Policy D-140.956, “Religiously Affiliated Medical Facilities and the Impact on a Physician's Ability to Provide Patient Centered, Safe Care Services,” asks that the American Medical Association (AMA):

conduct a study of access to care in secular hospitals and religiously affiliated hospitals to include any impact on access to services of consolidation in secular hospital systems and religiously affiliated hospital systems.

AMA lacks the necessary research infrastructure to carry out an extensive empirical study regarding the impact of such mergers on patients’ access to care. This report reviews the best evidence currently available in this area from governmental agencies, academic institutions, and scholarly and popular publications. Council on Ethical and Judicial Affairs Report 2-A-18, “Mergers of Secular and Religiously Affiliated Health Care Institutions,” provides ethics guidance for physicians in this context.

BACKGROUND

The changing landscape of the American healthcare sector and evolving market forces have motivated health care institutions to consider mergers, acquisitions, partnerships, and other types of transactional relationships for the purpose of consolidation [1]. The economic recession from 2007 to 2009 and the passage of the 2010 Affordable Care Act (ACA) may have played a substantial role in driving mergers in recent years; 112 mergers were reported in 2015, compared to 105 in 2012 and 66 in 2010 [1,3]. With the ACA encouraging the creation of Accountable Care Organizations for coordinated care and new value-based payment models, health care institutions were encouraged to merge and create economies of scale to reduce expenses and share profits across larger patient volumes, standardize and streamline protocols to improve operational efficiency, and expand their scope of services and care networks to facilitate patient access [3–5].

RELIGIOUSLY AFFILIATED HEALTHCARE IN THE UNITED STATES

Secular and religiously affiliated institutions alike feel pressures to merge [6], in particular, small, independent, rural, and/or financially struggling hospitals [7]. Rural populations often face wide health disparities and lack of access to care, and over 2,000 rural hospitals struggle operationally and financially with low patient volume, provider shortages, and poor facilities and resources [8]. Since 2010, more than 60 rural hospitals have closed in 20 states, and several hundred more may be
vulnerable to closure, especially in southern states [9]. Because of these issues, rural hospitals may be particularly susceptible to external and economic forces that lead them into merger transactions.

Religiously affiliated or faith-based health care institutions can include hospitals, clinics, and other centers of care partnered with, established by, owned by, and/or managed by a wide array of religious entities in the U.S., such as Catholic, Protestant (e.g., Methodist, Presbyterian, Baptist, Evangelical, Adventist), Mormon, and Jewish organizations. Catholic institutions are the most numerous, comprising over 600 hospitals and over 1,600 clinics and other care facilities [10]. Collectively, they serve as the nation’s largest group of nonprofit health care providers [10,11]. Catholic hospitals constitute nearly 15 percent of all acute care hospitals, treating about one-sixth of all acute care hospital patients, with 5 million admissions and 20 million emergency room visits a year [10]. Since 1997, over 140 mergers have occurred between non-Catholic and Catholic institutions [12]. From 2000 to 2016, the number of acute care hospitals with Catholic affiliations grew 22 percent, even as the overall number of acute care hospitals declined [11]. Ten of the 25 largest health systems are Catholic-affiliated [11]. An estimated 25 percent of Catholic hospitals and 15 percent of Catholic continuing care facilities are located in rural areas [10]. Out of over 1,300 Critical Access Hospitals (specially designated hospitals located in high-need rural areas), 132 are Catholic-affiliated [10,13]; as of 2016, 46 Catholic hospitals were the sole health providers for their communities [11].

Protestant and Jewish institutions also form a prominent part of the religiously affiliated healthcare sector. In the U.S., around 50 hospitals and health systems are affiliated with the United Methodist Church; the Adventist Health System manages 46 facilities; and close to 20 Jewish hospitals are in operation; accurate figures are difficult to find for the numbers of Presbyterian, Baptist, Mormon, or other health care institutions [14,15,16].

THE IMPACT OF MERGERS ON PATIENT CARE

Evidence about the impact of mergers between secular and religiously affiliated institutions is limited and largely anecdotal in nature. Much of our knowledge of these issues is derived from news articles and reports from advocacy organizations such as the American Civil Liberties Union (ACLU) and MergerWatch.

Based on what evidence we have the effects on clinical services and care of mergers that involve non-Catholic religiously affiliated institutions appear to be diverse. For example, some Baptist, Adventist, and Mormon institutions are opposed to abortions in accordance with their principles [1,2]; other merged entities, such as Missouri’s Barnes-Jewish Hospital, and the Protestant-affiliated Advocate Health Care in Illinois do provide abortions [17,18,19]. (An institution’s faith tradition may shape nonclinical aspects of patient experience, as when Jewish hospitals observe Shabbat and Jewish holidays, display ritual objects, provide kosher meals, or designate kitchens for Orthodox patients [20]. Similarly, at least one Adventist institution declines to serve nonvegetarian food or any stimulants [21,22].)

Not surprisingly given the prominence of Catholic institutions in U.S. health care, the published material focuses heavily on mergers that involve Catholic organizations, which are governed by the Ethical and Religious Directives for Catholic Health Services (ERDs) issued by the U.S. Conference of Catholic Bishops [23]. The ERDs address many aspects of institutional life in Catholic and Catholic-affiliated facilities, providing directives not only regarding the services available to patients, but also directives to guide partnerships between Catholic and non-Catholic health care institutions [23]. Other faith-based health care organizations do not have a comparable
body of detailed formal directives, though the websites of faith-based health systems or individual facilities generally state the institution’s core values.

Religious Directives for Catholic Health Services

The Catholic Health Association of the United States (CHA) identifies its member institutions as ministries of the Catholic Church [24]. In line with the religious values of the Church and the guidance of the ERDs, Catholic institutions often restrict the provision of certain health services, particularly in reproductive care [11,23]. The ERDs state that “abortion…is never permitted,” although “operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable” [23]. Additionally, Catholic institutions “may not promote or condone contraceptive practices,” and “direct sterilization of either men or women, whether permanent or temporary, is not permitted” [23].

Reproductive Health Services. Women have been denied a wide range of reproductive services at Catholic hospitals, even when there may be substantial risk to the woman’s health or life of the patient [25–28]. Women with nonviable pregnancies have reportedly been turned away from Catholic hospitals until severe hemorrhaging or infection occurs [29]. In other cases, patients who request tubal ligations to be performed at the same time as a C-section are refused this service, even if future pregnancies are risky [29]. Obstetrician-gynecologists have also reported feeling unduly constrained by Catholic hospital administrators when exercising their clinical judgment in managing miscarriage, nonviable pregnancies, and serious maternal complications [30–32]; in one sample, 52 percent of obstetricians-gynecologists in Catholic institutions reported experiencing conflict with their hospital’s religious policies [32].

In 2010 in rural Arizona, the secular Sierra Vista Regional Health Center became affiliated with the Catholic-based Carondelet Health Network and adopted the ERDs to guide its clinical services [25]. In one incident at Sierra Vista, a physician is reported to have recommended termination of pregnancy to a woman who had miscarried one of her twins and faced a low chance of the other twin’s survival and high risk of hemorrhage and infection. A hospital administrator denied the procedure; however, and the patient was instead driven by ambulance to a hospital 80 miles away for treatment. After the incident, Sierra Vista broke their relationship with Carondelet after one year of a two-year trial period and chose to affiliate with a secular network instead.

Patients have also reported being unaware that the services they want will not be provided until they have already arrived at a Catholic hospital or begun treatment, and religious facilities can be unwilling to refer patients elsewhere [26,29].

This is not to say that Catholic facilities always adhere strictly or uniformly to the ERDs. For example, under the ERDs, men could also be refused many reproductive services, including contraception, sterilization, and participation in decisions on prenatal diagnosis and artificial insemination [23]; however, at least one Catholic health system, Ascension Health, performs vasectomies for men but not tubal ligations for women [33]. In 2010, Sister Margaret McBride, an administrator at a Catholic Healthcare West hospital in Arizona, authorized the termination of a pregnancy due to the high risk of mortality for both mother and child [33]. Although both the CHA and the hospital supported McBride’s decision, the local diocesan bishop later excommunicated McBride and stripped the hospital of its Catholic affiliation, causing controversy in the Catholic health community [34].
Services for Transgender Patients. The CHA does not specifically deny services on the basis of sexual orientation. In January 2018, Sister Carol Keehan, president and CEO of the CHA, stated that “any services [that Catholic institutions] offer are available to everybody,” elaborating that “transgender patients have heart attacks … and gallbladder surgery” and that “[Catholic hospitals] have delivered many a lesbian couple’s baby and many a gay couple’s baby” [35]. The Human Rights Campaign’s Healthcare Equality Index evaluates nearly 600 American hospitals on the basis of their care, services, and policies relating to LGBTQ individuals and has previously rated several Bon Secours hospitals, which are members of the CHA, with moderate to high scores [36]. However, Catholic institutions have refused to perform gender-affirming surgery in the past; in one example, Franciscan Health in Indiana sued the Obama administration over a gender identity nondiscrimination rule mandated by the ACA [37]. The National Catholic Bioethics Center believes that “no Catholic health care organization should require its personnel to carry out, promote, refer for, or otherwise cooperate formally in procedures involved in gender transitioning, especially surgical or hormonal intervention” [38]. In 2017, the CHA’s senior director of ethics and theology stated, “For most medical providers the issue is settled in terms of seeing gender dysphoria as something that can be treated legitimately…[but] Catholic ethicists still have many questions about its moral permissibility” [39]. There have been media reports of instances in which transgender patients have been denied hysterectomies under the ERD restriction on sterilization [40,41] and mastectomies [42–44].

Physician-Assisted Suicide. In U.S. jurisdictions that have legalized physician-assisted suicide—as of March 2018, California, Colorado, the District of Columbia, Hawaii, Montana, Oregon, Vermont, and Washington—access to legally permitted “aid in dying” is unlikely to be available from religiously affiliated institutions and clearly will not be from Catholic-affiliated institutions. In guidance on care for patients who are seriously ill or dying, the ERDs unequivocally prohibit intentionally hastening death, stating “Suicide and euthanasia are never morally acceptable options” [23]. The ERDs provide that “Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way” [23]. The possible impact of these or similar restrictions is difficult to estimate, but reports indicate that the ERDs have had an effect in jurisdictions where physician-assisted suicide is legal. For example, in Washington state in 2010, the Catholic-affiliated PeaceHealth merged with the Clark County public hospital, which then stopped referring patients for PAS-related counseling [45]. In 2013, physicians at Harrison Medical Center in Bremerton, Washington, were restricted from prescribing medications for assisted suicide after Harrison affiliated with the Catholic-based Franciscan Health System [46]. As of 2012, some 30 percent of hospital beds in Washington were owned by Catholic institutions [47].

Effects on Health Plans

There is also evidence to suggest that mergers among secular and religiously affiliated health care institutions can affect the terms of health insurance plans. In 2017 in northwestern Indiana, for example, a proposed merger between a Catholic-affiliated Franciscan system and Methodist Hospitals would have left only one non-Catholic hospital in the county [37]. This hospital would not be included in the network of the only insurer offering plans for the region on the ACA exchange, in effect making Franciscan Health and Catholic hospitals exclusive providers for this plan. This may have forced patients on this plan to travel out of their network to receive services not provided by in-network facilities [37]. Some large Catholic health systems, such as Catholic Health Initiatives and Ascension Health, have also expressed interest in offering their own health insurance plans as they have expanded their merged systems [37]. Catholic institutions attaining
exclusive provider status with insurance plans, especially those offered by employers or on
subsidized ACA exchanges, could create serious concerns for patient access to care.

CONCLUSION

Although there has been limited scholarly research regarding the clinical impact specifically of
mergers among secular and religiously affiliated health care institutions, this literature suggests that
patients may have more difficulty gaining access to some services as a result of such mergers. A
growing body of anecdotal evidence in the form of media reports describing cases in which these
mergers appear to have affected care for individual patients argues to a similar conclusion, as do
efforts to monitor the impact of mergers among advocacy organizations.

RECOMMENDATION

Your Board of Trustees concludes that the foregoing fulfills Directive D-140.956, “Religiously
Affiliated Medical Facilities and the Impact on a Physician's Ability to Provide Patient Centered,
Safe Care Services,” and recommends that the directive be rescinded and the remainder of this
report be filed. (Directive to take Action)

Fiscal Note: Less than $500
REFERENCES


