospital; the

three partners unified their management under one parent corporation and merged their income statements but kept separate assets and liabilities (Catholics for a Free Choice 1995).

Contrary to the cases in which a Catholic hospital does not provide proscribed reproductive services on campus but shares in the revenue generated from the provision of these services by its partner, there have been cases where the partners agreed that the Catholic hospital would not share in such income. This strategy further distances the Catholic provider from the proscribed activities. An example is the 1995 joint operating agreement between St. Mary's and Columbia Hospitals in Milwaukee, Wisconsin. The two providers merged their revenues and expenses but retained their assets. Columbia continued to provide sterilization and infertility care, but St. Mary's would not share in income from these services (Family Planning Advocates 1996).

The creation of a separate corporate entity or facility to provide proscribed reproductive services is not uncommon. The new entity typically is created by the non-Catholic party prior to the completion of the affiliation. For example, Owensboro-Daviess County Hospital created a separate entity to provide contraception and sterilization when it merged with Mercy Hospital in Owensboro, Kentucky, in 1995 (Lewin 1995). Similarly, Good Samaritan Medical Center created an independent clinic on its campus to provide sterilizations prior to its 1994 affiliation with St. Mary's Hospital, a Catholic facility in West Palm Beach, Florida (Catholics for a Free Choice 1995).

The continuation of proscribed reproductive services may or may not involve the continuation of abortion services in cases where abortion was provided by the non-Catholic partner prior to the affiliation. For example, reproductive services including medically indicated abortions (i.e. abortions to save the life of the woman or of a fetus with a serious defect) continued at Charlotte-Mecklenburg Hospital Authority, a two-hospital public system in Charlotte, North Carolina, after its 1994 affiliation with Mercy Hospital. Hospital Authority acquired 70% of Mercy, but the hospitals remained separate entities. In another case, contraception and sterilization services continued, but abortions (except to save the life of the woman) were prohibited at Sierra Nevada Memorial, a community hospital in Grass Valley, California, after it joined Mercy Healthcare, a Catholic system based in Sacramento, California (Catholics for a Free Choice 1995).

Hospitals may establish mechanisms to facilitate women's access to abortion if the service is to be discontinued on campus. For example, Deaconess Medical Center in Great Falls, Montana, chose this strategy during its 1994 merger with Columbus Hospital, a Catholic facility. Following an agreement that Deaconess would discontinue abortions following the merger and given that the closest hospital to Great Falls was 90 miles away, Deaconess transferred funds to the

local Planned Parenthood affiliate to establish a travel fund for low-income women needing a hospital abortion for medical reasons. Deaconess continued to provide tubal ligations and emergency contraception to rape victims (Family Planning Advocates 1996). This arrangement distanced the merged entity from the provision of abortions.

Other cases illustrate strategies to provide proscribed services in different organizational arrangements. The accommodations reached in these cases seek to preserve women's access to specific services without jeopardizing the partners' collaboration. For example, in 1994, General Hospital Medical Center and Providence Hospital, both in Everett, Washington, merged into Providence General, a Catholic organization that does not provide any of the proscribed services. Before merging, General Hospital donated funds to the local Planned Parenthood and a group of obstetrician-gynecologists to provide sterilizations and abortions to low-income women (Lutz 1993). In another 1994 case, Leonard Hospital and its primary care clinics discontinued family planning and sterilization services after merging with St. Mary's Hospital to form Seton Health System, a Catholic provider in Troy, New York. Local activists and two women affected by the loss of services filed suit to challenge the state's approval of the merger. An agreement was reached in which Seton maintains a list of local reproductive service providers and Seton practitioners make referrals and follow-ups (Center for Reproductive Law and Policy 1996).

Discontinuation of proscribed reproductive services at the non-Catholic facility has occurred in some affiliations. These cases tend to be mergers in which a new organization with a Catholic identity is created or in which a non-Catholic provider is acquired by the Catholic partner. Examples include the 1990 merger of Burnham and Mercy Hospitals into Covenant Medical Center, a Catholic provider in Urbana, Illinois; the 1994 merger in New Jersey of Dover General and St. Claire's-Riverside Medical Center into Northwest Covenant Medical Center, a Catholic institution; and the 1995 acquisition of Mount Sinai, a Jewish hospital, by St. Francis Hospital in Hartford, Connecticut (Catholics for a Free Choice 1995). The latter case involved the closure of a prominent infertility service at Mount Sinai, in addition to the discontinuation of sterilization and abortion services except to save the life of the woman.

These transactions do not illustrate the outcomes for provision of proscribed reproductive services in cases in which a Catholic hospital is acquired by a non-Catholic hospital or system, or in which a Catholic hospital merges into a dominant non-Catholic organization. Such transactions may or may not involve alienation of Catholic property (see Glossary, Appendix A) and loss of Catholic identity. Cases in which Catholic ownership is not maintained may result in one of two outcomes: expansion of reproductive health services if the Directives are no longer followed, or continued compliance with the Directives and therefore

continued restrictions on reproductive services. An example of the latter scenario is the 1994 acquisition of St. Francis Hospital in Charleston, West Virginia, by Columbia/HCA. Despite new for-profit ownership, St. Francis continued to comply with the Directives as a condition of the affiliation agreement (Catholics for a Free Choice 1995).

This diversity of affiliations and of strategies for the provision of reproductive health services characterizes the current context for affiliations involving Catholic providers.

### **III. The Affiliation Process and the Role of Reproductive Health Services in the Case Studies**

The four case studies conducted for this project provide insight into the affiliation process between Catholic and non-Catholic health care providers and the role of reproductive health services in the process. The four successfully negotiated affiliations studied included an acquisition, a merger, a consolidation, and a 50/50 joint venture. (See Figure 1 for a summary of the contextual, organizational, and affiliation attributes of the four case studies, and Appendix C for the case study reports.) In case A, a non-sectarian not-for-profit hospital that was part of a large not-for-profit system acquired a financially stressed Catholic hospital of smaller size, which now operates as a non-sectarian hospital. In case B, a large academic medical center merged with a small, financially stressed Catholic hospital a few miles away as part of a strategy to form a non-sectarian integrated delivery system. In case C, a consolidation between two competing religious hospitals of similar size--one Catholic, one Protestant--formed a non-sectarian not-for-profit medical center. In case D, a 50/50 joint venture occurred between a large regional Catholic hospital system and a medium-sized, financially stressed public/district hospital, which did not assume a Catholic identity following the affiliation. None of the cases involved a non-sectarian organization adopting Catholic identity or agreeing to abide by the Directives.

#### **A. Factors Motivating the Case Study Affiliations**

The case studies illustrate that the prominence of market forces, including threats to financial viability, was a key factor driving organizations with disparate values and missions (including different religious traditions) to seek to accommodate their different commitments in affiliation agreements. A number of important factors motivating affiliations between Catholic and non-Catholic providers were identified. Key informants in all sites reported that a variety of market factors motivated the decision to affiliate, and they articulated these motivations in terms of improved access to capital, reduced duplication of services, economies of scale, and greater market power. In two cases, the survival of the Catholic partner was at stake due to financial problems.

In general, cases B, C, and D reported that the actual or anticipated increase in managed care penetration in local markets was an important factor motivating

the decision to affiliate. All three of these cases also cited the impending financial challenges posed by the shift toward capitated payments for health care services under managed care arrangements as an important factor. The partners to the affiliation in case A, however, did not report that the growth of managed care was a primary motivator. In that case, the most important motivator for the Catholic provider was the need to ensure the survival of the Catholic hospital; the non-Catholic hospital, on the other hand, was primarily motivated to affiliate by the need to increase its market share.

In addition to case A, hospital survival was an important motivator in cases B and D. Both the Catholic facility in case B and the district hospital in case D were struggling financially due to a declining census and operating inefficiencies. The hospitals had begun to close clinical departments and lay off staff in an attempt to reduce their deficits. Concern about possible closures and the consequent loss of inpatient and emergency services to the surrounding communities prompted the hospitals to seek affiliation.

As in case A, case B informants reported that the goal of increasing market share was an important factor motivating the decision to affiliate. In case A, the non-Catholic hospital had established a number of ambulatory care sites (primary care centers) in surrounding communities that provided referrals to the hospital. One center was actually opened in the Catholic hospital's service area. Acquiring the Catholic facility was therefore part of a larger strategy to strengthen the non-Catholic hospital's position as a major provider. As for case B, the merger of the two hospitals was part of a larger integration that involved a medical school and a physician group practice, with the goal of forming the only integrated system in the area.

## **B. The Role of Reproductive Health Services Issues in the Affiliation Process**

The case studies illustrate that ethical and religious concerns about reproductive health services are important issues in affiliations between Catholic and non-Catholic providers, that the abortion issue has the potential to derail affiliations, and that there are various strategies for dealing with reproductive issues in the affiliation negotiation process. The historical context of affiliation agreements, the financial status of the Catholic party, the pre-affiliation status of reproductive services in the affiliating organizations, and the community context were all factors that affected the role of reproductive health services in the affiliation process. We found no simple relationship between the type of affiliation and the nature of decisions about reproductive health services. There is evidence in all

cases that both theological considerations and market forces affected how affiliations were negotiated and how reproductive issues played out.

Theological considerations necessarily inform affiliation arrangements involving Catholic health care facilities. Although the document specifically guiding the provision of health care in Catholic institutions is the Directives, this document presupposes an earlier statement by the United States Catholic Bishops (NCCB 1981). In these documents, the Bishops identify the dignity of the human person, the biblical mandate to care for the poor, contribution to the common good, the responsible stewardship of resources, and conscience as the normative principles that inform the church's healing ministry. These principles not only support the church's position on reproductive services, but also its position on humane care for the dying and the proscription of euthanasia. More broadly, these principles support the church's commitment to social justice, which entails the view that health care is a fundamental right of all persons and that Catholic health care should distinguish itself by service to, and advocacy for, the poor and vulnerable. Social justice and concern for the common good entail that limited health care resources be used wisely and that employees in Catholic facilities be treated with respect and justice. It is therefore important to note that theological considerations not related to reproductive health services also may be explicitly introduced in affiliation arrangements.

In two of the case studies (A and C), earlier attempts at affiliation had failed because of differences over abortion, and this historical context provided the basis for strategies to deal with proscribed services in the second, ultimately completed, affiliation attempts. In case A, the first affiliation attempt (a proposed merger) in the early 1990s was abandoned because the system under which the non-Catholic hospital operated provided abortions at one of its other hospitals. The Catholic hospital believed that the Directives prohibited a merger under these circumstances. By the mid-1990s, however, the financial instability of the Catholic hospital was such that it could no longer survive as an independent provider. The decision by the Catholic hospital's governing board to sell its facility to the non-Catholic hospital (rather than to merge) was driven by the need to avoid conflict over the provision of abortion that emerged during the first attempt. The board decided that the continuation of hospital services to the community took precedence over maintaining a Catholic presence. As part of the acquisition agreement, the Catholic facility would no longer retain its identity as Catholic and, accordingly, would cease to operate under the Directives. However, the non-Catholic hospital agreed in writing that no "life-terminating procedures"--including abortion, euthanasia, or assisted suicide--would be provided on the former Catholic campus.

In case C, an earlier affiliation attempt had been made in the 1970s; over a three-year period, the two hospital governing boards pursued plans for a merger, but it

was only at the end of this period that the plans were communicated to the public (which then protested the merger, largely on the basis of anti-abortion sentiments) and to the religious order overseeing the Catholic hospital. Given that the Protestant hospital provided abortions, the Catholic Diocese could not authorize merger, and the affiliations plans were abandoned at considerable cost to both parties. Because of the role that abortion had played in defeating the earlier affiliation attempt, the decision was made in the 1990s to defer the abortion question to the governing board of the post-consolidation, non-sectarian medical center. Members of the two existing governing boards felt strongly that, for the benefit of the community, religious ideology should not be allowed to derail the consolidation. Contraceptive and sterilization services were not an issue for the governing boards in the affiliation process because these services had been provided at both institutions prior to affiliation. After consolidation, the new governing board voted to discontinue abortions (except to save the life of the woman) at the former Protestant hospital. This decision was supported by vocal segments of the community.

In case B, the prospects for survival of the Catholic hospital and the pre-affiliation status of reproductive services in the partnering hospitals were the key factors that shaped the role of reproductive services in the affiliation process. The merger in case B was the first affiliation attempt between the parties. In this case, the CEO of the Catholic hospital, the local Bishop, and the order of Sisters sponsoring the Catholic hospital recognized that marketplace changes and a declining census threatened the survival of the 83-bed hospital, which provided no obstetrical or related services. In addition, they recognized that increased competition between their hospital and the nearby academic medical center represented poor stewardship of community resources. The governing board of the Catholic hospital agreed that the alleviation of financial pressures and the means of responsible stewardship lay in a merger agreement with the academic medical center to form a new, non-sectarian, not-for-profit integrated delivery system. As part of the merger agreement, it was decided that the former Catholic campus would continue to operate under the Directives; in effect, this meant that no services in conflict with Catholic values would be offered on that campus. The Directives, however, would not apply on the medical center campus, where obstetrical, gynecological, contraceptive, sterilization, and infertility workups and treatments would continue to be provided. Because the medical center would continue its practice of providing only medically indicated second-trimester abortions, rather than elective abortions, the Bishop supported the merger agreement.

In case D, the community context shaped the role that reproductive health services played in the affiliation process. At the early stages of negotiation between the district hospital and the Catholic system, reproductive issues were a lightning rod for opposition by local reproductive rights groups, hospital



physicians, and community members who feared that partnership with a Catholic health system would mean a loss of reproductive services in the district hospital. Through a series of public meetings, representatives of the Catholic system and of the district hospital governing board made it clear that under the conditions of the 50/50 joint venture, the district hospital would not assume a Catholic identity and would not operate under the Directives. With the exception of abortion services, which were readily available at neighboring hospitals and clinics and which had rarely been provided at the district hospital, all other reproductive services would continue to be offered at the district hospital following the affiliation.

A key element in the affiliation process in case D was the articulation of common values in a document that became part of the affiliation contract. Developed by Catholic system ethicists, the diocesan Bishop, and the Catholic system legal counsel, the document outlined the values of the Catholic health care ministry that should be shared by the parties (i.e. social justice, the promotion of human dignity, and responsible stewardship of resources). The document also states that direct abortion and assisted suicide will not be permitted in affiliating hospitals. Because terminations of pregnancy to save the life of the woman are not considered “direct” abortions, they would be permitted at the district hospital under the terms of the joint venture.

All cases therefore developed explicit strategies for dealing with religious values and controversial reproductive health services early in the negotiation process. These strategies included decisions about the type of affiliation, the future Catholic identity (if any) of the partners, and the future role of the Directives in guiding service delivery. Although theological considerations influenced decisions regarding reproductive services, concerns about social justice and responsible stewardship of resources also played prominent roles in affiliation agreements.

### **C. Factors in Successfully Negotiated Affiliations**

Several key factors to successfully negotiating an affiliation agreement between Catholic and non-Catholic providers were identified. The first, as noted above, is the early formulation of a strategy for dealing with religious values and controversial reproductive health services, particularly abortion, within the context of affiliation agreements.

In addition, strategies to inform and involve the community throughout the affiliation process were employed in all four cases. Hospital publications explaining the need to affiliate and the process of affiliation were distributed

internally and externally to keep the community informed. Hotlines were established to respond to questions and concerns. In cases A and D, open forums were held to allow community members to express their concerns about the proposed affiliation. In case D, this approach was particularly valuable for ensuring that the abortion issue was addressed early and openly. Additional efforts to ensure community involvement included holding public ceremonies to “mark the death” of the former Catholic hospital (when Catholic identity was relinquished) and soliciting input from community members in naming newly formed organizations. These strategies were considered critical in cases A, B and C, in which the affiliations resulted in the loss of identity of the two Catholic hospitals and the creation of a single, new organizational identity.

Other strategies employed to ensure a successful affiliation focused on managing the affiliation process itself. Outside consultants were hired to help board members, religious leaders, and senior executives come to an agreement about how religious issues would be addressed. Consultants were also hired to facilitate the development of strategies and implementation plans or to assist in the process of obtaining approvals for an affiliation from the Department of Justice.

The strategy employed in case C to facilitate the Department of Justice review process was carefully thought out and executed. A steering committee was organized to oversee the process, and an outside consultant with expertise in managing merger approvals was hired. The partners to the consolidation recognized from other organizations’ failed attempts to affiliate that poor planning could result in a denial from the Department of Justice. The partners to the affiliation in this case were particularly sensitive to these issues, given that they stood to gain 80% of the hospital market share.

In addition to using consultants, careful management of how the affiliations were operationalized was critical to a smooth integration process. Typically, an integration team representing the partners’ senior executives, clinicians, and administrative personnel was assembled to oversee the transition. Workgroups to address the different operational areas were also formed to align services between campuses and to review policies and procedures. Top administrators for the affiliated institutions were selected early, and their responsibilities and performance expectations were defined. Particular attention to human resources issues was identified as critical, in part because of the need to bridge cultural differences stemming from different religious traditions or service ideologies in the affiliating organizations.

The models for structuring governance arrangements that were employed in cases B, C, and D facilitated the integration of the partners to the affiliations. In case B, for example, a new integrated delivery system was formed. Each of the four partners to the integration maintained a separate governing board and had

equal representation on a fifth board overseeing the system. Despite the small size of the board of the Catholic facility, its retained powers in the affiliation agreement ensured strong representation within the integrated delivery system. In case C, a single board for the new medical center was established, with equal representation from the two partners as well as community representation. A new corporation was formed to run the district hospital in case D; its board equally represents the Catholic system and the district hospital. The hospital also retained its own elected board, primarily to oversee the use of funds contributed by the Catholic system as part of the affiliation agreement.

Finally, key informants reported that gaining physician support for the proposed affiliations was a critical factor for successfully completing the affiliations. In case B, for example, physician involvement was solicited throughout the process by promoting a leadership role for physicians in managing consolidated clinical service lines. In case D, the strategy to promote physician involvement was to organize members of the district hospital's medical staff into a committee to evaluate the quality of medical care provided by the Catholic and for-profit health systems competing to affiliate with the hospital.

## **D. Post-Affiliation Challenges**

Affiliations are long-term processes that do not end when a formal agreement is negotiated. Although our site visits were conducted early in the post-affiliation phase of organizational development, it is important to note that ongoing challenges to completing integration activities were identified in all four cases.

One of the most important challenges that emerged in all of the cases was completing the process of merging disparate organizational cultures. The human resources issues that are involved in merging cultures were compounded by religious vs. non-sectarian orientations of the partners, by workforce reductions, and by changes in the models of clinical care delivery (e.g. from departments to multidisciplinary service lines). In case B, in particular, cultural integration emerged as one of the most important issues. Key informants reported that management had failed to consider the impact of the merger on staff productivity and morale. Failure to plan for the cultural change process has led to the publication of an underground newsletter and a disgruntled management team.

Although there were similar challenges of managing the cultural change process, the cases differed in their identification of challenges to the future of their partnerships. Cases B and D were still struggling with internal integration challenges. In case B, informants reported that an important challenge is finding

strategies to help build physician management skills. This emerged as an important skill deficit among physicians during clinical department consolidation activities. In case D, key informants reported that workforce reductions and managing disagreements between unionized labor and management were the key challenges.

Both cases A and C were focused on the challenges that lie ahead, now that basic integration strategies have been completed. In case A, informants reported that the most pressing needs are developing strategies for growth in new markets and for streamlining existing services. Case C informants also identified outcomes-focused challenges and the need to become more responsive to women's health care needs in the communities served by the new medical center.

## **IV. The Outcomes of Affiliations in the Case Studies**

### **A. Community Impact of Affiliations**

Hospitals are key institutions in communities, providing needed services to consumers, training for health care providers, and employment opportunities. Religiously sponsored hospitals often have long traditions of serving specific community populations, providing training and employment opportunities to members of religious communities, and serving the poor. Affiliations that alter the religious identification of hospitals or the configuration of the local health care system may have both positive and negative impacts on the local community.

In the four case studies, key informants consistently described the affiliations as having had an overall positive impact on the local community. In cases A and C, community surveys conducted post-affiliation showed support for the hospitals' collaborative efforts. Similarly, community support was evident in case D, where district residents voted, in advance, in favor of the joint venture. Positive outcomes of the affiliations that were reported in all cases included avoiding the closure of facilities, service improvements, cost reductions, and expansion of community-based health programs.

In three of the cases, one of the partnering hospitals had been threatened, prior to the affiliation, with possible closure due to reductions in inpatient revenues and to operating inefficiencies. In an effort to reduce their deficits, the two Catholic hospitals in cases A and B and the district hospital in case D had begun closing clinical departments and laying off employees. The closure of these facilities would have seriously limited the availability of inpatient and emergency care in the hospitals' service areas, especially in case A (where the Catholic hospital was the only provider of inpatient services in a mid-size town) and in case D (where the district facility was the only hospital in that portion of the county). The affiliations therefore were regarded as having ensured the survival of the hospitals as well as the continued availability of services to the communities.

Service improvements related to better service coordination or renovations of physical space were noted in all case studies. In case A, badly needed renovations to the former Catholic facility were completed following the

affiliation; the communication system was replaced; and a new patient transportation service was initiated between the hospital's two campuses. Enhanced service coordination was observed in case B, and improvements in ambulatory surgery and obstetrical facilities were evident in case C. Finally, a plan for capital improvements for a number of hospital units was approved in case D.

An important goal of affiliations in general is containing costs. Case C, the earliest affiliation among the four cases, had documented over \$50 million in savings during the past two years as a result of service consolidation, workforce reduction, and attaining operating efficiencies. The other cases, which were relatively new affiliations, also expected savings of varying magnitudes. Hospital executives hoped that lower costs would translate into smaller increases in rates and therefore improved financial accessibility of services. They also contended that lower operating expenses would free up resources that could be used for service expansion as well as for supporting community-based health projects.

Support for community-based programs has expanded following affiliations in all of the cases but has been driven by different factors. Case B distinguished itself in terms of its responsiveness to community needs, as reflected in the strategic plan of the newly formed system and in the initiatives that the system had implemented. Among other goals, the strategic plan focused on community health improvement and the expansion of primary care services. Accordingly, a new position for a vice-president for community health was created during the merger, and an assessment of system services based on the objectives of Healthy People 2000 (a national initiative to improve the public's health) was completed. Outreach to underprivileged populations was accomplished through clinical services in underserved areas and education programs. The system also is promoting development of school-based clinics and has funded community programs (e.g. parenting skills programs, a dental clinic, translator services).

Support of community health projects had increased in the other cases as well. In case A, lifting the restrictions on the provision of fertility-control services at the former Catholic hospital allowed the facility to initiate community education programs in contraception. Post-consolidation savings allowed case C's newly formed medical center to provide a grant to the local community health center to construct a new facility. The medical center also expanded its breast cancer education program for low-income community women. Finally, as part of case D's joint venture agreement, the Catholic system gave the district several million dollars that, together with the tax revenue generated, will be used by the district hospital to fund community health projects. At present, the hospital is funding projects in the areas of women's health and cardiovascular health.

The four sites varied in the extent to which they conducted community needs assessments: cases A and B were more active in this area than cases C and D. The non-Catholic hospital in case A, for example, conducted extensive market research on a regular basis to guide its decision-making processes and used such research tools as community surveys, focus groups, and one-to-one meetings with physicians. Similarly, case B's system evaluated community needs through surveys and focus groups, meetings with community-based organizations, and collaboration with the state health department to identify service gaps and prioritize needs.

Two problematic areas were identified in the case studies: diminished consumer choice and workforce reductions. Consumer choice of hospitals could be construed as having been diminished due to the loss of religious identity of a hospital or to discontinuation or consolidation of some services in affiliating facilities. Informants in all four case studies, however, emphasized that consumer options would have been more seriously constrained in the absence of the affiliation, especially if a facility were forced to close.

With regard to workforce reductions, downsizing occurred in all four cases and was described as one of the major challenges that the partners faced in operationalizing the affiliations. The numbers of both clinical and administrative staff members were typically reduced, leading to resentment and low employee morale. Our informants believed, however, that workforce reduction was not a negative outcome of affiliations. On the contrary, they stressed that affiliations prevented hospital closures, which would have meant more displaced workers, and they pointed out that lay-offs had already begun at the financially struggling hospitals prior to the affiliations.

On balance, informants in all case studies reported that they view the affiliations as beneficial to their communities.

## **B. Availability of Reproductive Health Services Pre- and Post-Affiliation**

Figure 2 summarizes the findings with regard to availability of reproductive health services in the case study sites, pre- and post-affiliation. With respect to reproductive health services broadly defined, these case studies provide evidence that affiliations between a Catholic and non-Catholic provider affect specific services differently and that the outcomes are determined by multiple factors, as described in the previous chapter. Among the services studied, obstetrical services were most likely to be enhanced as a result of affiliations, and abortion services were most likely to be curtailed.

The following sections present the context within which these services were examined and the findings for each type of reproductive health service in the case studies.

## **Obstetrical Care**

Prenatal, obstetrical, and postnatal services are supported by Catholic religious values and may, indeed, be central to the mission of many Catholic health care institutions. Prenatal genetic screening, however, may be controversial. According to the Directives, “prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect” and “genetic counseling may be provided in order to promote responsible parenthood and to prepare for the proper treatment and care of children with genetic defects” (NCCB 1995:20). Nevertheless, some Catholic hospitals, especially those in financial difficulty, do not provide obstetrical services. Declining patient volume is a problem in some communities, and this has both financial and quality implications for hospitals. Financially, it is more difficult to support obstetrical services when patient volume declines or when patient payer mix changes so that uninsured or underinsured women increase as a proportion of patients. Declining volume also has quality implications, particularly for high-risk obstetrical cases, since providers treat fewer cases and skills or teams may not be maintained. Affiliations therefore may provide both economies of scale and training opportunities in obstetrical care within a community.

The provision of prenatal and obstetrical services was improved in two of the case study sites as a consequence of affiliations. In case C, the partnering hospitals had both provided obstetrical services prior to affiliation; consolidation of the two hospitals therefore provided an opportunity for economies of scale and increased efficiency in obstetrical care. The affiliation also provided infusion of capital to improve obstetrical services. Following consolidation, obstetrics (including prenatal care and childbirth classes) was moved to one campus, where an expanded labor and delivery floor was under construction at the time of the site visit. The birthing unit also was being renovated and expanded in case D.

In two of the case studies (A and B), obstetrical services had not been provided at the Catholic hospitals prior to the affiliations, due to declining patient volume, and continued not to be provided after the affiliations. It is possible however, that the affiliations may have facilitated access to these services at the non-Catholic partner’s campus for patients in the formerly Catholic hospital’s service area and for clinicians. Also, at case B, strategic plans for a birth center had been developed by the women’s health line leadership and had been distributed to senior executives for review. (At case C, a proposal for a birth center, that would



have included nurse-midwifery services, was rejected when the obstetricians objected.)

Prenatal genetic screening and counseling were available to patients in all four cases, either on the same campus at which obstetrical services were provided or by referral within the community to specialized providers. These services were not affected by the affiliations.

### **Family Planning Services**

According to the Directives, “Catholic health institutions may not promote or condone contraceptive practices, but should provide, for married couples and the medical staff who counsel them, instruction both about the Church’s teaching on responsible parenthood and in methods of natural family planning” (NCCB 1995:20). Emergency contraception for victims of rape is permitted if there is no evidence that conception has already occurred, and it is recommended that sexually assaulted women “be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures” (NCCB 1995:16,31).

Among the reversible forms of contraception used by U.S. women ages 25 to 44 in 1990, methods requiring a physician prescription accounted for the majority of users, and oral contraceptives were the most frequently used method (Peterson 1995). The majority of users of reversible contraception obtain their methods from private physicians or managed care organizations, and about one-third attend family planning clinics. Family planning clinics are a particularly important source of contraceptive services for adolescent, minority, uninsured, and low-income women who do not have access to private physicians. Most family planning clinics are operated by public health departments, Planned Parenthood, or other agencies; in 1992-1993, an estimated 6% of family planning clinics were sponsored by hospitals (Henshaw and Torres 1994).

In general, family planning services (including the provision of counseling and contraceptive services) were not substantially affected in the case study sites as a consequence of affiliations. With regard to contraception, administrators and providers interviewed in all of the case study sites reported that this was a matter left to the discretion of the individual physician within the context of the physician-patient relationship. No policies were reported that interfered with physicians’ ability to prescribe contraception within their medical practices, either before or after affiliations.

None of the sites (regardless of religious affiliation) operated family planning clinics either before or after affiliations. Only one of the sites (case B) showed evidence of active involvement with community-based organizations to promote

family planning services. Case A had begun a program in community education for family planning in the former Catholic hospital's service area after the Directives ceased to apply on that campus.

Availability of services, including emergency contraception, for rape victims was in evidence in all four cases. In cases B and C, these services were provided on-site; in cases A and D, the services were provided by referral to a local rape crisis center.

## **Sterilization**

According to the Directives, "direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution when its sole immediate effect is to prevent conception." In 1987, 93% of tubal sterilizations were performed in hospitals, either as inpatient procedures or in outpatient surgery centers (Schwartz et al. 1989). Advocacy groups have raised questions about the costs, inconvenience, and risks to health that might be incurred if women cannot obtain postpartum tubal ligations in a Catholic hospital and must seek this service elsewhere. Data from the 1993 National Hospital Discharge Survey reveal that church-owned hospitals provided significantly fewer postpartum sterilizations than other types of hospitals (Clarke and Taffel 1995).

Availability of male and female sterilizations (vasectomies and tubal ligations, respectively) was not affected by affiliations in three cases (B,C, and D) and was expanded in case A, where the procedures became available at the former Catholic campus following its acquisition. Following the merger in case B, the non-Catholic campus continued to provide sterilizations, while the formerly Catholic campus continued to follow the Directives and did not provide them. In case C, both hospitals provided sterilizations both pre- and post-consolidation. In case D, provision of sterilization continued at the district hospital following its joint venture with the Catholic system. In all cases where sterilizations were provided, postpartum sterilization was available.

## **Infertility Services**

Infertility services include both diagnosis and treatment of fertility problems in men and women. The Directives include a number of statements and restrictions on techniques of assisted reproduction. Therapies for infertility are permitted for married couples only if the therapies do not interfere with the "unitive and procreative meanings of sexual intercourse and do not involve the destruction of human embryos" (NCCB 1995:18). Both heterologous

fertilization (using gametes from at least one donor other than the spouses) and homologous fertilization (using gametes of the spouses) are proscribed. Artificial fertilization (including artificial insemination) is proscribed because it is “extra-corporeal” and “separates procreation from the marital act in its unitive significance” (NCCB 1995:19).

The use of infertility services nationwide is measured in the National Survey of Family Growth. Between 1988 and 1995, the percentage of women of reproductive age who had ever used some kind of infertility service increased from 12% (6.8 million women) to 15% (9.3 million women) (Abma et al. 1997). The most frequently reported services were advice on becoming pregnant and infertility tests on the male or female partner; among specialized services, the most frequently reported was ovulation-inducing drug treatment. Infertility services are used disproportionately by college-educated, high-income, white, married women, who are most likely to be able to afford the service of medical specialists. The number of infertility clinics has been estimated at over 300 nationwide (Laurence and Weinhouse 1994).

In general, the case studies provided no evidence that availability of infertility services changed as a result of affiliations. In two cases (A and B), the non-Catholic partner continued to provide infertility diagnosis and treatment. In case D, the district hospital continued to provide basic infertility services and to refer to a local specialty group for advanced treatments. In case C, the services continued not to be offered at either campus. Case C had considered providing infertility services and had investigated community needs and resources. Analyses revealed that community demand for these services was low and that infertility specialists were not available locally. Consequently, clients requesting these services were referred to the academic medical center fifty miles away. The case studies indicate that advanced infertility services, similar to other high-technology services, are typically provided by large, tertiary care centers and not by small community hospitals.

## **Abortion**

The Directives define abortion as “the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus” and state that abortion is never permitted in Catholic health care institutions “even based upon the principle of material cooperation” (NCCB 1995:19). (“Material cooperation” is defined in the Glossary, Appendix A.) However, treatments for a seriously ill pregnant woman that “cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child” are permitted (NCCB 1995:19-20). Catholic providers are expected to

offer care to women “who have suffered from the trauma of abortion” (NCCB 1995:19).

Declining access to abortion services nationwide has been identified as a major problem by abortion rights advocates, and affiliations between religiously-sponsored and non-sectarian hospitals have been cited as one factor in this decline (Chavkin 1996). Although hospitals provide only a small proportion of abortions, they provide important services for women needing late-term abortions and treatment of abortion complications, and they provide training in abortion procedures for residents in obstetrics-gynecology. Nationally, the trend is for surgical abortions to be provided in non-hospital settings and as outpatient procedures. In 1992, only 7% of abortions were performed in hospitals, 89% were performed in clinic settings, and 4% were performed in physicians’ offices. Only 16% of short-term general hospitals provided abortion services in 1992 (down from 19% in 1988), and 51% of hospitals providing abortions performed fewer than 30. Only 11% of hospital abortions were performed on an inpatient basis (Henshaw and Van Vort 1994).

The case studies provided evidence that abortion was the most contentious reproductive health issue raised during the affiliation process and that it was the service most likely to be curtailed as a result of affiliations. In cases C and D, abortions (except to save the life of the woman) were discontinued as a matter of policy in non-Catholic hospitals that had provided both elective and medically indicated abortions prior to the affiliations. In both of these cases, administrators and clinicians reported that the hospitals had performed only a small number of abortions prior to affiliation, so that the new policy did not constitute major change. Abortion referrals were available in cases C and D. In case D, abortion counseling, direct referrals to local abortion providers, and transportation were provided, and clinicians did not perceive that there was an access problem for women seeking abortions. In case C, however, a potential access problem was observed: the nearest abortion provider was fifty miles away and not accessible by public transportation, and it was reported that some providers in local community-based health centers were unwilling to treat women with post-abortion complications. A needs assessment had not been conducted in the local community.

In contrast, no change in abortion policy occurred in cases A or B as a result of affiliations. Abortions continued to be proscribed at the former Catholic hospitals (although they now operate as non-sectarian providers). Abortion continued not to be performed at the non-Catholic hospital in case A except to save the woman’s life and the woman cannot access care elsewhere in the community (a rare combination of circumstances). In case B, second-trimester abortions continued to be provided at the non-Catholic hospital for life or health of the woman or for fetal anomalies.

The abortion policies observed in the case studies had been formulated with regard to surgical abortions. Only one case study site had directly addressed the provision of non-surgical abortions. In case D, the Catholic health system recently had approved a CME course on the uses of RU486 that will be provided at the district hospital and had indicated that it could not invade the privacy of the physician-patient relationship to enforce its position on abortion.

## **C. Emerging Issues**

Three emerging issues were identified as potentially important ones for the future availability of reproductive health services within the case study sites. These pertained to the provision of non-surgical abortions; provision of comprehensive benefits within health insurance plans; and developing service lines or programs in women's health.

### **Non-surgical Abortions**

Chemically-induced abortions are expected to increase for early-term abortions with the availability of methotrexate and, eventually, mifepristone (RU486). Because these medical methods may be administered within the privacy of physicians' offices, they are expected to increase the availability of abortions for women who identify a need for termination early in pregnancy (Castle and Coeytaux 1994). These methods will not, however, eliminate the need for surgical abortions in cases of more advanced gestational age or in the event of unsuccessful medical abortions.

With the exception of case D, as noted above, the case study sites had not yet addressed the implications of the availability of non-surgical methods of abortion for their providers and services. Some informants reported that they saw this as a non-issue, since medical abortions could be provided within the privacy of the physician-patient relationship according to the model established for contraceptive services. Others, however, drew no distinction between medical and surgical abortions and assumed that current policies proscribing surgical abortions (except to save the life of the woman) would apply equally to both types of abortion procedures. In at least one case, informants disagreed in their perceptions of how non-surgical abortions would be handled, suggesting that conflict would eventually surface and perhaps become matters to be considered by the governing board.

## **Benefits Packages**

Health insurance plans and purchasers increasingly define core benefits packages as including a wide range of reproductive health services, including fertility-control services such as contraception, sterilization, and abortion. Health care providers that do not offer the required range of services are not likely to be competitive in the managed care marketplace.

There was little evidence in the case study interviews that the issue of core benefits had been fully considered, particularly with respect to abortion services. Certainly there was little indication that the issue had arisen at the level of governing boards. In all likelihood, the pressure to offer core benefits will increase the need for affiliating institutions to develop mechanisms to ensure the availability of covered services.

## **Women's Health Care**

The case study sites varied in the degree to which they had conceptualized women's health services and taken steps to develop service lines or comprehensive programs to provide women's health care. The changing normative climate in women's health nationally has drawn attention to the fact that women's health encompasses more than reproductive health, and that reproductive services are a key component of comprehensive women's health care and should be integrated with other services. Hospitals and health care systems that provide a range of reproductive health services are better positioned than those providing no or limited reproductive services to offer comprehensive health care to women.

Nationally, there has been a trend toward hospital-sponsored women's health centers of various kinds: in the 1994 American Hospital Association annual survey, 32% of U.S. hospitals reported having some type of women's health center, up from 19% in 1990. The 1994 National Survey of Women's Health Centers, conducted at Johns Hopkins University with support from The Commonwealth Fund, identified multiple types of hospital-sponsored centers. These included comprehensive primary care centers, reproductive health centers, birth or childbearing centers, breast care centers, and others providing either highly specialized clinical services or mainly information and referral services (Weisman, Curbow, and Khoury 1995). Hospital-sponsored women's health centers tend to be market-oriented and to seek to tap local women's needs for both clinical and non-clinical services (for example, education and support groups). A defining feature of the hospital-sponsored comprehensive primary care centers is the integration of reproductive and non-reproductive services to provide comprehensive, coordinated care to women through the lifespan.

Three of the four case study sites (A, B, and D) were developing women's health programs based on community needs assessments and/or regional considerations. Since two of the case study affiliations involved a Catholic hospital that did not provide obstetrical services, it is possible that the affiliations enhanced access to more comprehensive care among women in the former Catholic hospitals' services areas. In case A, plans for establishing women's resource centers (to provide education, information, and referral services) at the hospital's ambulatory care sites and main campus were being developed. In case B, a new women's service line that integrates reproductive and midlife services emerged as one of seven major products following the affiliation. And in case D, development of a women's service line by the Catholic system's regional division was underway. Case C had not identified women's health as a priority area and had no immediate plans to do so, although some clinicians and administrators reported that they would like to see the medical center become more proactive in women's health and to expand the conception of women's health care beyond maternity or other specific reproductive services.





## V. Conclusions and Policy Implications

### A. Strategies for Managing the Affiliation Process Between Catholic and Non-Catholic Health Care Organizations

In response to marketplace changes, a growing number of religious and non-sectarian hospitals and health systems are affiliating and finding ways to accommodate differences in ethical and religious values. Affiliations may include a wide range of adaptive alternatives, all of which are assumed to have the potential to increase an organization's chances for survival and to improve performance.

Currently, Catholic hospitals are the most numerous religiously sponsored health care organizations in the United States and account for about 10% of U.S. acute-care hospitals. Catholic hospitals and health systems were involved in about 18% of the nation's hospital affiliations between 1990 and 1996. Affiliations between Catholic and non-Catholic health care organizations are growing in number and as a proportion of all affiliations involving Catholic institutions. Nearly 80% of affiliations involving a Catholic hospital or health system between 1990 and 1996 were between Catholic and non-Catholic partners. In most instances, the non-Catholic partner was a not-for-profit entity.

Formal models for affiliations between Catholic and non-Catholic partners are quite varied and include mergers, acquisitions, consolidations, joint ventures, and long-term lease agreements. Furthermore, the agreements reached to accommodate different ethical and religious values or commitments to specific services vary widely. In some instances, these agreements result in a loss of Catholic identity, and some formerly Catholic institutions continue to follow the Directives after affiliations, while others do not. Various arrangements for making reproductive health services available have been devised. In four case studies of different types of affiliations between Catholic and non-Catholic partners, the project found that regardless of the affiliation type, both market forces and value-based concerns were apparent in decision-making processes. Although the partners in each case were driven by market changes to consider strategic affiliations to ensure organizational survival or competitiveness, their

business decisions were impacted by their ethical and religious traditions, as well as by the historical and community contexts of earlier affiliation attempts.

Similarities in the strategies for managing the affiliation process were observed in the case studies, and several factors associated with the successful negotiation of an affiliation were identified, regardless of the partnership model selected. Key among these was identifying a strategy, early in the affiliation process, to address the partners' different ethical and religious values and the impact of these values on the provision of controversial services. Although reproductive health services (particularly abortion) figured prominently in the value-based concerns raised in all four cases, concerns about social justice and responsible stewardship also were evident. Other factors characterizing successfully negotiated affiliations included: identifying strategies to obtain necessary approvals from the Department of Justice and the Catholic Church; developing a plan for managing the operational consolidation and cultural changes required to support integration, including human resources issues related to workforce reduction; developing strategies to promote active physician involvement, as well as development of physicians' administrative skills, during the affiliation process; and actively involving the community by soliciting input and providing information throughout the affiliation process.

## **B. Issues Regarding Reproductive Health Services in Affiliations**

Although value-based concerns about reproductive health services were apparent in the affiliation process in all four case studies, few changes in the availability of reproductive health services occurred as a consequence of these affiliations. Abortion (for purposes other than to save the life of the woman) was the only service for which there was evidence of a negative effect on availability. Obstetrical services were expanded and improved in two of the cases following affiliations, due to infusions of capital and the ability to realize economies of scale. Availability of family planning, sterilization, and infertility services generally were unchanged as a result of affiliations.

Abortion was the most contentious service considered during affiliation negotiations, and hospital-based abortion services (except to save the life of the woman) were discontinued in two of the cases as a consequence of affiliation. In one case, the abortion policy decision was made by a vote of the newly established governing board of a consolidated medical center, and in one case by pre-affiliation agreement between a Catholic system and a district hospital engaging in a joint venture. In both cases, abortion referrals were provided post-affiliation. In the two cases in which abortion availability was unchanged as a

result of the affiliation, abortion continued to be available at the non-Catholic facility under certain conditions and continued to be proscribed at the former Catholic facility. (In both cases, the Catholic partner became a non-sectarian provider, although, in one case, the Directives continued to be followed at the former Catholic facility.) As described earlier, cases involving more complex financial arrangements to distance a Catholic partner from abortion provision by another partner to an affiliation have been reported in the media but were not observed in our case studies.

The geographic separation of services by campus to avoid potential conflicts over provision of controversial services also was observed for gynecological care. In case B, all outpatient surgeries were consolidated on the former Catholic campus following the merger, with the exception of ambulatory gynecological surgery, which was consolidated on the non-Catholic campus. Informants explained that although it would have been more efficient and logistically easier to provide gynecological procedures with other types of surgery, the decision to keep them separate was made to accommodate the continued compliance of the former Catholic facility with the Directives while meeting women's needs for proscribed reproductive care (such as sterilization procedures). In other cases, geographic separation of services by campus was driven by financial and quality considerations. This was observed for different types of medical and surgical services, including obstetrical care. For example, the decision in case A to continue not providing obstetrical care on the former Catholic campus and the decision in case C to consolidate pregnancy-related services on one campus were made because of volume issues and to realize economies of scale.

The four case studies, together with public information about other instances of affiliations between Catholic and non-Catholic health care organizations, show that specific reproductive health services are impacted differently by affiliations. Most notably:

- Hospital-based surgical abortions (other than to save the life of the woman) are often curtailed after affiliations, although in some cases they may continue to be provided by the non-Catholic partner. Prohibitions against abortion referrals typically are not observed, and in some instances, policies ensuring referrals have been adopted.
- The provision of obstetrical services is often threatened in financially struggling hospitals. Declining patient volume has both financial and quality implications, particularly for high-risk obstetrical care, and may result in discontinuing these services. Affiliations therefore may strengthen and, in some cases, expand obstetrical care to the community as a result of capital infusion and economies of scale.

- Explicit policies that prohibit providers from counseling their patients about family planning options and from prescribing contraceptives within their medical practices typically are not observed at religious hospitals, either pre- or post-affiliation. Because organizations are not likely to invade the privacy of the physician-patient relationship to enforce their positions about fertility-control services, provision of contraception generally is not impacted by affiliations involving Catholic and non-Catholic parties.
- Provision of emergency contraception does not appear to emerge as an important issue during affiliations because emergency contraception is permissible at Catholic facilities when conception has not occurred and because victims of sexual assault often are referred to local or regional rape crisis centers.
- Sterilization services involve procedures that typically are performed on an inpatient or outpatient basis on a hospital's campus. These services may become more widely available after an affiliation if the Directives no longer apply, or curtailed if the Directives are followed. However, because sterilizations may be provided under the principles of cooperation (see Glossary, Appendix A), models for preserving these services often are observed.
- Infertility services generally are provided by large, tertiary care centers and not by small or mid-size hospitals. These services tend to be preserved post-affiliation, based on the principles of cooperation. Instances in which the non-Catholic hospital providing the services assumes Catholic identity, however, may be an exception.

Determinants of availability of reproductive health services following affiliations between Catholic and non-Catholic health care organizations are complex and vary by case. The project found no simple correspondence between the type of affiliation and these outcomes. Factors affecting how decisions regarding the availability of services were made include, for example, the range of services provided by the partnering organizations prior to the affiliation, the history of prior affiliation attempts, the relative financial strength of the Catholic partner, the level of community involvement during the affiliation process, and community traditions, particularly with regard to women's reproductive rights.

## **C. Lessons Learned and Implications for Policy**

Affiliations between Catholic and non-Catholic health care providers have generated concern among community groups and policymakers. Both

reproductive rights and anti-abortion advocacy groups have influenced the fate of affiliations in some instances. In addition to their potential impact on reproductive health care and other proscribed services, however, affiliations between Catholic and non-Catholic providers also may impact on the community by preserving local health care institutions and services, training opportunities, and jobs. This study has described four cases of successfully negotiated affiliations in which community impact was generally positive and in which the overall impact on availability of various reproductive health services was generally neutral, although there was some enhancement in the case of obstetrical services and some curtailment of hospital-based surgical abortion services.

Government has an interest in ensuring individuals' access to basic health services, particularly among the most vulnerable members of the community who may not have the options to seek care elsewhere if facilities close or if needed services are not available. Boozang (1996) argues that sectarian health care providers may benefit the community sufficiently to justify "negotiated accommodation" between religious principles and the state's interest in ensuring patient access to health care. Creative affiliation arrangements have the potential both to facilitate the survival of sectarian health care providers and to ensure that members of sociodemographically diverse communities have access to services that might be regarded as controversial within some religious traditions. The goal of these arrangements is to balance the needs of sectarian providers while ensuring access to care without adding to the burdens of those seeking services.

With regard to availability of reproductive health services, particularly abortion services, an important concern is protecting women in need of these services from undue hardship or risk to physical or mental health as a consequence of complex organizational arrangements for service provision. For example, as a result of some arrangements, women may be required to travel long distances for care, to make additional visits, to delay care, to pay more for out-of-plan services, or to seek specific services from providers unknown to, or not coordinated with, their primary care providers.

In addition, the case studies demonstrated the importance of ensuring that community members are informed of the policies and practices of affiliating health care providers. Although the partners to observed affiliations devoted substantial time and resources to informing the community and soliciting its input to the affiliation process, it is not known whether this occurs in most instances of affiliations or how well community members understand the arrangements that are made with regard to controversial services. An important role for policymakers is to ensure that the community receives full disclosure of the impact of affiliations on availability of such services.

In summary, assessments of the impact of affiliations between Catholic and non-Catholic health care providers for the health care of the community should consider a range of possible outcomes. Community and advocacy groups play an important role in directing public attention to issues of concern in local communities and in focusing attention on the need for impact assessments prior to, during, and after affiliations. Policymakers at the state and local levels, furthermore, frequently play an important role in ensuring that community members have access to needed health care services and that health care providers adhere to standards of care and meet the needs of pluralistic communities. All stakeholders, however, need to be sensitive to the range of possible costs and benefits to a community when religious and non-religious health care providers affiliate.

**Figure 1. Affiliation Characteristics**

	<b>Case A</b>	<b>Case B</b>	<b>Case C</b>	<b>Case D</b>
<b>Partner</b>	<ul style="list-style-type: none"> <li>Acquisition of Catholic hospital by a NFP hospital affiliated with a NFP system; Catholic hospital now non-sectarian</li> </ul>	<ul style="list-style-type: none"> <li>Merger of academic medical center and small Catholic hospital to form non-sectarian NFP integrated system; the Directives continue to apply at Catholic campus. Merger is part of a larger integration that involved a medical school &amp; physician group practice</li> </ul>	<ul style="list-style-type: none"> <li>Consolidation of Catholic and Protestant hospitals to form non-sectarian NFP medical center.</li> </ul>	<ul style="list-style-type: none"> <li>50/50 joint venture between a district hospital and a Catholic system</li> </ul>
<b>Type of Affiliation</b>	<ul style="list-style-type: none"> <li>Acquisition with alienation of Catholic property</li> </ul>	<ul style="list-style-type: none"> <li>Merger</li> </ul>	<ul style="list-style-type: none"> <li>Consolidation with alienation of Catholic property</li> </ul>	<ul style="list-style-type: none"> <li>Joint Venture – New non-sectarian NFP corporation formed to run hospital</li> </ul>
<b>Year of Affiliation</b>	<ul style="list-style-type: none"> <li>1995</li> </ul>	<ul style="list-style-type: none"> <li>1995</li> </ul>	<ul style="list-style-type: none"> <li>1994</li> </ul>	<ul style="list-style-type: none"> <li>1996</li> </ul>
<b>Region</b>	<ul style="list-style-type: none"> <li>Northern Central</li> </ul>	<ul style="list-style-type: none"> <li>Northeast</li> </ul>	<ul style="list-style-type: none"> <li>Northern Central</li> </ul>	<ul style="list-style-type: none"> <li>West Coast</li> </ul>
<b>Local Market Characteristics</b>	<ul style="list-style-type: none"> <li>NFP system 1 of 3 hospital players in the local market. Catholic hospital located in economically depressed community. Low managed care penetration.</li> </ul>	<ul style="list-style-type: none"> <li>New system is the only hospital player in the local market that is surrounded by a great deal of rural poverty. Capitated managed care expected to increase.</li> </ul>	<ul style="list-style-type: none"> <li>New medical center is the major hospital player in a 'conservative' and 'older' middle-class community. Managed care is growing.</li> </ul>	<ul style="list-style-type: none"> <li>Catholic system is a major hospital player in a multiple provider, largely middle-class community.</li> </ul>
<b>Financially Stronger Partner</b>	<ul style="list-style-type: none"> <li>Non-Catholic hospital</li> </ul>	<ul style="list-style-type: none"> <li>Academic Medical Center</li> </ul>	<ul style="list-style-type: none"> <li>Equal Partners</li> </ul>	<ul style="list-style-type: none"> <li>Catholic system</li> </ul>
<b>Earlier Affiliation Episode</b>	<ul style="list-style-type: none"> <li>1990s</li> </ul>	<ul style="list-style-type: none"> <li>1960s (different partners)</li> </ul>	<ul style="list-style-type: none"> <li>1970s</li> </ul>	<ul style="list-style-type: none"> <li>1995</li> </ul>
<b>Factors Motivating Recent Affiliation</b>	<ul style="list-style-type: none"> <li>Survival of Catholic hospital</li> <li>Increasing market share</li> </ul>	<ul style="list-style-type: none"> <li>Managed care</li> <li>Capitation</li> <li>Survival of Catholic hospital</li> </ul>	<ul style="list-style-type: none"> <li>Positioning for managed care growth</li> <li>Capitation</li> <li>Reducing service duplication</li> </ul>	<ul style="list-style-type: none"> <li>Managed care</li> <li>Capitation</li> <li>Survival of district hospital</li> <li>Expansion of Catholic system</li> </ul>

<b>Key Issues in Affiliation Process</b>	<ul style="list-style-type: none"> <li>Physician-hospital relationships</li> <li>Workforce reduction</li> <li>Loss of Catholic identity</li> </ul>	<ul style="list-style-type: none"> <li>Maintaining Catholic mission and values</li> <li>Physician-hospital relationships</li> </ul>	<ul style="list-style-type: none"> <li>Abortion</li> <li>Maintaining Catholic mission and values</li> <li>Communicating acceptance of consolidation.</li> </ul>	<ul style="list-style-type: none"> <li>Provision of women reproductive services</li> <li>Workforce reduction</li> </ul>
<b>Factors Facilitating Affiliation Process</b>	<ul style="list-style-type: none"> <li>Market research</li> <li>Internal/external communication strategies</li> <li>Addressing Catholic issues early on</li> </ul>	<ul style="list-style-type: none"> <li>Early approval of Bishop</li> <li>Physician support</li> </ul>	<ul style="list-style-type: none"> <li>Agreement that decisions not to be constrained by religious ideology</li> <li>Full board commitment and proactive involvement in affiliation</li> <li>Support of Catholic order</li> <li>Internal/external communications strategies</li> </ul>	<ul style="list-style-type: none"> <li>Community education and involvement in decisions</li> <li>Formal commitment between partners to promote shared values</li> </ul>
<b>Post-Affiliation Governance</b>	<ul style="list-style-type: none"> <li>Single board for non-Catholic hospital</li> </ul>	<ul style="list-style-type: none"> <li>New system board with equal representation from each of the 4 partners. Also, each partner kept its own board.</li> </ul>	<ul style="list-style-type: none"> <li>New board for medical center with equal representation from the 2 partners and community representation</li> </ul>	<ul style="list-style-type: none"> <li>New board for joint venture corporation with equal representation from Catholic system &amp; district hospital. Hospital continues to have its own elected board.</li> </ul>
<b>Current Challenges</b>	<ul style="list-style-type: none"> <li>Stabilization and enhancement of services</li> </ul>	<ul style="list-style-type: none"> <li>Utilization of Catholic campus</li> <li>Building physician management skills</li> <li>Cultural integration</li> </ul>	<ul style="list-style-type: none"> <li>Cultural integration</li> <li>Responsiveness to women's health needs</li> </ul>	<ul style="list-style-type: none"> <li>Financial stability</li> <li>Further workforce reductions planned</li> <li>Union issues</li> </ul>

NFP: Not-for-profit

## Figure 2. Reproductive Health Services

	Case A	Case B	Case C	Case D
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<b>Affiliation Description</b>	<ul style="list-style-type: none"> <li>Acquisition of Catholic hospital by a non-Catholic NFP hospital affiliated with a NFP system; Catholic hospital now non-sectarian.</li> <li>1995</li> </ul>	<ul style="list-style-type: none"> <li>Merger of academic medical center and small Catholic hospital to form non-sectarian NFP integrated system; the <u>Directives</u> continue to apply on former Catholic campus.</li> <li>1995</li> </ul>	<ul style="list-style-type: none"> <li>Consolidation of Catholic and Protestant hospitals to form non-sectarian NFP medical center.</li> <li>1994</li> </ul>	<ul style="list-style-type: none"> <li>50/50 joint venture between a district hospital and a Catholic system.</li> <li>1996</li> </ul>
<b>Prenatal/Obstetrical Care</b>	<ul style="list-style-type: none"> <li>Prenatal &amp; OB services, including prenatal genetic counseling, continue at non-Catholic campus.</li> <li>OB services discontinued at former Catholic campus in 1994; not provided after acquisition.</li> </ul>	<ul style="list-style-type: none"> <li>Prenatal &amp; OB services, including prenatal genetic counseling, continue at non-Catholic campus.</li> <li>OB services not provided at former Catholic campus before or after merger.</li> </ul>	<ul style="list-style-type: none"> <li>Prenatal &amp; OB services provided pre- and post-consolidation.</li> <li>Prenatal genetic counseling continues in on-site specialty clinic.</li> <li>Labor and delivery unit being expanded.</li> </ul>	<ul style="list-style-type: none"> <li>Prenatal &amp; OB services continue at district hospital.</li> <li>Prenatal genetic screening continues to be referred to local specialty group.</li> <li>Birthing unit being remodeled.</li> </ul>
<b>Family Planning</b>	<ul style="list-style-type: none"> <li>Contraception services continue at non-Catholic campus.</li> <li>Post acquisition, former Catholic campus stopped applying the <u>Directives</u> and began community contraception education.</li> <li>Both campuses continue not to operate family planning clinics.</li> <li>Rape services and emergency contraception provided at rape crisis center in system hospital 10 miles away.</li> </ul>	<ul style="list-style-type: none"> <li>Contraception services continue at non-Catholic campus.</li> <li>Former Catholic campus continues to apply the <u>Directives</u> to provision of contraception.</li> <li>Both campuses continue not to operate family planning clinics.</li> <li>Rape services &amp; emergency contraception continue at non-Catholic campus.</li> <li>System partners with community-based organizations to promote reproductive health.</li> </ul>	<ul style="list-style-type: none"> <li>Contraception services continue at both campuses.</li> <li>Both campuses continue not to operate family planning clinic.</li> <li>Rape services &amp; emergency contraception continue to be provided in the Emergency Room.</li> </ul>	<ul style="list-style-type: none"> <li>Contraception services continue at district hospital.</li> <li>Hospital continues not to operate family planning clinic.</li> <li>Rape services &amp; emergency contraception typically referred to rape crisis center at County Hospital but continue to be available at district hospital.</li> </ul>
<b>Sterilization</b>	<ul style="list-style-type: none"> <li>Continues at non-Catholic campus for men &amp; women.</li> <li>Became available at former Catholic campus post-acquisition.</li> </ul>	<ul style="list-style-type: none"> <li>Continues at non-Catholic campus for men &amp; women.</li> <li>Continues not to be performed at former Catholic campus.</li> </ul>	<ul style="list-style-type: none"> <li>Was performed at both hospitals for men &amp; women and continues to be provided at new medical center.</li> </ul>	<ul style="list-style-type: none"> <li>Continues at district hospital for men &amp; women.</li> </ul>
<b>Infertility Diagnosis And Treatment</b>	<ul style="list-style-type: none"> <li>Continue at non-Catholic campus.</li> </ul>	<ul style="list-style-type: none"> <li>Continue at non-Catholic campus.</li> </ul>	<ul style="list-style-type: none"> <li>Continue not to be provided (low demand and specialists not available).</li> </ul>	<ul style="list-style-type: none"> <li>Basic workups and treatment continue at district hospital.</li> <li>Advanced treatment referred to specialists.</li> </ul>
<b>Abortion</b>	<ul style="list-style-type: none"> <li>One abortion performed at non-Catholic hospital in last 10 years to save life of woman.</li> <li>Abortions continue not to be performed at former Catholic campus.</li> <li>Referrals provided to Planned Parenthood or system hospital 10 miles away.</li> <li>Board has not addressed non-surgical abortions; perception is that provision of RU486 will be left to MD-patient relationship.</li> </ul>	<ul style="list-style-type: none"> <li>2nd trimester abortions continue at non-Catholic campus in cases of fetal anomaly or for health or life of woman.</li> <li>Abortions continue not to be performed at former Catholic campus.</li> <li>Referrals provided to local providers of elective abortion.</li> <li>Board has not addressed non-surgical abortions.</li> </ul>	<ul style="list-style-type: none"> <li>Discontinued at former Protestant hospital after consolidation, by decision of new Board, except for life of woman.</li> <li>Nearest provider 50 miles away.</li> <li>No policy against abortion referrals.</li> <li>Board has not addressed "mandated benefits" that include abortion or non-surgical abortion.</li> </ul>	<ul style="list-style-type: none"> <li>Discontinued at district hospital after joint venture except for life of woman.</li> <li>Abortion referrals made by hospital personnel to local providers.</li> <li>Catholic system approved CME course on non-surgical abortions to be offered at district hospital.</li> <li>Provision of RU486 will be left to MD-patient relationship.</li> </ul>

Directives: The Ethical and Religious Directives for Catholic Health Care Services (National Conference of Catholic Bishops 1995).

CME: Continuing Medical Education

MD: Physician



NFP: Not-for-profit  
OB: Obstetrics

**Table 1. Catholic Health Care Provider Affiliations By Type Of Ownership Of The Affiliating Party And Year <sup>a</sup>**

Year	Ownership of Affiliating Party			Total
	Catholic	Non-Catholic Not-for-Profit	Non-Catholic For-profit	
1990	1	1	0	2
1991	2	2	1	5
1992	1	4	0	5
1993	1	1	0	2
1994	3	18	6	27 <sup>b</sup>
1995	8	31	7	46
1996	13	29	2	44
Total	29 (22%)	86 (66%)	16 (12%)	131 (100%)

a Based on data from the American Hospital Association (AHA) and Modern Healthcare (see Appendix B). Affiliating providers include hospitals and health systems.

b The increase in the total number of formal affiliations between 1993 and 1994 may be related to:

- (1) the fact that prior to 1994 hospital affiliations were monitored only by the AHA and not by Modern Healthcare, so that some cases might have been missed.
- (2) the clarification of the Department of Justice review guidelines for hospital affiliations during that time period (see text).

**Table 2. Types Of Affiliations Involving Catholic Health Care Providers, 1990-1996<sup>a</sup>**

Type of Affiliation <sup>b</sup>	Ownership of Affiliating Party		Total
	Catholic and For-profit Providers	Catholic Providers Only	
	Catholic and For-profit Providers	Catholic Providers Only	Total
	and		
	Other		
	Not-for-profit		
	Providers		

	N (Column %)	N (Column %)	N (Column %)	N (Column %)
Merger	41 (48%) <sup>c</sup>	0	12 (41%) <sup>d</sup>	53 (40%)
Acquisition (Catholic acquiring Non-Catholic)	19 (22%)	4 (25%)	N/A	23 (18%)
Acquisition (Non-Catholic acquiring Catholic)	8 (9%)	9 (56%)	N/A	17 (13%)
Acquisition (Catholic acquiring Catholic)	N/A	N/A	9 (31%)	9 (7%)
Joint Venture/Holding Company Arrangements	7 (8%)	3 (19%)	4 (14%)	14 (11%)
Lease Arrangements (Catholic leasing Non- Catholic)	5 (6%)	0	0	5 (4%)
Consolidation	4 (5%)	0	0	4 (3%)
Not clearly reported	2 (2%)	0	4 (14%)	6 (5%)
<b>Total</b>	<b>86</b>	<b>16</b>	<b>29</b>	<b>131 (100%)</b>

- a Based on reports of the American Hospital Association and Modern Healthcare (see Appendix B). Catholic health care providers include hospitals and health systems.
- b Refer to the Glossary (Appendix A) for definitions of types of formal affiliations.
- c Includes 5 virtual mergers where income statements are merged but balance sheets remain separate.
- d Includes 1 virtual merger.

## References

Abma J.C., Chandra A., Mosher W.D., Peterson L.S., Piccinino L.J. Fertility, Family Planning, and Women's Health: New Data from the 1995 National Survey of Family Growth. National Center for Health Statistics. Vital Health Stat 23(19). 1997.

- American Civil Liberties Union. 1995. "Hospital Mergers: The Threat to Reproductive Health Services," Reproductive Rights Update. New York: American Civil Liberties Union Reproductive Freedom Project.
- American College of Obstetricians and Gynecologists. 1994. Induced Abortion: Important Medical Facts. Washington, D.C.: ACOG.
- American Hospital Association. 1990-1996 editions. AHA Guide to the Health Care Field. Chicago: American Hospital Association.
- Bayley, Carol. 1995. "Women's Reproductive Health: A Catholic Perspective." Western Journal of Medicine 163[suppl.]:71-72.
- Boozang, Kathleen M. 1996. "Developing Public Policy for Sectarian Providers: Accommodating Religious Beliefs and Obtaining Access to Care." Journal of Law, Medicine and Ethics 24:90-98.
- Castle, Mary Ann, and Francine M. Coeytaux. 1994. "RU486 Beyond the Controversy: Implications for Health Care Practice," Journal of the American Medical Women's Association 49:156-159,164.
- Catholics for a Free Choice. 1995. Reproductive Health at Risk: A Report on Mergers and Affiliations in the Catholic Health Care System 1990-1995. Washington, D.C.:Catholics for a Free Choice.
- Center for Reproductive Law and Policy. 1996. Reproductive Freedom News 10:4.
- Chavkin, Wendy. 1996. "Topics for Our Times: Public Health on the Line--Abortion and Beyond." American Journal of Public Health 86:1204-1206.
- Clarke, Sally C., and Selma M. Taffel. 1995. "Trends and Differentials in Postpartum Sterilization for Cesarean and Vaginal Deliveries: United States, 1970-93." Paper presented at the Annual Meeting of the American Public Health Association.
- Delbanco, Suzanne, and Mark D. Smith. 1995. "Reproductive Health and Managed Care: An Overview," Western Journal of Medicine 163[suppl]:1-6.
- EDK Associates. 1995. Health Care Reform Crossroads: The Gap Between Catholic Church Mandates and Women's Needs. New York:EDK Associates.
- Family Planning Advocates of New York State. 1996. MergerWatch--Hospital Mergers: The Hidden Crisis for Family Planning. An Activist's Guide. Albany: Family Planning Advocates.
- Griese, O. 1987. "The Principle of Material Cooperation in Catholic Identity." Pp. 373-419 in Health Care: Principles and Practices. Braintree: The Pope John Center.
- Haas-Wilson, Deborah, and Martin Gaynor. 1997. "Increasing Consolidation in Health Care Markets: What are the Antitrust Policy Implications?" Pittsburgh: Carnegie Mellon University, Heinz School of Public Policy and Management Working Paper #97-10.
- Healy, E.F., S.J. 1942. Moral Guidance. Chicago: Loyola University Press.
- Henshaw, Stanley K., and Aida Torres. 1994. "Family Planning Agencies: Services, Policies and Funding," Family Planning Perspectives 26:52-59,82.
- Henshaw, Stanley K., and Jennifer Van Vort. 1994. "Abortion Services in the United States: 1991 and 1992," Family Planning Perspectives 26:100-106,112.

- Jaeger, B.J., A.D. Kaluzny, and K. Magruder-Habib. 1992. "Interorganizational Relationships," Chapter 9 in J.S. Rakich, B.B. Longest, and K. Darr (eds.), Managing Health Care Organizations, Third Edition. Baltimore: Health Professions Press.
- Japsen, Bruce. 1995a. "CHA Membership to Vote on Requiring Not-for-Profit Status." Modern Healthcare 25(23):18.
- . 1995b. "Catholic Group Bans For-profits." Modern Healthcare 25(24):2-3.
- . 1995c. "Catholics Urge Hospitals to Stay Not-for-profit." Modern Healthcare 25(46):30.
- . 1996. "Mergers and Acquisitions Report: Another Record Year for Dealmaking." Modern Healthcare 26(52):37-46.
- Keenan, J.F., and T.R. Kopfensteiner. 1995. "The Principle of Cooperation." Health Progress April:23-27.
- Kwon, Ik-Whan, Scott R. Safranski, David G. Martin, and William R. Walker. 1988. "Causes of Financial Difficulty in Catholic Hospitals." Health Care Management Review 13:29-37.
- Laurence, Leslie, and Beth Weinhouse. 1994. Outrageous Practices: The Alarming Truth About How Medicine Mistreats Women. New York: Fawcett Columbine.
- Lewin, Tamar. 1995. "As Health Mergers Rise, Some Say Catholic Standards May Affect Care." The New York Times National, March 8.
- Lutz, Sandy. 1993. "Two-hospital Towns Try Togetherness." Modern Healthcare 23(49):39-42.
- . 1994. "Let's Make a Deal: Healthcare Mergers, Acquisitions Take Place at Dizzying Pace." Modern Healthcare 24(51):48-52.
- . 1995. "Mergers and Acquisitions Report-1995: A Record Year for Hospital Deals." Modern Healthcare 25(51):43-52.
- Maida, A.J., and N.P. Cafardi. 1994. Church Property, Church Finances and Church-Related Corporations: A Canon Law Handbook. St. Louis: Catholic Health Association.
- National Coalition on Catholic Health Care Ministry. 1995. Catholic Health Care Ministry in Transition: A Handbook for Responsible Leadership. Silver Spring, MD: NCCHCM.
- National Conference of Catholic Bishops. 1981. Health and Health Care: A Pastoral Letter of the American Catholic Bishops. Washington, D.C.: United States Catholic Conference Publishing Services.
- . 1995. Ethical and Religious Directives for Catholic Health Care Services. Washington, D.C.: United States Catholic Conference, Inc. (Reprinted in Origins 1994;24:449-462.)
- Official Catholic Directory. 1995 edition. New Providence: P.J. Kennedy and Sons.
- Peterson, Linda A. 1995. "Contraceptive Use in the United States: 1982-90," Advance Data from Vital and Health Statistics, No. 260. Hyattsville, MD: National Center for Health Statistics.
- Prince, Thomas R. 1991. "Assessing Financial Outcomes of Not-for-Profit Community Hospitals." Hospital and Health Services Administration 36:331-349.

- . 1994. "Assessing Catholic Community Hospitals Versus Nonprofit Community Hospitals, 1989-1999." Health Care Management Review 19:25-37.
- and Ramachandran Ramanan. 1994. "Operating Performance and Financial Constraints of Catholic Community Hospitals, 1986-1989." Health Care Management Review 19:38-48.
- Schwartz, Dana Belmonte, Phyllis A. Wingo, Libby Antarsh, and Jack C. Smith. 1989. "Female Sterilizations in the United States, 1987." Family Planning Perspectives 21:209-212.
- Showalter, J.S., and John L. Miles. 1988. "Restructuring Health Care Organizations While Maintaining Recognition as a Catholic Institution." Saint Louis University Law Journal 32:1111-1143.
- Slee, Vergil N., Debora A. Slee, and H. Joachim Schmidt. 1996. Health Care Terms: Third Comprehensive Edition. Saint Paul: Tringa Press.
- Smith, R.E. 1995. "The Principles of Cooperation and Their Application to the Present State of Health Care Evolution." Resource 9 in National Coalition on Health Care Ministry, Catholic Health Ministry in Transition: A Handbook for Responsible Leadership. Silver Spring: National Coalition on Health Care Ministry.
- Stedman, Thomas Lathrop. 1990. Stedman's Medical Dictionary, 25<sup>th</sup> Edition. Baltimore: Williams and Wilkins.
- Timmreck, Thomas C. 1987. Dictionary of Health Services Management 2<sup>nd</sup> Edition. Owings Mills: National Health Publishing.
- U.S. Department of Justice and the Federal Trade Commission. 1994. Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust. Washington, D.C.: U.S. Department of Justice., 10 Street and Constitution Ave. NW, Washington, D.C. 20530.
- U.S. Department of Justice, Antitrust Division. 1996. Opening Markets and Protecting Competition for America's Businesses and Consumers: Goals and Achievements of the Antitrust Division of the U.S. Department of Justice: Fiscal Year 1993 through March 1996. Washington, D.C.: U.S. Department of Justice, 10 Street and Constitution Ave. NW, Washington, D.C. 10530.
- Weisman, Carol S., Barbara Curbow, and Amal J. Khoury. 1995. "The National Survey of Women's Health Centers: Current Models of Women-Centered Care." Women's Health Issues 5:103-117.

## Appendix A: Glossary

**ABORTION:** Abortion refers to the spontaneous or induced termination of a pregnancy. The American College of Obstetricians and Gynecologists (1994) defines abortion as “expelling or removing the developing fetus from a woman’s uterus before the fetus is viable (can live outside the uterus on its own). The medical procedure used to do this is induced abortion.”

The National Conference of Catholic Bishops (NCCB 1995:19-20) defines abortion as “the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus.” Accordingly, “every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion.” Abortion, in this sense, is never permitted under Catholic doctrine. Where the direct intention of a termination of pregnancy is “the cure of a proportionately serious pathological condition of a pregnant woman,” the procedure is not, strictly speaking, an “abortion” under Catholic doctrine. Such terminations of pregnancy to save the life of the woman are permissible “when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of unborn child.” Most whom we interviewed regarding the availability of pregnancy terminations to save the life of the woman in a Catholic facility referred to this service as “therapeutic” or “medically necessary” abortion. In the report, we identify these services as “abortions to save the life of the woman.”

**ACQUISITION:** A type of affiliation in which one health care organization purchases another organization, which ceases to operate as a separate entity.

**ALIENATION OF PROPERTY:** A concept under Catholic Canon Law, alienation is “either the conveyance to another party or the encumbrance or placing in jeopardy of loss any interest in the stable patrimony (immovable goods or fixed capital) of a public or juridic person” (Maida and Cafardi 1994:302).

**ASSISTED REPRODUCTION:** Technologies to treat infertility in either the male or female partner and to enhance reproduction. (See “infertility treatments.”)

**CONSOLIDATION:** A type of affiliation in which two or more health care organizations dissolve and are unified in a new legal entity with one governing board and one CEO (Jaeger, Kaluzny, and Magruder-Habib 1992).

**CONTRACEPTIVES:** Refers to methods or agents to prevent pregnancy (also called “birth control”). Distinctions are often made between surgical and non-

surgical methods, reversible and irreversible methods, medical (requiring a physician's prescription) and non-medical, or natural and artificial methods. Methods of contraception currently in use include: surgical sterilization (male and female); oral contraceptives; contraceptive implants (Norplant); injectables (Depo-Provera); intrauterine devices (IUDs); diaphragms; condoms (male and female); spermicidal foams, suppositories, or creams; periodic abstinence; natural family planning; and withdrawal. The most prevalent methods in the United States are female sterilization and oral contraceptives.

**COOPERATION:** See "principles of cooperation."

**EMERGENCY CONTRACEPTION:** Oral contraceptives (sometimes called "morning after pills") taken to reduce the risk of pregnancy within 72 hours of unprotected intercourse.

**FAMILY PLANNING:** Refers to the determination of the number of children and the spacing of children within a family by the use of contraceptive methods. (See "contraceptives.") Family planning services include provision of these methods along with education and counseling of the individual or couple.

**HOLDING COMPANY:** In this type of affiliation, the holding company, a new legal entity, controls member health care organizations. The governing boards of the member organizations lose their power to the new holding company board. Member organizations still have separate balance sheets (i.e. assets and liabilities) and income statements (i.e. revenues and expenses).

**INFERTILITY:** Stedman's Medical Dictionary (1990:780) defines infertility as "relative sterility; diminished or absent fertility; does not imply (either in the male or the female) the existence of as positive or irreversible a condition as sterility." U.S. medical experts consider a couple to be infertile after one year of unprotected intercourse without pregnancy (Chandra and Mosher 1994).

**INFERTILITY TREATMENTS:** A variety of technologies to assist pregnancy, including, for example, artificial insemination (with spouse or donor sperm), in vitro fertilization, ovulation-inducing drug therapy, oocyte donation, embryo donation, and surrogate gestation.

**JOINT VENTURE:** A type of affiliation in which two or more health care organizations develop an alliance or association (possibly a new corporate entity) for specific purposes. Partners continue to operate as independent providers (i.e. maintain separate governing boards, income statements, and balance sheets) and share ownership and governance of the new corporation.

**LEASE AGREEMENT:** A contract that allows one party (the lessee) to use, possess, and manage assets of another party (the lessor) for a specified time and



for a set payment. The lessor maintains ownership of assets. Assets may include lands, buildings, and property of health care facilities (Timmreck 1987).

**MANAGEMENT CONTRACT:** A relatively loose type of affiliation between two health care organizations, in which one supplies senior management (e.g. chief executive officer, chief financial officer) to another (Jaeger, Kaluzny, and Magruder-Habib 1992).

**MERGER:** A type of affiliation in which one or more health care organization is absorbed by another. Assets, liabilities, and income statements are merged. The result is one corporate identity, typically a system with a new name, one governing board, and one CEO (i.e. single ownership and governance). (See “virtual merger.”)

**OBSTETRICAL CARE:** Refers to the range of services associated with pregnancy and childbirth, including prenatal care, labor and delivery, and postpartum care of the mother.

**PRECONCEPTION CARE:** Refers to educational, counseling, psychological, or genetic screening services to individuals or couples prior to conceiving a child.

**PRENATAL CARE:** Refers to the care of a pregnant woman to maintain or improve her health, to prepare for childbirth, and to increase the likelihood that the pregnancy will result in a full-term, full birthweight, healthy infant.

**PRENATAL GENETIC COUNSELING/SCREENING:** Genetic counseling refers to “a clinical service with informational, educational, and psychological components” about the likelihood that patients’ offspring have “genetic (hereditary) conditions, defects, or diseases” (Slee, Slee, and Schmidt 1996:247). Prenatal genetic screening refers to the tests used prenatally to determine if a parent is a carrier of a genetic disorder or if a fetus has inherited a genetic disorder or predisposition.

**PRINCIPLES OF COOPERATION:** The principle involves justifications for active participation in wrongdoing (Griese 1987). Cooperation in this sense is akin to complicity, that is, partnership or involvement in wrongdoing. The Directives distinguish between formal and material cooperation. Cooperation is “formal” when the form of the act (that is, its intention and object) is shared by both wrongdoer and cooperator. Formal cooperation is always morally wrong because the cooperator intends, either explicitly or implicitly, the object of the wrongdoer’s activity. Cooperation is “material” when the act is achieved by participation of both wrongdoer and cooperator, although the cooperator may not share the intention of the wrongdoer. Material cooperation may be morally licit, depending on conditions of intention, duress (i.e. forces compelling collaboration), distance (i.e. between the cooperator and the evil act), necessity

(i.e. extent to which the cooperation is necessary for the very existence of the wrongful activity), gravity (i.e. consequences of the evil), and the possibility of scandal. It is also important to evaluate proportionality (i.e. the ratio of good to evil) when an act of material cooperation is considered (Keenan and Kopfensteiner 1995).

**SCANDAL:** Refers to generating confusion about Catholic moral teaching (NCCB 1995:27). Scandal is said to occur when persons perceive an inconsistency between professed church teaching and reality. Because of scandal, people may become critical of the church and its members or cynical about religion. Finally, inconsistency between church teachings and practices is scandalous because by making evil seem good or seem like an attractive object, inconsistency may lead another to sin (Healy 1942; Smith 1987).

**STERILIZATION:** Stedman's Medical Dictionary (1990:1475) defines sterilization as "the act or process by which an individual is rendered incapable of fertilization or reproduction, as by vasectomy, salpingectomy, or castration." Female sterilization typically is by tubal ligation or hysterectomy. Male sterilization is by vasectomy.

**VIRTUAL MERGER:** A type of affiliation in which two or more health care organizations merge their income statements (revenues and expenses) but maintain separate balance sheets (assets and liabilities). A joint governing board representing the partners is formed and has some (but not ultimate) power over services provided by the partners. No new corporate identity is created. This type of affiliation has the advantage of allowing partners to maintain ideologically separate identities and tax status.

# Appendix B: Methods

## I. Trend Analysis Methods

To profile recent affiliations involving Catholic hospitals/health systems, a database of 131 such transactions occurring between 1990 and 1996 was constructed in three steps. The database includes: (1) transactions involving community hospitals that affiliated with other hospitals or health systems, and (2) transactions involving significant organizational changes. The database does not reflect major corporate affiliation activity, transactions that were reported but later dissolved, or attempted affiliations that failed.

The first step in constructing the database was obtaining annual lists of hospital affiliations from two sources: the American Hospital Association (AHA) and Modern Healthcare, a weekly publication of Crain Communications Inc. that tracks health care industry news and trends. The Constituency for Health Systems at the AHA provided lists compiled between 1990 and 1993. Annual reports compiled by Modern Healthcare staff provided information about formal affiliations occurring between 1994 and 1996. Partnerships involving significant changes in control or financial statements of a hospital were listed, including: mergers, acquisitions, consolidations, joint ventures, and lease agreements. Looser forms of affiliation, such as management contracts or cases where a hospital joins a network, were not listed. For each transaction, the lists identified the names of the partners and the new organizations formed (if any), affiliation type, state, and year of affiliation.

The second step was identifying transactions involving Catholic parties. This was done by matching the above lists with the 1995 Official Catholic Directory, the recognized authority for publishing the list of “agencies, extensions, and affiliates of the church” (Showalter and Miles 1988). Since it is possible that a Catholic hospital that dissolved following an affiliation would not be listed in the 1995 Directory, the lists were also matched with the AHA guides to the health care field to identify hospitals belonging to a Catholic system. This strategy minimizes the possibility that a Catholic hospital affiliation is not identified for failure to determine Catholic identity in cases where the Catholic partner dissolved following the transaction.

The third step was to determine the type of ownership of the non-Catholic partner(s). Transactions involving Catholic partners were matched with the AHA guides for the appropriate years, and the ownership type of the non-

Catholic partner(s) was identified as public, private not-for-profit, or for-profit. (For two transactions, the systems affiliating with the Catholic hospital were not listed in the AHA guides but were identified in the Directory of the Federation of American Health Systems, the trade association of for-profit systems.)

Using this information, the 1990-1996 database of Catholic hospital/health system affiliations was divided into three categories: (1) transactions involving Catholic partners only; (2) transactions involving Catholic and non-Catholic not-for-profit providers (including private not-for-profit and public organizations); and (3) transactions involving Catholic providers and non-Catholic for-profit organizations.

The limitations of the approach used to construct the database are as follows:

(1) Affiliations that were not publicly announced or reported were not included in the source lists. It is not possible to locate such cases or to estimate their number.

(2) Despite the fact that the source lists were matched against the Official Catholic Directory and the AHA guides, it is possible that certain transactions were not identified as involving a Catholic partner for failure to confirm Catholic identity. If this occurred, the number of such cases would be very small, however.

(3) AHA and Modern Healthcare do not systematically monitor affiliations prospectively. It is therefore possible that the database includes affiliations that were announced but later failed.

## II. Case Study Methods

### A. Case Study Selection

Based on the database described above and information obtained from key informants, we selected twelve cases of affiliations between Catholic and non-Catholic providers (the most prevalent category of affiliations) as possible case study sites. The selected cases met the following eligibility criteria:

(1) Cases were mixed with regard to affiliation type and included six mergers, two acquisitions, two joint ventures, one consolidation, and one long-term lease agreement.

(2) Cases were geographically dispersed and represented all regions of the country.

(3) Cases were mixed with regard to ownership of the non-Catholic partner: eight of the non-Catholic partners were private not-for-profit; three were public; and one was for-profit.

(4) All but one affiliation occurred between 1994 and 1996. This reflects the fact that relatively few partnerships were reported between 1990 and 1993.

(5) Cases were mixed with regard to the extent to which a Catholic presence was maintained post-affiliation. For example, the merger cases included some where the newly formed system was Catholic and some where the newly formed system was non-sectarian.

(6) Cases varied in terms of the outcomes with regard to reproductive health services, as far as this could be ascertained from available information.

Of the twelve cases contacted and invited to participate, four agreed to participate in the study. Declining cases cited three main reasons: (1) a memorandum from the President and CEO of the Catholic Health Association (CHA), alerting members to the CHA Executive Committee's position that "there are serious negative consequences of this study for the whole health ministry" and recommending "that CHA not support nor participate in the study;" (2) fear that participation might expose the partners to criticisms around sensitive issues, including the provision of reproductive health services; and (3) busy schedules of hospital executives that did not allow time for hosting a two-day site visit. The CHA memo, dated September 5, 1996, was distributed following numerous telephone conversations and a meeting between the project investigators and CHA representatives, in which the investigators explained the aims and methods of the project.

The characteristics of the four participating cases reflect all but one of the selection criteria noted above. All occurred between 1994 and 1996, they were geographically dispersed, they illustrated different affiliation types (including a merger, acquisition, consolidation, and joint venture), they had varying outcomes with regard to reproductive health services, and the non-Catholic partners were both private not-for-profit and public providers. The cases do not, however, include an instance where the Catholic partner is relatively dominant, such as acquisitions of non-Catholic assets by a Catholic institution or a merger of a Catholic and non-Catholic hospital into a Catholic entity. CHA's memo could have influenced the decision of such cases to decline participation.

It is possible that participating cases also differ from declining cases in two other ways. First, participating cases may represent relatively less conservative religious

communities with fewer concerns about possible scandal. Second, the administrators in participating cases may be more comfortable with the progress of the post-affiliation process and therefore more willing to discuss their situations.

In any event, the four cases are not meant to be representative of all affiliations between Catholic and non-Catholic health care organizations. Rather, they are illustrative models of successfully negotiated affiliations and of outcomes for reproductive health services.

## **B. Case Study Methods**

The chief executive officer at each of the contacted sites was mailed an introductory letter explaining the purpose of the project and the provisions for confidentiality. A site visit was conducted at each of the four sites that agreed to participate.

Each case study was conducted over a 1-2 day period during which a three-person team of investigators traveled to the site and conducted semi-structured interviews with key informants identified prior to the visit. At each site, an effort was made to interview senior administrators (e.g. the CEO, chief operating officer, vice-presidents, planning/marketing director), managers of women's services, members of the governing board, clinicians (including physicians and non-physicians), and ethicists. We were particularly interested in interviewing individuals who had participated in the affiliation process and continued to assume responsibilities within the organization. Interviews focused on the following topics: (1) history of the partners and community characteristics; (2) the affiliation process, including motivating factors, earlier attempts at affiliation (if any), key issues in operationalizing the partnership, post-affiliation governance, and current challenges; (3) status of reproductive services, including the range of services provided pre- and post-affiliation and decision elements in service provision; and (4) community impact of the affiliation.

Each site visit also included a review of hospital and affiliation documents (e.g. organizational charts, annual reports, affiliation agreement documentation, hospital publications communicating the affiliation internally to staff and externally to the community, media coverage of the affiliation, proposals/plans for women's services) and of information on other community providers of reproductive health services.

A case study report was prepared for each case, following a uniform format. Each report was sent to the CEO to be reviewed for accuracy, and minor

revisions were then made. (See Appendix C.) The case study protocol, including the interview questions, is available from the investigators.

## **Appendix C: Case Study Reports**

### **I. Case Study A**

In 1995, a not-for-profit hospital located in a North Central state acquired a neighboring Catholic community hospital. The non-Catholic hospital is a 368-bed tertiary care provider located in a large city in an area known for its ethnic diversity and blue-collar industries. It is non-sectarian, with a Lutheran background, and part of a large not-for-profit system. This and two other systems (one Catholic and one non-sectarian) are the major hospital players in the local health care market. The Catholic hospital was a 178-bed general provider located in an economically depressed town 15 miles away.

In 1994, the corporate sponsor and governing board of the financially struggling Catholic hospital realized the need for a strategic partner if the hospital was to continue to serve its community. At the time, the non-Catholic hospital was enjoying growth in patient volume and revenues and was seeking to extend its services into surrounding communities. A letter of intent to transfer the Catholic hospital's assets to the non-Catholic hospital was signed in early 1995, and the sale process (which involved Catholic property alienation) was completed within nine months. The Catholic facility now operates as a general, non-sectarian hospital. Its new name combines the name of its current owner with its geographic location.

#### **The Affiliation Process**

##### **Earlier Attempt at Affiliation (Early 1990s)**

The 1995 acquisition was a second attempt at affiliation between the two hospitals. In the early 1990s, the Catholic hospital was purchased by a Catholic health care system. The hospital had been experiencing reduced patient volume and revenues and had accumulated millions of dollars of debt. The Catholic

system and the hospital governing board determined the need for an affiliation and made their decision known to area providers. An affiliation was expected to facilitate the hospital's access to capital, physician networks, and managed care contracts. It would also allow the hospital to reduce its expenses and consolidate some of its services.

The non-Catholic hospital was enjoying a number of successes at the time. The hospital had established ambulatory care sites in several of its neighboring communities, including the Catholic hospital's service area. These centers provided primary care services and referrals to the parent hospital. In the late 1980s, the hospital had joined a health system that provided different services to its members. In addition, the physical space of the hospital was expanded and progress in cardiac, cancer, rehabilitation, and women's health care was made. These factors, combined with extensive market research, had produced a 40% increase in patient volume in recent years. The hospital was therefore ready for further growth.

Given the geographic proximity of the two hospitals and the referral patterns between them, the hospitals' executives agreed that an affiliation would be advantageous to both. Discussions ensued about different forms of affiliation. It was determined, however, that the Directives would prohibit the Catholic hospital from affiliating with the non-Catholic hospital because the latter's sister hospital (sponsored by the same health system) performed abortions. The affiliation plans were halted.

### **Successful Affiliation (1995)**

With the continued decline in the Catholic facility's performance, its sponsor hired a hospital management group in 1994 to position the hospital for sale. One of the consultants became the hospital's top executive after the CEO resigned and implemented both financial and operational improvement initiatives. The hospital's sponsor then negotiated with the local Catholic system to acquire the facility. These negotiations failed when the Catholic system refused to assume the long-term debt of the hospital.

Meanwhile, the executives of the non-Catholic facility proposed that their governing board offer to purchase the Catholic hospital, and the board quickly agreed. A letter of intent to transfer the Catholic hospital's assets and liabilities to the non-Catholic hospital was signed in early 1995. Although the Catholic hospital's sponsor and governing board struggled over the loss of Catholic identity, they felt a strong responsibility to the community and agreed that the survival of the hospital was more important than the Catholic presence. Abortion did not emerge as a critical issue because the Catholic hospital was



being sold outright to the not-for-profit system (i.e. no joint ownership or shared governance arrangements were considered). The acquisition was completed after nine months of negotiations that involved the Archdiocese. The executive consultant of the Catholic hospital was retained as the Executive Director of this campus.

## **Operationalizing the Acquisition**

As soon as the letter of intent was signed, two transition task forces were formed with representatives from both facilities: an Operations Task Force and an Employee/Community Task Force. The Operations Task Force focused on: developing new organizational charts that define the accountabilities and responsibilities of all levels of leadership; meeting regulatory requirements; reviewing all policies and procedures; and communicating any new standards/expectations to the employees. The Employee/Community Task Force focused on: defining and communicating the compensation and benefits package for new employees (those previously employed by the Catholic hospital); developing management training and new employee orientation programs; merging the mission and vision of the two organizations; managing the cultural transition from Catholic to non-Catholic; and communicating change internally and externally. One individual facilitated both task forces.

Transition teams addressed three problematic areas: emotional issues, operational issues, and hospital-physician relationships. Emotional issues related to concerns raised by the former Catholic hospital's community about the future of the facility and the expressed preferences of some community members that the hospital be sold to the Catholic system. Workforce reduction and changes in the nursing model (from a paternalistic to a shared governance model) caused resentment among several of the former Catholic hospital's employees, a number of whom resigned. Hospital-physician relationships became an issue following two decisions: (1) requiring the medical staff of the former Catholic hospital to be re-credentialed by the non-Catholic hospital; and (2) terminating the contracts of anesthesiologists and emergency physicians with the Catholic hospital, since they were not considered as competent as their colleagues practicing at the non-Catholic facility.

Several factors contributed to the success of the affiliation. First, extensive market research was conducted in the Catholic hospital's community, and strategic plans for the facility were developed accordingly. The market research tools used included: a survey of community demographics and needs; market segmentation and attitudinal research; focus groups with residents; and one-to-one meetings with community physicians. Attitudinal research monitored

different market segments and provided information on the community's attitudes toward the hospital to the public relations department.

A second success factor was the emphasis on internal and external communication during and after the transition process. Internally, the letter of intent was announced during a meeting attended by executives and employees of the two hospitals, and the announcement was followed by a survey of the perceptions/concerns of board members, providers, and employees of the Catholic facility. Ten editions of a Transition Newsletter were published, and several administrator forums were held by the CEO of the purchased campus to update campus employees about new plans. Externally, a program was developed in which teams of two employees (one from each hospital) participated in community events, discussed the acquisition, and provided feedback to the hospitals about community concerns. Furthermore, the new name of the former Catholic campus was selected with community input. Focus groups were used to generate potential names, and a telephone survey assessed people's opinions of the names.

A third success factor was addressing cultural issues early on. The transition team realized the importance of grieving over the loss of Catholic identity and held a "good-bye" party, a ceremony to remove the religious symbols, and an event to highlight the history and culture of the facility. A book summarizing the history of the Catholic facility was produced. In addition, the Team devoted time to addressing the concerns of those who had attended mass at the hospital's chapel and senior citizens who were saddened by the departure of their priest. (The Archdiocese no longer recognized the hospital chapel as Catholic, withdrew the chaplain, and insisted on a name change and the removal of religious symbols.)

## **Status of Reproductive Services**

The site visit took place 15 months after the acquisition process ended and approximately two years after the letter of intent was signed and formal negotiations between the two hospitals began. Although there have been no major changes in the range of women's health services to date, the acquisition is beginning to increase the availability of services, including reproductive services, in the former Catholic hospital's service area.

Prior to the acquisition, the Catholic hospital provided a limited range of reproductive services with a focus on screening and treatment of gynecological conditions. The obstetrical service had been closed in 1994 following a sharp decline in patient volume. This was not a popular decision among community

members, but the hospital argued that the low volume made it difficult for the unit to survive both from financial and quality-of-care standpoints. No contraception, sterilization, infertility, or abortion care was provided on the Catholic campus. Physicians renting office space in a medical plaza that was owned by the hospital provided fertility-control services in their offices, however.

A wide range of reproductive services is provided by the non-Catholic hospital including obstetrics and gynecology (each has a separate inpatient suite), prenatal services, prenatal genetic screening, contraception, sterilization (for men and women), and advanced infertility treatments. The hospital also provides community education about reproductive issues. There is no family planning clinic on-site. There are also no plans for starting a freestanding birthing center because market research indicates that community women prefer an inpatient setting for childbirth. Rape counseling, including emergency contraception, is provided by one of the system hospitals located 10 miles away; rape victims presenting to the emergency rooms of the other system hospitals are stabilized and transferred to this facility.

The non-Catholic hospital's policy is that no surgical abortions are provided on its campus except when the life of the woman is threatened and she cannot receive care elsewhere. Only one abortion had been performed in the last decade that met these two conditions (a woman with a case of advanced cancer). The hospital refers for abortion, however, either to the local Planned Parenthood or to a system hospital 10 miles away (which is the only hospital in the state that performs abortions). The hospital has no policy restricting its physicians from performing abortions in their offices; physicians are not likely to provide this service, however, given the activity of anti-abortion groups. Complications of abortion are considered gynecological care and treated on campus. Provision of non-surgical abortions has not been discussed at the executive or board levels, but it is expected that this procedure will be provided in physicians' offices based on personal discretion. The hospital has a policy that employees who feel uncomfortable, for ethical or moral reasons, about participating in certain procedures can notify their managers and be re-assigned.

In addition to reproductive care, women's services at the non-Catholic facility include comprehensive breast care (mammography, case management, support groups), a cardiac awareness center, midlife services, and various support groups. The hospital is planning a psychosocial program for cancer patients and their families, as well as a women's resource center at one of its ambulatory care sites. The center will provide education, information, and referral services that are in high demand in the community (e.g. nutritional information, midlife program). Future plans call for a number of resource centers at the hospital's ambulatory care sites and a main center on the hospital campus.

The acquisition is beginning to result in expanded women's services at the former Catholic campus. Community contraception education has begun, and the first tubal ligation has been performed on campus. Gynecological care and mammography services have been strengthened, and there are plans to start a women's resource center on the campus. No obstetrics or infertility services will be provided at this site, however, because of financial considerations (revenues are not expected to cover costs). Women needing these services are referred to the non-Catholic campus. As part of the acquisition agreement, the non-Catholic hospital agreed that no "life-terminating procedures"--including abortions, euthanasia, or assisted suicides--would be performed on the former Catholic campus.

Although abortion was not an obstacle during the acquisition process, the issue is likely to arise in the future in the context of another possible affiliation. The not-for-profit system hospitals are initiating plans for merging their operations, and conflict among their governing boards regarding the provision of abortion is likely given that one of the system hospitals is committed to providing abortions and is currently the only hospital in the state to do so. (Currently, the operations of the system hospitals are not integrated.) If the hospital that performs abortions changes its policy to facilitate its merger with the other system hospitals, women's access to hospital-based abortion throughout the state will be undermined.

## **Impact on the Community**

Overall, the acquisition was reported to have positively impacted the community. A survey showed that the community was supportive of the sale. The acquisition "saved" the only inpatient facility in a mid-size town and produced service improvements and cost reductions. It also expanded community education programs to a larger audience. The purchased campus was renovated, old accounting and communication systems were replaced, and patient transportation services to the main (non-Catholic) campus were initiated. Decisions about what clinical services are offered on the former Catholic campus are now made based on financial and quality challenges, with the understanding that a small community hospital does not need to duplicate advanced services offered at a nearby tertiary care center. For example, the radiation therapy and rehabilitation units were closed, and patients are now transported to the main campus.

Since the population served by the former Catholic hospital is largely indigent, the acquisition has maintained, and probably improved, the access of this traditionally underserved segment of the population to health care. The non-

Catholic hospital is committed to caring for underserved groups. Currently, its department of family practice operates three clinics in low-income communities that are staffed by mid-level providers (primarily nurse practitioners), with rotating family physicians.

The non-Catholic hospital continues to involve the community in its decision-making processes. Neighborhood meetings, clergy meetings, and community forums on specific topics are consistently held to assess needs and concerns. The hospital is planning to monitor services provided by other organizations, with the intention of using these assessments when making decisions about service mix.

## Summary

This case illustrates an affiliation between a Catholic and non-Catholic hospital that preserved an essential community provider and created an opportunity for expanding access to services, including reproductive services. While abortions continue not to be provided by either facility (except under the two conditions noted above), other fertility-control services (sterilization, contraception counseling) are becoming more available. There are also plans for enhancing women's access to education and support services.

Several lessons for organizations planning similar transitions emerge from this case. First, early communication about changes and plans, both to the staff and to the community, was important. Communication helped raise staff morale, curb the rumor mill, and establish commitment to the community. Second, human resources issues received special attention. This included early selection of managers and involving them in the planning process; defining roles and accountabilities for managers having responsibilities at more than one site; providing education about change management; distributing new policies/procedures early on; and defining and communicating the policy for workforce reduction. Third, considerable time was allowed for dealing with loss and change. Keeping the transition team and newsletter in operation for a year or longer facilitated the change process. Fourth, the early integration of the departments of the two hospitals and having a third party evaluate the process was a plus.

## II. Case Study B

In 1995, a 499-bed academic, not-for-profit medical center and an 83-bed Catholic hospital received permission from the Department of Justice to merge. The facilities were located in the North East region of the country, four miles apart, and were the sole providers of hospital services in their area. The merger was part of a larger integration strategy that involved a physician group practice (consisting of 10 practices under a not-for-profit umbrella) and a university-based medical college, with the goal of developing an integrated delivery system. This was achieved by dissolving the Catholic hospital and group practice into a re-organized medical center that now operates as a not-for-profit system with a new name, governing board, and scope of activity.

The medical center was a tertiary care provider offering a wide range of services. Many regarded it as the place to go for highly technical care. The Catholic facility offered a limited range of services and was known for its concern for the well-being of patients and attention to providing “tender-loving care.” Although the two facilities had essentially the same medical staff, they often competed for resources and patients.

Although the overall unemployment rate in the predominantly agricultural state is less than 5%, there is a great deal of rural poverty. The population served by the medical center was heterogenous and included the professionals of its surrounding communities, a large number of the working poor, and most of the African American and Asian American populations. The population served by the Catholic hospital was more homogenous and consisted mainly of the elderly, white, and French-speaking Catholics who were strongly committed to the mission and values of their provider.

This report focuses on the process and outcomes of the merger between the medical center and the Catholic hospital and not on the integration issues pertaining to the two other partners.

### The Affiliation Process

#### **Earlier Affiliation Between a Catholic and Non-Catholic Provider (1960s)**

In the 1960s, three hospitals operated in this community: one was non-sectarian, and two were Catholic hospitals under the sponsorship of the same order. The

Catholic order's mission included promoting cooperation among health care providers and reducing service duplication. In 1967, ethical concerns that service duplication by one of the Catholic providers and its non-sectarian neighbor compromised this mission led to the Catholic hospital merging into the non-sectarian hospital to form the Medical Center. The Catholic hospital's physical space was then purchased by the state university and became the location for the network of physician group practices. The merger and change in function of the Catholic facility led to much dissent among Catholic community members. Key informants suggested that some community members have "never gotten over it" and now feel that the medical center has closed the one remaining Catholic facility.

### **Second Affiliation Between a Catholic and Non-Catholic Provider (1990s)**

In 1993, in response to marketplace changes, four organizations established a goal to create an integrated delivery system that could provide a wide range of services. The key players driving the integration strategy were the senior leaders of the four organizations. The anticipated growth of managed care and of capitation were cited as the factors motivating their decision. Other important motivators were reducing service duplication, achieving economies of scale, and improving service coordination. In addition, the CEO of the Catholic hospital, the local Bishop, and the Order of Sisters providing care in the institution were concerned that declining revenues and admissions threatened the survivability of the hospital. They saw the merger as a strategy for preserving the Catholic health care mission in the state.

### **Toward a New Organization**

In 1993, the leaders of the four organizations considered several affiliation alternatives and agreed that the best way to work together would be through one system. The leaders obtained the approval of their respective governing boards, formed a governance group to oversee the transition, and established different committees to operationalize the merger. Each party kept its own legal counsel, and all four agreed to an external consultant to assist in the development of directional strategies for the newly formed system. The Department of Justice review was described as uneventful since the census figures for the Catholic hospital had fallen to a level below the DOJ's threshold for a potential antitrust violation.

Organizationally, the merger resulted in dissolving the Catholic hospital and group practice and re-organizing the medical center into a new integrated system with an 18-member governing board: four members representing each of the four partners, the system CEO, and board chair. (Each of the 4 organizations also kept its own board). The dean of the medical school is currently leading the new system. Clinical departments were re-organized into seven health care services, and administrative teams were created to lead the services. Each team consists of a physician (the team leader), an administrator, and a nurse. At the Catholic hospital's request, an ethics committee of the system's governing board was formed to evaluate corporate ethical issues.

Although the facilities had initially intended to pursue a full-asset merger, gaining control over the Catholic land and buildings would have required approval from the corporate parent of the religious hospital and, eventually, from the Vatican. Instead of pursuing a full merger, the two hospitals agreed to a lease-back arrangement with a 99-year commitment. The Catholic church retained ownership of the real estate component; the new system gained control over the equipment, operations, and title to the business. System bylaws recognize that the Directives will continue to apply on the former Catholic campus. Religious symbols continue to decorate this campus, and the Vice President of Mission sustains the facility's time-honored traditions.

To communicate the merger both internally and externally, a merger newsletter was published and distributed, and a hotline was established to respond to questions from employees and the community. In addition, town meetings were held at the medical center to provide community members with an opportunity to express their concerns. A funeral and mass were held to "mark the death" of the Catholic facility, and a time capsule was buried on the property. Community input in selecting the system's name was solicited.

The system is currently facing a number of operational challenges. First, the integration of disparate professional cultures has not proceeded smoothly. Insufficient attention to managing the human relations issues that emerge during mergers and a downsizing initiative that disproportionately affected employees of the former Catholic hospital have led to internal difficulties. Second, the Catholic administrators are concerned that the system is not adequately preserving the value of compassion in patient care and employee relations that prevailed at the religious facility. Third, the Catholic administrators and the community regret that the former Catholic campus is not being utilized appropriately. At present, the campus provides outpatient surgery and walk-in free clinics only. Initial plans to provide rehabilitation services on this campus did not materialize due to complex federal reimbursement issues. Plans are being developed to initiate this service in 1997.



A fourth challenge relates to the new role of physicians as service leaders. Many feel that the physician leaders are not adequately trained in finance and management to appropriately handle their responsibilities. An underground newspaper has emerged chastising the administration for “turning over power to the physicians.” One administrator commented that teaching physicians to operate as employees and managers (not as entrepreneurs) is an issue that many integrated delivery systems are facing. Strategies for addressing these skill deficits and for promoting collaboration among physicians are being identified.

## Status of Reproductive Services

The site visit was completed approximately two years after the DOJ approved the merger. Key informants reported that the merger has improved community women’s access to health care services and has had no negative impact on the provision of reproductive health services. Current plans to address women’s needs are likely to improve the comprehensiveness of care as well as service coordination among historically fragmented providers.

Prior to the merger, the Catholic hospital provided basic gynecological care and surgery. No obstetrical services and none of the proscribed reproductive services were provided on campus. The hospital did not object, however, to providers offering contraception or sterilization services in their offices in professional buildings, and it had no policy against abortion referrals. The medical center provided a wide range of reproductive services including prenatal care, prenatal genetic counseling, obstetrics, gynecology, contraception, sterilization (for men and women), and infertility workups and treatments. Treatment for rape victims and emergency contraception also were provided. Although the center has no policy against provision of abortion, it typically offers only second-trimester abortions (around twelve procedures a year) in cases of fetal anomaly or for health or life of the woman. Center providers treat post-abortion complications as gynecological care. First-trimester abortions typically are provided at the local Planned Parenthood, a community women’s health center (an independent center that provides reproductive services), and physicians’ offices; center providers arrange referrals. Women needing second-trimester, elective abortions typically go out of state to get care.

During the merger discussions, the partners agreed that the Directives would continue to apply on the former Catholic campus. No restrictions apply to services provided by the main campus (the medical center), however. The Bishop, who had supported the affiliation, did not object to the system performing terminations of pregnancy since no elective abortions are provided.

Informants anticipated that the Catholic constituency would object to the provision of euthanasia should the issue come up in the future.

Following the merger, the system identified a women's service line as one of its seven major products. This has established an organizational structure to support the provision of women's services and a commitment that women's health care needs will be an important focus of the system's activities. The service is led by a team including a physician, a nurse midwife, and an administrator. Currently, it focuses on obstetrical and gynecological care and includes a community education program on midlife issues. All reproductive services that were provided by the medical center, including abortions, continue to be offered by the new system. The system does not operate a family planning clinic. All women's services are provided on the non-sectarian campus and none are provided on the former Catholic campus. (Outpatient gynecological surgery is actually the only ambulatory surgery that is not provided on the former Catholic campus.) This decision was made by system administrators to avoid potential barriers to the provision of certain services in the future. The system's conscience clauses were revised to clarify that employees who are unwilling to participate in certain procedures, for ethical or moral reasons, can be excused. Women's services are provided both by physicians and non-physician providers (certified nurse midwives and nurse practitioners). The system has good working relationships with the community women's health center but no formal relationships with the local Planned Parenthood.

The system seems to have fulfilled two goals with regard to women's services: the cesarean section rate was decreased to 15%, and the breast care center is operational. The breast center provides coordinated breast care services and is led by a multidisciplinary team. The system is now working to fulfill two new goals: strategic plans for a women's inpatient unit and a birthing center have been developed by the leadership team and distributed to senior administrators for comment and review. These plans have been formulated in response to community assessments of women's needs.

Community assessments of women's needs are done in different ways including monthly meetings between hospital providers and community women (focus groups) and surveys that assess family planning needs. The women's service leadership team also works closely with a state-wide advisory group to assess needs and has been soliciting input from community based organizations to ensure service coordination. In addition, directors of area health and human service organizations are invited on a yearly basis to meet with the administration to identify service gaps and prioritize health care needs. These interactions have resulted in the system funding a number of initiatives to support community programs (e.g. a parenting skills program, a dental clinic, and a translator service). The state health department also performs community health assessments at the

county level and has identified two areas that need attention: women's health (particularly domestic violence) and children's health (particularly alcohol abuse and smoking). The system recognizes the importance of these social issues and works with the health department to plan and fund interventions.

## **Impact on the Community**

A strong sense of loss of the Catholic hospital has made it difficult for many in the community to recognize the broader impact of the merger. Some community members are concerned that choice in hospital care has diminished and that it is difficult to maintain a caring atmosphere within a larger organization. According to key informants, the positive outcomes of the merger include cost reductions, service coordination, and expansion of education and health promotion programs. The latter has resulted primarily because of a shift in focus from tertiary/trauma care to primary care/prevention. The system is also well-positioned for future changes in the health care marketplace as a result of integrating hospital and physician services under one umbrella.

A new position for a Vice President of Community Health Improvement was created during the merger. The V.P. works with the state health department to meet the goals of Healthy People 2000, a national initiative to improve the public's health. An assessment of system services was completed based on the objectives of the national report; health program and service development activities also will be conducted consistent with these goals. The system provides outreach to underserved populations through clinical services in underserved areas and also through education programs. In addition, the system is promoting the development of school-based clinics, in which education about reproductive health issues will likely be a focus.

The system's strategic plan reflects a commitment to the community. The plan focuses on six areas: (1) community health improvement (through investments in health promotion and education); (2) primary care (through the development of satellite clinics); (3) care re-design (by shifting from an inpatient to outpatient focus); (4) network development; (5) integrating finance and delivery (by creating a new health plan sponsored by the system); and (6) corporate culture.

There is recognition that time and effort need to be invested to address two related issues: community feelings of loss of the Catholic hospital and the nurturing of one culture for the merged organization. A culture committee was formed to improve internal and external communications and to bring together the disparate cultures of the partners. A new dynamic head for the pastoral care department was appointed, and the V.P. of Mission is negotiating a new role as

V.P. of Mission, Values and Ethics. In addition, two surveys were conducted recently to help the administration better understand emerging cultural issues: a spirituality survey, in which administrators evaluated each other's values, and a survey of employee attitudes that addressed the prevailing low morale.

## Summary

It is difficult to assess the full impact of changes and strategic plans on access and quality of services in the community because little time has elapsed since the merger. Our interviews suggest that the merger will likely improve women's access to better coordinated services and will also enhance relationships among community health services organizations. Following the merger, a women's service line was created, and the breast care program was strengthened. Plans for a women's inpatient unit and a birthing center have also been developed. The merger has had little impact on provision of reproductive services to date. The non-Catholic campus continues to provide a wide range of services (including some second-trimester abortions); the former Catholic campus continues not to provide any services that conflict with the Directives.

Key success factors in this case were the commitment of the leaders of the four partners to create a health care system and the early involvement and approval of the Bishop. Senior administrators identify a number of lessons learned about the merger process, including: (1) training physicians for new administrative responsibilities; (2) learning to manage culture changes; (3) investing time and effort in addressing human resources issues; (4) developing a plan for internal and external communications with accountabilities defined; and (5) setting realistic time margins around targets.

## III. Case Study C

In 1994, a Catholic and a Protestant hospital received approval from the Department of Justice (DOJ) to consolidate. Both facilities were located in the Mid-West in a mid-size city known for its production of agricultural equipment and supplies. The community was described as aging and as "conservative" and "religious." The Catholic hospital was a 265-bed acute care facility serving a low-to middle-class population and was characterized by its family-oriented culture. Located 2.5 miles away, the Protestant facility was a 237-bed acute care provider serving a community of middle class, well-insured people and was known for its business-like, "high tech," and data-driven culture.

A non-sectarian 502-bed Medical Center comprised of the two facilities emerged from the consolidation and is operating under the auspices of a corporate parent organization (the Catholic property was alienated during the consolidation). The Center's new name reflects a futuristic orientation as much as a religious orientation. The Catholic hospital was renamed West campus, and the Protestant facility was renamed East campus. The system also includes a medical group of employed physicians and a health plan. Center administrators maintain that institutional commitments to different religious ideologies that preceded the consolidation have been replaced by a transcendent ecumenical mission and that the current culture reflects a "blending" of the two former disparate management and clinical cultures. Religious artifacts continue to decorate parts of the Catholic hospital and grounds.

## **The Affiliation Process**

### **Earlier Attempt at Affiliation (1970s)**

The 1994 consolidation was a second attempt at affiliation between the two hospitals. In the late 1970s, primarily at the urging of their overlapping medical staffs, the hospitals had developed plans for completing a full-asset merger. Substantial resources and three years of work were invested in planning the merger. News of the proposed affiliation was not communicated, however, to the public or to the religious order overseeing the Catholic hospital until the end of the merger planning process. Various Catholic and anti-abortion groups in the community protested the merger, and argued for a continued Catholic presence in the community's health care system. The Catholic Church responded during the final hour of negotiations, stating that it would not allow the Catholic hospital to affiliate with an organization that provided abortions. The merger did not take place, and both hospitals continued to operate and compete.

### **Successful Affiliation (1990s)**

In the early 1990s, members of the two hospitals' governing boards could no longer ignore the potential impact of more recent marketplace changes on the survivability of both the Catholic and Protestant hospitals. Although both facilities were financially healthy, the growth of managed care and the related threat of capitating payments for services were forcing the hospitals to respond proactively. In addition, local employers were closely examining their rising health care costs and analyzing the extent to which service duplication by the two

hospitals was contributing to the problem. Several other hospitals in the region had already completed mergers, and this was creating increased competition and concerns about the ability of the two facilities to secure a share of the growing managed care market. These factors led to an assessment of the financial structure and operations of the two hospitals and to the boards' decision to embark on a strategy to consolidate assets and operations.

Several factors facilitated the 1994 consolidation. First, close ties existed among several board members of the two hospitals who started meeting privately to discuss a possible affiliation. Second, the two CEOs and the medical staff, many of whom worked in both hospitals, openly supported the consolidation. A third factor, and the one considered critical, involved the abortion issue. Abortions were provided at the Protestant hospital but not at the Catholic facility. The two hospitals agreed that the decision to provide or not to provide abortions in the consolidated system would be made by the new governing board after it had been formed. In other words, it was decided that the abortion issue would not be allowed to derail the consolidation. A fourth factor was that the sponsoring Catholic order recognized that the community would be best served if the two hospitals joined forces. To facilitate the affiliation, the religious order donated the hospital in its entirety to the community, on the condition that both hospitals enter into the consolidation as full and equal partners.

## **Toward a New Organization**

Once the decision was made to pursue a consolidation as equal partners, a steering committee was organized to oversee the preparation for the DOJ review and the implementation of a consolidation plan. The consolidation team was comprised of three board members from each hospital, the two CEOs, the two chiefs of medical staff, and the two corporate attorneys.

To facilitate the DOJ review process, an experienced antitrust attorney was hired to liaise between the consolidation team and the DOJ. The purpose of hiring the consultant was to ensure that issues which had stalled mergers in the past were addressed early by the consolidation team. In particular, the consolidation would result in one institution gaining control over 80% of the local market -- a factor that would historically have caused antitrust concerns for the DOJ. The hospitals demonstrated that the community's interests were served by permitting the consolidation, which would facilitate access to capital, produce cost savings, and improve the quality of care. The hospitals committed to specific financial performance targets and delineated plans for using the anticipated savings (e.g. to develop new services, expand existing programs). After 12 months of negotiations, the DOJ approved the consolidation.

Early in the process, the steering committee had selected the top administrators of the new Medical Center and operationalized the consolidation plan. The CEO of the Protestant hospital became the CEO of the new organization, and the CEO of the Catholic hospital was named the new COO. The CEO selected the management group, and several operational task forces charged with aligning services between the two campuses were formed. A consulting firm was hired to facilitate the development of a new strategic management plan and an operating plan. Specific strategies included a new mission, vision, values, and set of objectives for the institution.

A new governing board was created with equal representation from the two facilities. Five board members and one physician from each of the hospitals, and the CEO and Chief of Medical Staff of the new Medical Center were selected to sit on the new board. In addition, after the community voiced concerns that the previous boards had not been culturally diverse, three new members from the community were appointed to the new board.

The role of the pastoral care departments of the two hospitals in the consolidation process was very limited. Strong Christian commitments continue to affect decision making and behavior, however, and are exemplified by the three ethical principles of the Medical Center (compassion, justice, and dignity) and the strong commitment to the underserved and disenfranchised. The new organization has a strong ethics committee that reviews policies with respect to clinical issues.

Community participation was solicited in forging the identity of the new institution. A consolidation newsletter was distributed by the hospital to communicate changes internally, and a hotline was established. Articles were published in local newspapers announcing the consolidation. Local community members also were asked to submit potential names for the new Medical Center.

## **Status of Reproductive Services**

The site visit took place approximately three years after the approval of the consolidation by the DOJ. In general, women's health concerns have not been an important focus of the Medical Center's activities, and no comprehensive women's health program exists. Service gaps in the provision of preventive care, midlife services, and patient education were observed. The impact of the consolidation on the provision of reproductive services for women was described as minimal. Prior to the consolidation, both hospitals provided some reproductive services, and the new Medical Center continues to do the same. Abortions, which had been provided infrequently at the Protestant hospital, were

discontinued following the consolidation except to save the life of the woman. Infertility services were not provided at either hospital and continue not to be offered. The Medical Center has no specific policy concerning family planning services.

At present, services specific to women include prenatal care, obstetrics, gynecology, sterilization, and breast care, all of which were provided by the two hospitals prior to the consolidation. A new space for labor and delivery services was being remodeled on one of the campuses at the time of the site visit to consolidate obstetrical services (around 2,300 births are provided annually ) and to expand the neonatal intensive care unit. Obstetrical services include education classes for expectant mothers (which, according to the providers, need to be updated), a high-risk pregnancy clinic, and a genetic counseling clinic. The two clinics are staffed by visiting specialists from an academic medical center in another city. A recent proposal by the directors of inpatient and outpatient services to start a birthing center, including nurse-midwifery services, was not popular among the hospital obstetricians, who were described as relatively conservative in their practice styles.

During a closed meeting immediately following consolidation, the new governing board discussed the abortion issue with the help of an outside ethicist who was consulted to facilitate the meeting. The board voted against the provision of abortion except when the life of the woman is threatened. This decision was welcomed by the community and by clinicians. The fact that the Protestant hospital had provided only a small number of abortions helped the board reach its decision, since this was considered an indication of low demand for hospital-based abortions in the community.

Currently, the only abortion provider in the area is a reproductive health clinic located in a city 50 miles away and not accessible by public transportation. Medical Center administrators assume that this provider is meeting the needs of community women for abortion care, but no assessment has been conducted to determine whether this was actually the case. Interestingly, the local Planned Parenthood affiliate has started an education center in the area and has announced plans for providing medical services, as well. This is creating a great deal of controversy in the community which, overall, is not very welcoming of Planned Parenthood's traditional services. The Medical Center has no plans to cooperate with Planned Parenthood. There are also indications of unmet needs for treatment of post-abortion complications, particularly among low-income women seeking services at community health centers, where the physicians tend to be anti-abortion.

There was disagreement among those we interviewed over the degree of "closure" on the abortion issue. Some perceived that it had been "put to rest"



by the post-consolidation board decision, and that the Medical Center had reached a satisfactory accommodation internally and with the community. Others perceived that there were surfacing issues with which the organization would have to contend. These included the matter of “mandated benefits” packages in managed care plans and whether or not the abortion policy would have to be amended when non-surgical abortion methods become available. These issues had not yet reached the governing board.

The Medical Center has no specific policy concerning the provision of contraceptive services and does not operate a family planning clinic. Provision of contraception is left to the discretion of individual physicians. The Center provides emergency contraception for rape victims in the emergency room. Sterilizations--including tubal ligations and post-partum tubals for women and vasectomies for men--are performed. Infertility services are not provided for two reasons: analyses indicated that the demand for services in the community is not high enough to justify the cost, and limited infertility specialists are available in the local area. Patients requesting infertility counseling and/or treatment are generally referred to a major academic medical center 50 miles away.

Other providers of reproductive services in the community, particularly to underserved women, are a community health center and a women’s health center. The Medical Center has strong working relationships with both providers, and especially with the women’s health center, for which it provides backup and inpatient services. The Medical Center serves large numbers of underserved women, directly and by supporting community-based organizations. Among obstetrical patients, more than 40% are covered by the Medicaid program. Sizeable proportions of clients also belong to minority groups.

Several administrators are suggesting the development of an on-site service line for women’s health that would integrate the provision of a comprehensive range of services including health education and prevention, primary care, reproductive services, and midlife services. The Medical Center is not likely to devote resources to such a program in the near future, but there is interest in providing more attention to women’s health care. (A newly-formed hospital system located nearby has a well-established women’s health program.) An intermediate step that providers had proposed is the allocation of resources to case manage all high-risk women clients, both medically and socially indicated. The development of case management protocols has begun as part of the quality improvement program.

## **Impact on the Community**

The consolidation is viewed as having had a positive impact on the community, both in terms of cost reductions and quality improvements. Over \$50 million were saved in the first two years following the consolidation, primarily because of limiting service duplication and increased operating efficiencies. These savings freed resources that were used to support community-based activities and also allowed the Medical Center to control its rate increases. The administrators cited a Gallup survey that was conducted to assess people's opinions about the consolidation as evidence of the community's support of the Medical Center.

The consolidation is impacting the community in different ways. First, support of community health projects has increased. For example, the Medical Center recently provided a grant to the community health center to help construct a new building. The Center also sponsors the local Race for the Cure and uses part of the revenues for outreach activities and breast cancer education for low-income women. Also, a fund-raising campaign among Center employees and in the community helps subsidize services to the poor.

Second, the health system that emerged following the consolidation is expanding and diversifying its activities: in addition to owning and operating the Medical Center, the system currently owns and operates a medical group and a health plan. The medical group recruits physicians into the community and purchases and manages physicians' practices. The health plan exists for purposes of contracting with managed care organizations or with employers to provide managed care. Another hospital in the community has also become affiliated with the system, and negotiations with other hospitals are underway. Administrators noted that as the system expands and differentiates itself from the Medical Center, the range of reproductive services provided may have to be re-evaluated.

Other outcomes of the consolidation include strengthening the family practice residency program at the Medical Center and enhancing ambulatory surgery. The Center is also promoting a new role for its pastoral care department, in which chaplains are assigned to different functions in the community, in addition to their service line assignments.

## **Summary**

This case is illustrative of a successful affiliation between two hospitals with different religious heritages. The consolidation has strengthened the two

providers and expanded their role in serving the community. The consolidation has had mixed effects on service delivery to community women. Obstetrical services have been expanded. Abortion services (though they had been quite limited prior the consolidation) have been discontinued. Neither internal assessments of services provided to female clients nor community assessments of women's needs have been conducted. There is some interest, however, in developing women's health services more comprehensively.

The case offers several lessons about affiliations between Catholic and non-Catholic parties. Critical success factors here were: obtaining early support for the consolidation from the sponsoring Catholic order; deciding that the abortion issue would be addressed by the new governing board and would not be allowed to derail the affiliation; hiring external consultants to facilitate the DOJ review process and strategic planning effort; naming the executives of the new organization early in the process; and soliciting community participation in the creation of the new Medical Center. Other important factors were operationalizing the consolidation quickly to stabilize conditions and making management decisions that were sensitive to the religious heritages of the two hospitals.

## **IV. Case Study D**

In 1996, the governing board of a public/district hospital in the Western region of the country voted in favor of a joint venture with a Catholic health care system. (The district hospital is accountable to district voters, who may fund it through tax revenues and elect its governing board members). The district hospital had been experiencing operating losses due, in part, to the growth of managed care. Key decision makers recognized that it could not continue to operate as an independent provider. Two corporate "suitors" proposed to affiliate with the hospital: a Catholic system and a for-profit health care system. After soliciting the input of community members, medical staff, and employees, the board voted to affiliate with the Catholic system. The facility continues to operate as a non-sectarian community hospital.

The 438-bed hospital was established in the 1950s after the voters of five neighboring towns elected to form a hospital district and passed bond issues to finance the project. The hospital was built in a mid-size town with a predominantly white, middle-class population. The Catholic system is a large hospital chain and operates Catholic and non-Catholic providers through a number of regional offices. The system sought to strengthen its provider network through an affiliation with the public facility.

Following the governing board's vote for a 50/50 joint venture with the Catholic system, a new not-for-profit corporation was formed to run the hospital. The new corporation's governing board includes representatives from the district board and the Catholic system. The hospital's assets were transferred to the new corporation, and the Catholic system gave the district several million dollars to fund community projects. The hospital continues to provide a range of reproductive services including obstetrics and fertility-control. Pregnancy terminations for purposes other than to save the life of the woman were discontinued following the joint venture.

## **The Affiliation Process**

### **Earlier Attempt at Affiliation (1995)**

Faced with major financial difficulties as a result of declining admissions, operating inefficiencies, and an inability to acquire managed care contracts, the district hospital had laid off many employees and closed its walk-in and cardiac rehabilitation units in the 1990s. The governing board saw three alternatives: closing the hospital, selling the facility, or affiliating with a strong partner. In 1995, the hospital signed a letter of intent to partner with the Catholic system. However, the hospital soon realized that district health care laws require it to go through a formal process of requesting and evaluating affiliation proposals from all interested parties before making affiliation decisions. The Catholic system withdrew its offer, and the hospital began a nationwide search for a partner.

### **Successful Attempt at Affiliation (1996)**

With the help of an investment banking firm, approximately 125 requests for proposals were sent out in 1995 to health care systems across the country. Three responses were received: the first was for a management agreement and was rejected by the board; the second was from the Catholic system; and the third was from a large for-profit chain. Similar motivations were driving the two systems: both had substantial stakes in the state's health care market and wanted to strengthen their networks. The Catholic and the for-profit systems proposed alternative types of affiliations. The board elected to pursue a 50/50 new corporation joint venture with one of the two systems, an arrangement that would provide the hospital with the capital, management expertise, and managed care contracting power while maintaining some local control over decision-making.

The hospital began its due diligence process, which included making site visits to hospitals operated by the two systems and conducting public meetings. Teams representing the executive and professional staffs, the board, and the employees made site visits and concluded that both systems were financially stable organizations and good potential partners. Meanwhile, the board was being lobbied by reproductive rights advocates fearful that an affiliation with the Catholic system would limit access to reproductive services and by unions fearful of for-profit business practices.

Opposition to the affiliation with the Catholic system was expressed by local reproductive rights groups, the American Civil Liberties Union, Catholics For A Free Choice, a number of hospital physicians, and members of the community. At four public meetings, officials of the Catholic system explained that an affiliation with the system would not transform the facility into a religious hospital and that all fertility-control services, with the exception of abortions, would continue. Given the availability of abortion services at neighboring hospitals and clinics and the relatively few abortions performed at the district hospital in the past, the discontinuation of the service soon became a “non-issue.” Concerns about the for-profit status of the other suitor appeared to be more serious than concerns related to reproductive services. The community was concerned that for-profit health care would negatively impact both access to care and quality. The unions were also concerned that an affiliation with the for-profit chain could lead to staff lay-offs, reduction in benefits, and the closing of unprofitable medical services.

The four public meetings provided an important forum for communication. Each meeting began with a consultant describing changes in the health care system and the need for affiliations. Community members could then raise concerns and have their questions answered by hospital and system officials. The Catholic system had a strong presence at these meetings, but the for-profit system had a weak presence, and the community’s and unions’ concerns about for-profit health care remained largely unaddressed.

The community favored an affiliation with the Catholic system although it seemed that people were “more against the for-profit system than for the Catholic system.” Within the hospital, the physicians and a number of board and staff members favored an affiliation with the for-profit system, which appeared more progressive and stronger financially than the Catholic system. The community’s desire to keep the not-for-profit orientation of the hospital, however, was largely responsible for the board’s unanimous vote in the spring of 1996 to affiliate with the Catholic system. This vote was facilitated by the fact that both systems offered comparable financial return for the transfer of the hospital’s assets.

## **Operationalizing the Affiliation**

Following the board's vote, a management service agreement was signed between the two parties, and the Catholic system began managing the hospital. An Integration Planning Committee was formed together with workgroups for the following areas: the business office, managed care, human resources, communications, information systems, programs/services, facilities, clinical support, and finance. Workgroups developed action plans for their respective areas and met regularly to evaluate their progress. The Catholic system brought in a new administrator to direct the facility. The services of external consultants were not used during the affiliation process.

Since the hospital is a public entity, state law required district residents to vote on significant transfers of assets from the district to a non-profit corporation. To prepare for the election, the hospital started a public relations campaign to inform voters and the press about the details of the affiliation. An election was held in the summer of 1996, and 95% of those who returned the mailed ballots voted in support of the affiliation ( the response rate was 36%).

The hospital officially joined the local division of the Catholic system in the fall of 1996, at which time its administrative and support departments were centralized at the regional level. A new nonprofit corporation with a 10-member governing board was formed to run the hospital. (The district retained its 5-member district board). The corporation's board is composed of five members appointed by the district board and five selected by the Catholic system. The Catholic division's CEO is empowered to break a deadlock. The hospital's assets were transferred to the new corporation; in return, the system assumed the hospital debt and gave the district several million dollars to fund community projects. The district board oversees use of these funds.

Given that the mission and values of the Catholic system and district hospital were very close, administrators felt that a minimal amount of time and effort would be needed to merge organizational cultures. Hospital employees were introduced to the system's mission during several meetings with system executives and also during their first meeting with the new administrator.

## **Status of Reproductive Services**

The site visit took place four months after the joint venture was completed. Key informants believed that the affiliation will positively impact the range and quality of services that the hospital provides for women, with the exception of surgical abortion services, which were discontinued. The hospital is upgrading its

birthing unit, funding community women's health projects, and planning to become a "center of excellence" in women's health care. Further, the local division of the Catholic system is developing a women's service product line for its member hospitals.

Although the facility is now sponsored by a Catholic system, it continues to operate as a non-sectarian community hospital. The Directives do not apply on the hospital's campus. A statement on community sponsorship that defines the values shared between the system and the hospital applies, however. The statement originated in an earlier affiliation between one of the Catholic system's divisions and a community hospital that provided sterilization and contraceptive services and wished to continue doing so. With help from two ethicists, a representative of the local Bishop's office, and its own legal counsel, the division developed a statement which subsequently became part of its affiliation contract with that community hospital. Since then, the system has used this statement in other collaborations, including its affiliation with the district hospital. The statement discusses the social and pastoral responsibility of health care providers and the professional-patient relationship, and it defines two procedures that are not permitted at the system's affiliated facilities: "direct abortion" and assisted suicide. (Direct abortion is defined as the termination of pregnancy for a purpose other than saving the life of the woman.) The Catholic system consulted with the local Bishop during the affiliation process. The Bishop expressed no objection to the affiliation going forward under the outline of common values for community sponsorship.

The district hospital agreed to the statement on community sponsorship and no longer provides surgical abortions in non life-threatening situations. Abortion was an important issue during the affiliation process, although the hospital performed only about 15 abortions per year, of which half were medically indicated and half were not. Reproductive rights groups and a number of hospital physicians expressed their concerns and argued that a community-supported facility should provide services needed by all community members. Similar concerns were raised at the public forums and were addressed by the Catholic system's ethicist. Board members were confident that discontinuing surgical abortions would not limit women's access to the procedure given its availability at neighboring hospitals and clinics.

To ensure that clients can obtain the service when needed, the hospital's policy on termination of pregnancy was revised, with funds allocated for counseling and transportation for women requesting abortions. The policy clarifies that women requesting an abortion will be referred to one of the hospital's social workers who will do an assessment and provide the patient with all information needed to make an independent decision, including a list of gynecologists and Planned Parenthood locations. Patients presenting with medical complications from an

abortion will continue to be treated at the hospital. The hospital will also accept referrals from Planned Parenthood for services that it provides. (The local Planned Parenthood was informed about the new policy and agreed to it.) Hospital employees will not be required to participate in a pregnancy termination, and there will be no discrimination against hospital-affiliated providers who perform abortion in their practices off-site. This policy was distributed to hospital departments but not to community members.

The hospital has recently discussed non-surgical abortions with the Catholic system, primarily with regard to educating providers about RU486 within its continuing medical education program. The system clarified that it supports educating providers about all medications, particularly those that have multiple uses such as RU486. The system acknowledges that RU486 could be used for pregnancy termination in physicians' offices, but the system cannot invade the privacy of the patient-physician relationship to enforce its position on abortion.

The hospital continues to provide a range of reproductive services, including birthing and fertility-control services. Both low- and high-risk prenatal and obstetrical care are provided to about 1,200 women each year. Prenatal genetic screening is referred to a local specialty group. With financial support from the sponsoring system, the hospital is remodeling the obstetrics/perinatal unit and is expected to turn the birthing unit into another profit center. In addition, the hospital continues to provide sterilization (including tubal ligations and vasectomies), contraception (including emergency contraception), community education about reproductive issues, and infertility care. (The hospital continues not to operate a family planning clinic.) Infertility work-ups and basic treatments are provided on-site, and patients are referred to specialized providers for advanced techniques.

In this community, care of rape victims is centralized at the County Hospital which has a designated rape unit. If a rape victim presents to the district hospital's emergency room (ER), she will, with her consent, be escorted to the County Hospital. If the patient prefers to get care at the district hospital, she will receive the full range of care, including the "morning-after" pill. If a woman who has not been raped presents to the ER seeking emergency contraception in order to avoid pregnancy, providers are to assist her in finding a primary care physician. If she prefers to be seen in the ER, providers are permitted to prescribe contraception.

Other women's services have not been a focus at the hospital to date. Breast care is offered by a number of hospital departments (e.g. radiology, surgery) but not in a coordinated fashion. Education and midlife services are also lacking. Except for a survey of perinatal needs that was conducted prior to initiating the



remodeling of the obstetrics unit, no assessments of women's needs have been made.

Recently, the district board announced that it will fund community projects in women's health care and cardiovascular medicine. In addition, a women's service product line is being developed by the Catholic system's local division. This project is still in its infancy, but a task force has been formed to assess women's needs and to plan a comprehensive service line.

## **Impact on the Community**

District voters supported this affiliation. Without the affiliation, the hospital's almost certain closure would have meant the loss of more than 1,000 jobs and would have left a portion of the county without inpatient facilities and an emergency room. The hospital is now in a stronger position to continue to serve its community given its access to capital, management expertise, and managed care contracts.

The affiliation is also likely to improve access to health care in a number of ways. First, the system provided the district with several million dollars that, together with the tax revenue generated, will be used to fund community health projects. Second, the governing board of the new corporation has approved a plan for capital improvements that includes renovating the birthing unit, cardiovascular services, and other services. Third, the hospital is planning to expand its primary care services and increase the number of primary care providers. While this is being done largely to enhance the profitability of the hospital's service mix, it should also improve access to prevention and primary care in the community.

## **Summary**

This case is illustrative of an affiliation between a public hospital and a Catholic health care system that helped position the hospital for survival with minimal negative impact on the range of reproductive services provided. The facts that the affiliation was a 50/50 joint venture and that the hospital did not become a Catholic facility were critical in terms of the outcome with regard to reproductive services. The hospital does not operate according to the Directives but according to a statement on community sponsorship that proscribes two procedures: termination of pregnancy not intended to save the life of the woman and assisted suicide.

Critical success factors of this affiliation were communicating the hospital's plans to the community and involving the district in the decision-making process. Of course, community involvement was a requirement given the public status of the facility, but it was the education that took place about the outcomes of the affiliation, particularly with regard to reproductive services, that alleviated people's fears and garnered their support. Other success factors included identification of common values in the statement for community sponsorship, the support of the Bishop, and the commitment of the district board to selecting the best strategies for the hospital and the community.

Currently, the hospital is contending with two related challenges: downsizing and improving its financial performance. The hospital's support departments have been centralized at the regional level, which means that some employees will move to the regional offices and some will be laid off. Lay-offs will also include the clinical staff. The hospital's deficit is shrinking, but the breakeven point has not yet been reached. The hospital is making progress, but there is still a great deal of work to be done in order to restore its financial health.