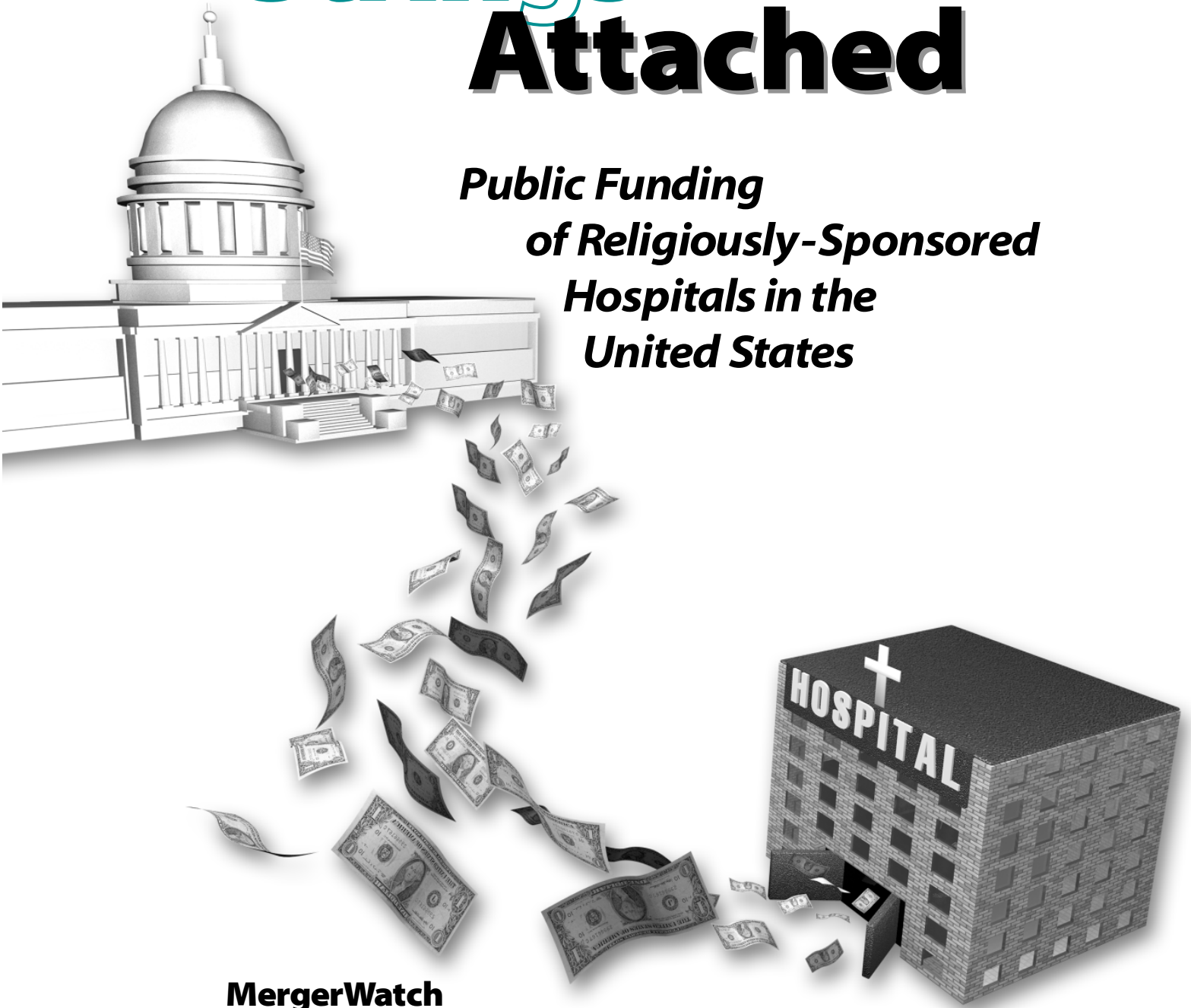


No Strings Attached

***Public Funding
of Religiously-Sponsored
Hospitals in the
United States***



MergerWatch

*A Project of the Education Fund of
Family Planning Advocates of NYS*

*In collaboration with
Empire Health Advisors*

No Strings Attached



Public Funding of Religiously-Sponsored Hospitals in the United States

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***A Publication of The Education Fund of
Family Planning Advocates of NYS***

JoAnn M. Smith, President & CEO

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Introduction

Across the United States, there is growing conflict between religiously-sponsored hospitals and the diverse communities they serve.

Citing religious teachings, many of these sectarian hospitals have policies barring the provision of certain health care services. Most frequently banned are reproductive health services: contraception, emergency contraception for rape survivors, sterilizations, abortions, infertility services and counseling about “safer sex” practices, such as the use of condoms, to prevent the transmission of HIV. In some cases, patients’ end-of-life choices, such as to refuse or remove artificial nutrition and hydration, have also been restricted. Emerging medical treatments derived from embryonic stem cells are likely to be the next category of services banned at these religious health care facilities.

The impact of these religious health care restrictions on patients is being magnified by consolidation in the American hospital industry, which is bringing together sectarian hospitals with nearby nonsectarian hospitals, often forming merged entities that follow religious doctrine. Further, many managed care plans are restricting patients’ choices of which local hospitals they may use, leaving them fewer options of where to receive care.

As a result, more and more patients are finding that the only available hospital is one owned by or affiliated with a religious denomination that restricts access to health services. MergerWatch, a project of the Education Fund of Family Planning Advocates of New York State, works with health care consumers nationwide to address this serious threat to patients’ rights and health.

Public funding and religious health care doctrine

Among the questions most frequently asked by consumers facing the potential loss of hospital services because of religious health care doctrine are these:

Is it appropriate for a hospital that is licensed to serve the general public and receives public funding to be allowed to use religious teaching to restrict the health care it provides to a diverse community? What are the rights of patients and care-givers in such a situation, and how might they be protected?

With support from the Robert Sterling Clark Foundation, the MergerWatch Project engaged an independent health care consulting firm and embarked on a year-long research project to attempt to find answers to these questions. This first-of-its-kind national study analyzes data on more than 4,500 acute

care community hospitals in the United States, including about 600 that identify themselves as religiously-sponsored.

As this study demonstrates, religious hospitals (like their nonsectarian counterparts) rely on public funding – Medicare, Medicaid and government appropriations – for about half their operating revenues. Medicare alone provides more than \$41 billion a year to hospitals which identify themselves as religiously-sponsored. These facilities also benefit from tax-exempt status, obtain low-cost financing through tax-exempt government bond programs and, in some cases, use municipal buildings and even manage publicly-owned hospitals.

Sectarian hospitals are able to receive public funding while using religious doctrine to guide health care because of a combination of: 1) a lack of explicit standards for protecting patients' rights and 2) the proliferation of special government exemptions, known as "refusal clauses," which permit hospitals to refuse to provide services that violate religious teachings. In essence, the public dollars going to religiously-sponsored hospitals arrive with few or no policy "strings" attached.

Questions for state and federal policymakers

We raise some difficult questions for state and federal policymakers, including:

- In medical decision-making, whose ethical or religious "conscience" should be paramount – the individual whose health is at stake or institution that provides the health care?
- Should a sectarian hospital be allowed to refuse to provide any services that violate religious teachings, even when it relies heavily on public funding and serves the general community?
- What if a patient has no reasonable alternative choice of a hospital or needs emergency care for sexual assault, ectopic pregnancy or other conditions?
- Do institutional religious health care restrictions interfere with the ability of physicians and other caregivers to serve their patients?

Faith-based health care: Implications for other government programs

This study presents striking examples of the conflicts that can arise when government funds "faith-based" delivery of services. Religiously-sponsored hospitals already enjoy the kind of "level playing field" in competing for public money that is being advocated for government-authorized programs by the White House Office of Faith-Based and Community Initiatives.

Policymakers need look no further than publicly-funded religious hospitals for evidence that, without adequate protections in place, government funding of faith-based programs can mean the imposition of moral litmus tests on delivery of services and the imposition of one religious viewpoint on clients of many faiths and backgrounds.



Executive Summary

Religiously-sponsored (or sectarian) hospitals have long played an important role in the American health care system, which relies on a mixture of public and private health providers.

Many of these sectarian hospitals were founded by particular denominations or religious orders to serve the medical and spiritual needs of members of that faith. Catholic hospitals, for example, could ensure the provision of last rites to critically ill Catholic patients, while Jewish hospitals offered kosher foods and Sabbath observances. These religious hospitals also provided admitting privileges for physicians from that denomination who may have experienced discrimination at other established hospitals. Because of this appeal to patients and physicians of the same faith, and the frequent availability of established alternative hospitals for other patients, these religious institutions were able to maintain sectarian principles with little or no controversy, without burdening people of other faiths.

Since the mid-twentieth century, however, religiously-sponsored hospitals have served an increasingly diverse population of patients and have employed many physicians and other personnel who are not of the same faith as the hospital sponsors. The participation of religious hospitals in the secular world has been further promoted through consolidation in the hospital industry, which has brought nearby hospitals together in mergers and other forms of business partnerships.

By 1999, the most recent year for which complete national data were available, this study found that religiously-sponsored hospitals were operating nearly 1 of every 5 acute care community hospital beds in the United States. Further, religious hospitals served as the sole or primary source of hospital care for a number of communities.

Section I of this report provides a statistical portrait of religiously-sponsored hospitals based on 1998 and 1999 national databases, as well as data from six study states. To ensure a focus on community hospitals which are devoted to acute care, the study excluded data concerning hospitals which are part of the federal Veterans Administration System and hospitals devoted to non-acute care purposes, such as long-term care, rehabilitation or psychiatric care. The national database included 4,573 hospitals in 1999, of which 604 identified themselves as religiously-sponsored in cost reports to the federal government.

The majority of those (nearly 70 percent) were identified as being Roman Catholic-sponsored through comparisons with listings in the American Hospital Association guide.

The statistical portrait of religiously-sponsored hospitals that was assembled from this database includes the following key findings:

- Religious sponsors operated 13 percent of all acute-care community hospitals in America in 1999, with 18 percent of the beds. Sectarian hospitals tended to have more than the average number of beds.
- Religious hospitals provided inpatient care for more than 5.3 million people in 1999, accounting for nearly 19 percent of all inpatient discharges at community hospitals.
- Forty-eight of the 585 religiously-affiliated hospitals in the 1998 national study database were recognized by the federal government as being the sole providers of hospital care for a geographic region.
- Many religiously-sponsored hospitals had organized themselves into large regional and even national systems, with billions of dollars in revenues. Of the 20 largest non-federal health systems in the 1999 study database, 10 were religiously-sponsored.

Religious hospitals' reliance on public funding

Like their nonsectarian counterparts, America's religiously-sponsored hospitals rely heavily on public funding for their basic operating expenses, the study found. Surprisingly, little or none of the operating funds of these religious hospitals come from churches or other religious sources:

- Combined Medicare and Medicaid payments accounted for half the revenues of religiously-sponsored hospitals in 1998.
- In 1998, religious hospitals nationwide received more than \$45.2 billion in public funds: \$35.7 billion in Medicare payments, an estimated \$8.8 billion in Medicaid payments and nearly \$700 million in other types of government appropriations. In 1999, Medicare alone provided \$41.3 billion of sectarian hospitals' patient revenues.
- The other half of religious hospitals' operating revenues came almost entirely from insurance companies and other third party payers, not from churches or other religious sources.
- By 1999, of all community hospitals, religiously-sponsored facilities were the most reliant on Medicare payments, with Medicare alone accounting for 36 percent of gross patient revenue (compared to 34 percent for all hospitals)

Religious hospitals, like nonsectarian facilities, used federal funds from the 1946 Hospital Survey and Construction Act (better known as Hill-Burton) to

rapidly expand in the 1950s and 60s. Many of those same hospitals now utilize tax-exempt government bond issues to obtain low-cost financing of reconstruction and further expansion, the study found. In two large states, New York and California, religious hospitals received at least \$650 million from such government bond issues in 1998. Like other non-profit entities, religious hospitals enjoy the benefits of tax-exempt status, including exemption from property taxes and eligibility for charitable donations.

In some regions of the country, the relationships between religiously-sponsored hospitals and government have become even more intertwined. Sectarian health systems are leasing publicly-owned hospital buildings and even operating public hospitals under contract with municipalities and regional hospital districts. The study found at least five major religious systems that are managing publicly-owned hospitals.

Service to the poor: Medicaid and charity care

Although religious hospitals often express a special mission to serve the poor, and some individual sectarian facilities do provide considerable charity care, religious hospitals as a group lag far behind public hospitals in providing charity care and service to low-income Medicaid recipients.

Although religious hospitals often express a special mission to serve the poor, as a group they lag far behind public hospitals in providing charity care and service to low-income Medicaid recipients.

In aggregate, religious hospitals provide no more (and, in some cases, less) health care for the poor than do nonsectarian and for-profit hospitals, according to analyses of Medicaid revenue and charity care data from six study states (California, Florida, Maryland, Minnesota, New Jersey, New York) which were chosen because they include 30 percent of the acute care hospital beds in the nation and have hospital data readily available from state agencies or hospital associations:

- Public hospitals reported that 28 percent of their revenues came from serving low-income Medicaid patients, by far the highest proportion of any type of hospital.
- Religious hospitals, by comparison, reported 12 percent of their revenues came from serving Medicaid patients, slightly lower than nonsectarian and for-profit hospitals.
- Public hospitals provided the most free charity care, with reported write-offs equivalent to 5.1 percent of their gross patient revenues.
- Religious hospitals lagged behind, with reported charity care write-offs equivalent to 1.9 percent of gross patient revenues, slightly less than nonsectarian not-for-profits (2 percent) and more than for-profit hospitals (only 0.8 percent).

Religious health care restrictions

As they serve and employ a more diverse community, some hospitals with sectarian origins have adapted to their changing role by becoming more non-sectarian in nature and making the delivery of health care a “neutral” activity.

Hospitals founded by such religious groups as Presbyterians, Episcopalians, Lutherans and Jews generally fall into this category.

Other religious hospitals, however, are clearly struggling to maintain a religious identity. The nation’s Roman Catholic hospitals, as well as facilities operated by Seventh Day Adventist and some Baptist organizations, maintain policies which, to varying degrees, use religious principles to guide their delivery of health care and employment practices.

While holding licenses to serve the entire community and relying heavily on public funding, these sectarian hospitals (particularly those with Roman Catholic sponsorship) restrict patients’ access to services and information, as described in Sections II and III of this report:

- Reproductive health services — including contraception, sterilization, abortion, infertility services and genetic counseling — are often banned.
- Rape victims have been denied emergency contraception to prevent pregnancy.
- Seriously ill patients have found their end-of-life choices — such as the choice to refuse artificial nutrition and hydration — subject to review by religious authorities.
- HIV prevention counseling may be limited to “abstinence only,” omitting any discussion of condom use or “safer sex” practices.
- Medical research and the introduction of new treatments — such as those resulting from stem cell research — are limited by religious teachings.

Physicians and other clinical care staff at religious hospitals have been required to adhere to religious principles in the delivery of health care, potentially interfering with their responsibilities to their patients. Hospital employees must accept employee health insurance coverage that is limited by religious directives and thus omits coverage for such services as contraception, sterilization and infertility treatments.

When confronted by religious health care restrictions, patients and physicians in a growing number of American communities may have no convenient or affordable choice of an alternative nonsectarian hospital. Ongoing consolidation in the hospital industry has brought neighboring religious and nonsectarian hospitals together in merged health systems which adopt religious doctrine. In addition, managed care plans have limited patients’ options by restricting them to hospitals which belong to “in plan” networks. Sometimes, those networks include only religious hospitals.

Special government accommodations of religious hospitals

In order to ensure their continued eligibility for public funding, while following religious health care doctrine, these sectarian hospitals have fought for and won special government accommodations, as described in Section IV.

American policy-makers on both the federal and state levels should find ways to address the serious issues which have been raised by government support of hospitals that restrict patients' access to services and complete medical information.

Religious authorities have publicly suggested they would shut down maternity wards or entire hospitals if forced to provide services which conflict with religious policies. In response, policymakers have either permitted religious hospitals to proceed without interference or have granted religious hospitals institutional exemptions from what would otherwise be mandates to provide services. Some of these exemptions specifically allow religious hospitals to receive public funding (such as Medicare and Medicaid), while denying patients access to certain services.

Restoring patients' rights: recommended policy changes

These public policies protecting religious hospitals have ignored the individual rights of patients, such as their right to give informed consent for medical treatment only after having been informed of all potential treatment options. As described in Section V, a number of bioethicists, health care and civil liberties advocates, legal scholars and religious leaders have concluded that the balance of public policy needs to be changed to restore the rights of patients and their caregivers.

This report recommends that before moving forward with additional public funding of religiously-delivered services, American policymakers on both the federal and state levels should find ways to address the serious issues which have been raised by government support of hospitals that restrict patients' access to services and complete medical information. In sections VI, VII and VIII, the report presents potential policy approaches to protect patients' rights, ensure the ability of hospital staff to meet their patients' needs and prevent the use of public funding to impose one religion's health care doctrine on an entire community. These recommendations would:

- **Require advance disclosure to patients of policies at religious hospitals that restrict access to services or treatment choices;**
- **Protect patients' right to informed consent, made with knowledge of all potential treatment options (including those not offered at a hospital due to religious restrictions);**
- **Protect the rights and responsibilities of physicians and other caregivers to discuss all treatment options with their patients;**
- **Require referrals to alternate providers when institutional religious policies forbid the provision of needed services;**

- Require provision of needed services in cases of emergency or when no alternative provider exists;
- Urge medical associations and hospital accrediting bodies to develop strengthened standards of care, and work for better enforcement of these standards by state and federal regulatory agencies;
- Urge states to ensure that communities are not left without alternatives to a religious hospital with restrictive policies;
- Limit the granting of new exemptions to hospitals and health systems which serve and employ people of all faiths.

In addition to these policy approaches, the study recommends consumer education to increase patients' awareness of religious health care restrictions and promote consumer demand for comprehensive health care.



Methodology

Empire Health Advisors, an independent health care consulting firm in Saratoga Springs, NY, conducted data acquisition and analysis for this report.

National data for 1998 and 1999 (the most recent years for which financial data were available) were acquired from Market Insights, a data vendor. The database was designed to include only non-federal acute care hospitals, thus excluding from the analysis hospitals that belong to the Veterans Administration system, as well as facilities dedicated to rehabilitation, long term care or other non-acute care services. The total number of hospitals meeting the study criteria was 4,363 for 1998 and 4,573 for 1999.

All hospitals in the database were assigned to one of four categories based on their self-designations in institutional cost reports to the federal Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services). The categories were public (such as hospitals run by municipalities) and three types of private hospitals: for-profit, nonsectarian not-for-profit and religiously-sponsored not-for-profit. Because of this reliance on the hospitals' own designations, the "religiously-sponsored" category in this report may not include some historically-nonsectarian hospitals that have adopted religious health care doctrine through mergers or affiliations with sectarian facilities.

National data elements analyzed included total gross revenue by payer, volume of inpatient days and discharges by payer and other sources of government funds. These data produced the following key indicators of government funding: gross Medicare revenue, Medicare inpatient days and discharges, Medicaid inpatient days and discharges, disproportionate share payments and government appropriations.

Because Medicaid revenues are not reported in a consistent manner on a national basis, the study examined Medicaid revenues in six study states (California, Florida, Maryland, Minnesota, New Jersey and New York) utilizing 1998 data obtained from state agencies and hospital associations. This sample of states included 30 percent of the hospital beds in the United States and 35 percent of gross patient revenues for the nation's hospitals. The same six-state sample was also used to study charity care.

Policy analysis and research on the impact of religious health care restrictions were conducted by staff of the MergerWatch Project, in consultation with a number of legal scholars, public policy analysts, ethicists, physicians, public health experts and civil libertarians. Three public policy roundtable discussions of our research findings were held in the spring of 2001 in Albany, New York City and Washington, D.C., in order to refine our recommendations.



I. Statistical portrait of religiously-sponsored hospitals in the United States

The American health care system relies on a mixture of public and private hospitals. There are four categories of hospital sponsorship: public (such as hospitals operated by municipalities), private for-profit (hospitals owned by investors) and two categories of private not-for-profits: religiously-sponsored and nonsectarian (non-religious) hospitals.¹

Religiously-sponsored hospitals have long been an important part of America's health care system. Often founded by particular denominations or religious orders to meet the medical and spiritual needs of people of that faith, religious hospitals have come to serve people from a wide variety of faiths and backgrounds.

How significant is the role of religiously-sponsored hospitals in the United States today? A statistical portrait of religious hospitals was assembled using the 1998 and 1999 study databases, which each included more than 4,000 acute care community hospitals. (Excluded from the database were hospitals that are in the federal Veterans Administration system and hospitals devoted to non-acute care purposes, such as rehabilitation or long-term care.) Each of the community hospitals was assigned to one of the four sponsorship categories based on its self-designation in federal cost reports.²

Number and size of religious hospitals

Religiously-sponsored hospitals constitute a significant proportion of the network of acute-care community hospitals in the United States:

- Religious sponsors operated 13 percent of the nation's community hospitals in 1998 and 1999, with 18 percent of the beds (or nearly one in every five beds).

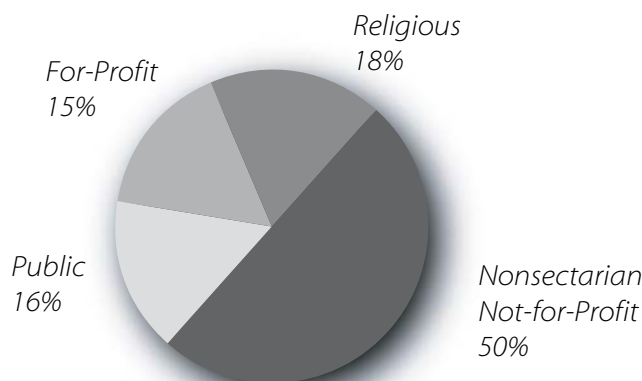
Community Hospital Sponsorship (1999)

| <i>Sponsorship Type</i> | <i>Number of Hospitals</i> | <i>Number of Hospital Beds</i> | <i>Percent of Total Hospitals</i> | <i>Percent of Total Hospital Beds</i> |
|-----------------------------|----------------------------|--------------------------------|-----------------------------------|---------------------------------------|
| Religious | 604 | 126,662 | 13% | 18% |
| Nonsectarian Not-for-Profit | 2,111 | 357,782 | 46% | 51% |
| Public | 1,149 | 114,813 | 25% | 16% |
| For-Profit | 709 | 107,362 | 16% | 15% |
| Total | 4,573 | 706,619 | 100% | 100% |

* Beds in service (for 1998 data, see Table 1 in the Appendix)

- Religious hospitals were found to be one-third larger than the average hospital — with 200 beds compared to the average of 149 for all hospital types.
- Many religiously-sponsored hospitals have organized themselves into large regional and even national systems, with billions of dollars in revenues. Of the 20 largest non-federal health systems in the 1999 study database, 10 were religiously-sponsored. (See Table 20 in Appendix.)

Hospital Beds by Sponsorship in the United States (1999)



Patients served by religious hospitals

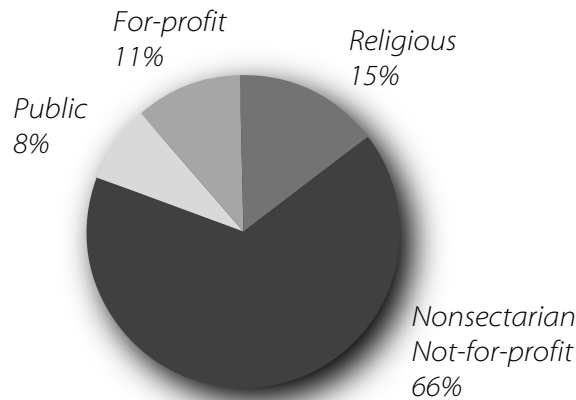
Religiously-sponsored hospitals serve millions of patients each year:

- Religious hospitals provided inpatient care for more than 5.3 million people nationwide in 1999, accounting for 19 percent of all “inpatient days” (the number of days of inpatient care delivered) and 19 percent of “inpatient discharges” (the number of patients discharged from inpatient care, regardless of how long they stayed in the hospital). For further information, see Table 15 in the Appendix.
- Religious hospitals took in 19 percent of community hospitals’ gross patient revenue nationwide in 1999.

In some regions of the country, religiously-sponsored hospitals are the sole or primary source of hospital care for patients:

- Forty-eight of the 585 religiously-sponsored hospitals in the 1998 national study database were also on the federal government’s list of recognized “sole community providers” of hospital care for a geographic region. These are facilities that are the only hospital for more than 35 miles, or are located in a rural area and meet certain criteria which effectively make the hospital an area’s only provider. These hospitals were located primarily in the western and southern regions of the United States. (See Table 4 in Appendix.)

Distribution by sponsorship of beds in “sole provider” hospitals (1998)



- Fifteen percent of the beds in “sole community provider” hospitals nationwide in 1998 were in religiously-sponsored hospitals.

Religious hospitals’ reliance on Medicare and Medicaid Funding

Since the mid-twentieth century, privately-operated hospitals, including those with religious sponsorship, have become increasingly reliant on public funding. This trend began with the 1946 Hill-Burton Act, which financed hospital construction, and accelerated dramatically with enactment of the Medicare and Medicaid programs in 1965.

The national database used for this study provided information on several key sources of government funding received by hospitals, including Medicare, Medicaid, so-called “disproportionate share” payments (which support hospitals serving a larger than average share of indigent individuals) and other types of government appropriations.

Medicare revenues

The analysis looked first at revenues derived from Medicare, the federal program of health insurance for elderly and disabled persons. *The findings were:*

- Nationally, religious hospitals received more than \$35.7 billion in Medicare funding in 1998 and \$41.3 billion in 1999. (See Tables 5 and 6 in the Appendix.)
- Medicare payments accounted for 36 percent of religious hospitals’ revenues in 1999, a percentage that was higher than for all other types of hospitals. (See Table 9 in the Appendix.)

Medicare Revenues by Hospital Sponsorship (1999)

| Sponsorship Type | Number of Hospitals | Medicare Gross Patient Revenue (billions) | Medicare as a Percent of Revenue |
|-----------------------------|----------------------------|--|---|
| Religious | 604 | \$41.3 | 36% |
| Nonsectarian Not-for-Profit | 2,111 | \$110.9 | 35% |
| Public | 1,149 | \$23.2 | 27% |
| For-Profit | 709 | \$32.1 | 35% |
| Total | 4,573 | \$207.5 | 33% |

Medicaid revenues

Because Medicaid revenues are not reported in a uniform manner on federal hospital cost reports, the study utilized hospital Medicaid data reported to and obtained from government agencies and hospital associations in six sample states: California, Florida, Maryland, Minnesota, New Jersey and New York. These states include 30 percent of the nation's hospital beds. The data were from 1998, the most recent year for which state-level data could be obtained. (See Tables 7 and 10 in the Appendix.) *The findings of this analysis were:*

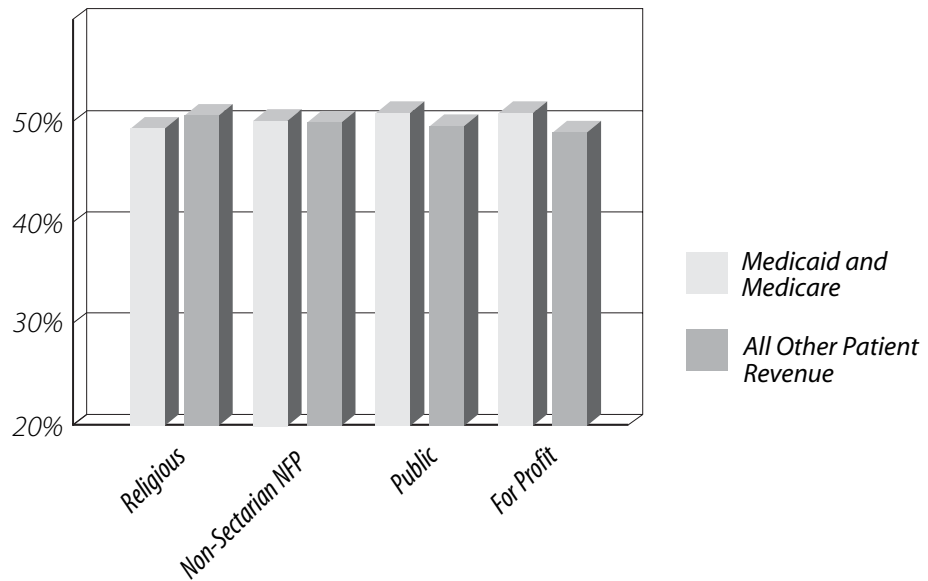
- In the six states, religious-sponsored hospitals reported having received a total of \$3.4 billion in Medicaid funding, which accounted for 12 percent of their total 1998 revenue.
- Based on this six-state sample, the analysis estimated that \$8.8 billion in Medicaid revenue was paid to religious hospitals nationwide in 1998.

Medicare and Medicaid revenues combined

To examine hospitals' combined Medicare and Medicaid revenues, the study again used 1998 data from the six study states. *The findings were:*

- Religiously-sponsored hospitals, like the other categories of hospitals, received about half their revenues from a combination of Medicare and Medicaid payments.
- Combined Medicare and Medicaid payments to religiously-sponsored hospitals nationally in 1998 amounted to \$44.5 billion when the estimated \$8.8 billion in Medicaid revenue was added to the \$35.7 billion in Medicare revenues obtained from the national database.

Patient Revenue by Source and Sponsorship
 1998 Six-State Sample

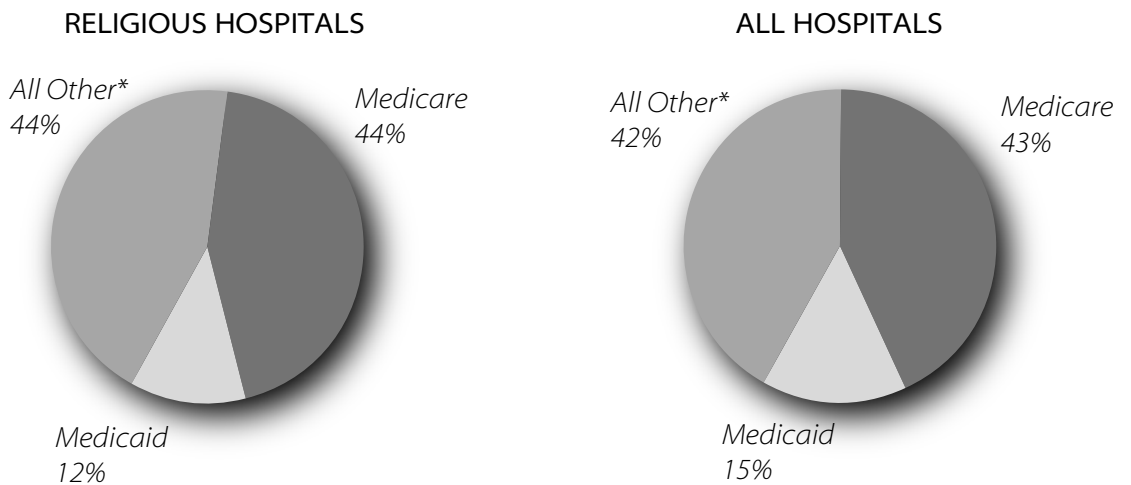


Medicare and Medicaid as percentages of inpatient days and discharges

An additional measure of combined Medicare and Medicaid payments was taken using the national database, which include data on “inpatient days” (the number of days of inpatient care charged to those payment sources) and “inpatient discharges” (the number of patients who were discharged from inpatient care and whose care was paid for by Medicare or Medicaid). *The findings of this analysis were:*

- 56 percent of inpatient days at religious hospitals were paid for by Medicare or Medicaid in 1999, a percentage comparable to all hospitals, but with a relatively larger proportion from Medicare and a smaller share from Medicaid. (See tables 12 and 13 in the Appendix.)

Inpatient Days by Payor — National Data (1999)



*Includes commercial insurance, private pay and third party payors.

- 48 percent of inpatient discharges at religious hospitals were paid for by Medicare or Medicaid, a percentage comparable to other private hospitals, but below that for public hospitals. (See Table 15 in the Appendix.)

Other types of public funding

Hospitals receive one percent or less of their revenues from so-called “disproportionate share” funds that support hospitals serving a larger than average share of indigent individuals. *Analysis of this funding stream showed that:*

- Religiously-sponsored hospitals received \$682 million in disproportionate share payments in 1998 and \$760 million in 1999. (See Tables 5 and 6 in the Appendix.)

The remaining other types of government appropriations account for another two percent of hospitals’ revenues nationally, with public hospitals receiving the majority of this funding.

Religious hospitals receive limited funding from religious sources

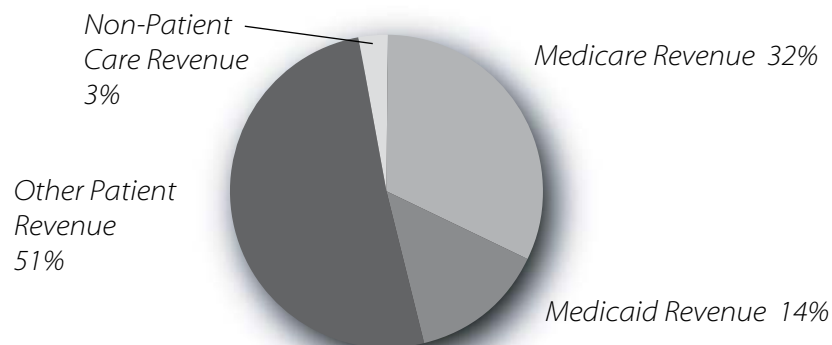
The non-governmental operating revenues of religiously-sponsored hospitals do not, as might be supposed, come from church collections or other religious sources of funds.

Using California as a study state, the analysis found that for religious hospitals, 46 percent of all revenues came from Medicaid or Medicare, 51 percent was patient revenue from other third-party payers, such as commercial insurers, and only 3 percent was classified as non-patient revenues.

Of those non-patient revenues, the majority came from county appropriations (31 percent) and income from investments (30 percent). Only 5 percent derived from unrestricted contributions, such as charitable donations from church members. So, at best, charitable contributions made up a tiny fraction (.0015 percent) of religious hospitals’ operating revenues.

In other words, while religious in name and official sponsorship, these hospitals rely almost entirely on non-religious sources of funding for day-to-day operations.

Religious Hospitals in California (1998) *Percent of Revenue by Source*



Service to the Poor: Medicaid and Charity Care

Religiously-sponsored hospitals often express a special mission of serving the poor, and ask for government accommodations of their religious restrictions because of this mission. Indeed, service to the poor was among the founding purposes of a number of religiously-sponsored hospitals, and some individual

Religious hospitals provide no more care for the poor than any other type of privately-operated hospital, and are far outdistanced by public hospitals.

religious hospitals still do provide generous service to the poor. But, the study found that, in aggregate, based on what has been reported to state agencies and/or hospital associations, religious hospitals provide no more care for the poor than any other type of privately-operated hospital, and are far outdistanced by public hospitals.

The study examined hospitals' service to the poor in two ways: by looking at the proportion of Medicaid patients served by religious hospitals, as compared to other categories of community hospitals; and by using detailed data from the six study states to examine religious hospitals' level of charity care provided, as compared to other hospitals. All data are from 1998. The findings were:

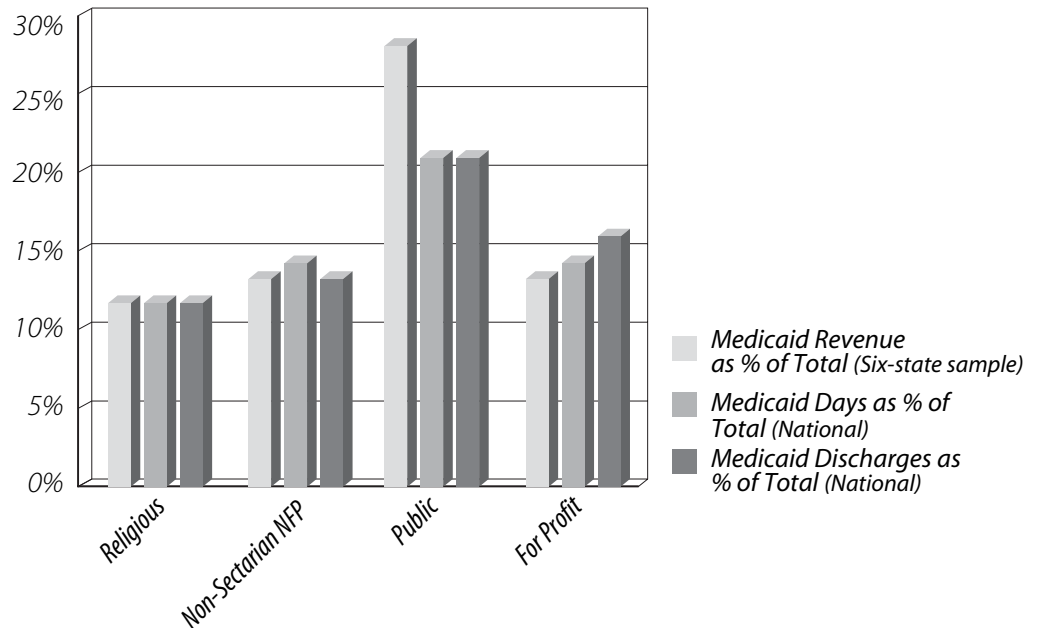
Medicaid revenues (six-state study)

- Public hospitals had the highest percentage of Medicaid revenues (28 percent of their gross patient revenues) of any category of hospital.
- Religious hospitals, by comparison, reported 12 percent of their revenues as coming from Medicaid, slightly lower than the percentages for nonsectarian and for-profit hospitals.

Medicaid inpatient days and discharges (national data)

- Religious hospitals reported a lower percentage of Medicaid inpatient days (12 percent) than for-profit hospitals (14 percent), and far lower than public hospitals (21 percent).
- Religious hospitals reported a lower percentage of Medicaid inpatient discharges (12 percent) than nonsectarian not-for-profit hospitals (13 percent) or for-profit hospitals (16 percent). Public hospitals again reported 21 percent.

Service to Medicaid Patients (1998)
(measured by revenues, days and discharges)



Charity care

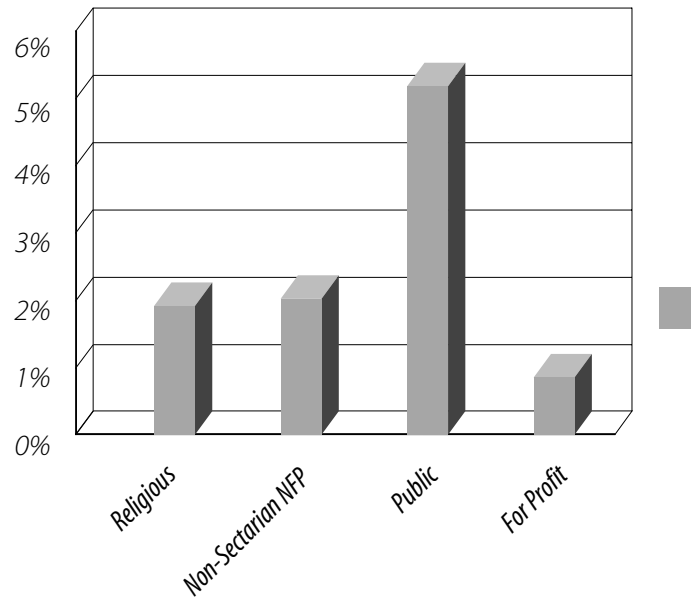
Hospitals' provision of charity care can be difficult to compare because of differences in defining and reporting this type of care. Some studies report on "uncompensated care," which is a combination of bad debt (care for which payment was expected but not received, including uncollected bills and other expenses not attributable to serving the poor) and charity care (care for which no payment was expected).³

Other studies exclude bad debt and report only on charity care. But even those studies produce differing results. Some include in the charity care category both actual care for patients who could not pay and a wide variety of community benefits which hospitals provide, such as public education, training programs and support to various community-based agencies (including provision of free meeting space for these groups). Further complicating the picture is the fact that the value of charity care can be measured by what a hospital would have charged for patient care, or by what that care actually cost the hospital. States and the federal government often have differing requirements for how hospitals should report charity care.⁴

For the purpose of this report, "total charity care" was defined as the sum of the following data elements: charity care write-offs for patient care provided (measured by what the hospital would have charged), other indigent care and community benefits, and charity care provided to fulfill obligations under the federal Hill-Burton program. Not included was "bad debt," because that category often includes uncollected bills and other types of expenses not attributable to serving the poor. (See Tables 17, 18 and 19 in the Appendix.) *The findings of this analysis were:*

- Public hospitals reported the highest level of charity care write-offs, with charges equivalent to 5.1 percent of their gross patient revenues. All privately-operated hospitals, including those which are religiously-affiliated, lagged behind. Religious hospitals reported charity care write-offs equivalent to 1.9 percent of gross patient revenues, slightly less than nonsectarian not-for-profits (2 percent) and more than for-profit hospitals (only 0.8 percent).
- Public hospitals also reported the highest level of total charity care, which came to 14 percent when indigent care programs in two of the study states (California and Minnesota) were factored in. By comparison, religious hospitals in the six study states reported total charity care equivalent to 2.2 percent of gross patient revenues.
- Public hospitals, by far, provided the most total charity care in comparison to the other types of hospitals. While public hospitals accounted for just 10 percent of the total hospital beds in the six study states, they reported 42 percent of all charity care expenditures.

Charity Care Write-offs as a Percent of Revenues by Hospital Sponsorship (1998)



The finding that public hospitals provide much higher levels of charity care than all types of private hospitals (including religiously-sponsored ones) is consistent with a number of earlier studies. Public teaching hospitals in urban areas have been found to deliver the highest levels of charity care of all hospitals.⁵

Fewer studies have attempted to measure charity care provided by religious hospitals, but some have identified patterns similar to those found in this analysis. *Modern Healthcare* magazine, a health industry trade publication which conducts an annual survey of hospital and health systems, last reported on their levels of charity care in 1999. The magazine found that for 1998, the level of charity care provided by hospitals (as measured by expenses as a percent of net patient revenues, not gross patient revenues as was used in this study) was as follows: all systems combined (4.3 percent); public systems,

(23.2 percent); Catholic (3 percent); other religious (3.7 percent); secular not-for-profit (3 percent) and for-profit (1.6 percent). A separate measurement of community benefits reported costs equivalent to an average of 5.1 percent of net patient revenues, with Catholic hospitals at the national average, public hospitals far above average at 13.3 percent, secular not-for-profits at 4.9 percent and for-profits at only 2.8 percent.⁶

A June 1999 report issued by the Service Employees International Union (SEIU) criticized declining charity care at hospitals belonging to the Catholic Healthcare West (CHW) system, which the union said provided charity care in 1998 of less than 1 percent of net revenues. “Here we have people (in Catholic health care) who have historically made it their mission to serve the poor and uninsured. If they’re abdicating on their responsibility, then it has tremendous implications for all of us,” SEIU Executive Vice President Eliseo Medina said. The union has been working at organizing employees at CHW hospitals.⁷

Officials of the CHW system and the Catholic Health Association criticized both the SEIU study and the *Modern Healthcare* survey as misleading, saying that the statistics did not include all of the community benefits that Catholic hospitals provide, including job training, shelters for battered women and other social services. Asked by the *National Catholic Reporter* if Catholic hospitals should give more than average care for the needy, Catholic Health Association spokeswoman Julie Trocchio said “We’d expect Catholic hospitals to be more responsive to the poor. But to say they should give more charity care is too narrow.” The newspaper reported that some experts view hospitals’ claims of community benefits skeptically and warn they can actually be “disguised marketing.”⁸

Religious hospitals’ use of government bond programs

In addition to relying on public funding for basic operating expenses, religiously-sponsored hospitals also use the proceeds of government-issued tax-exempt bonds to obtain low-cost financing for construction, expansion and even acquisition of competing nonsectarian hospitals. State bonding programs were examined in the two largest study states: New York and California.

- New York: In 1998, religiously-sponsored hospitals received a total of \$147.1 million in tax exempt bond financing from the New York State Dormitory Authority (DASNY). This money was utilized for renovations and service improvements at existing hospitals. That amount more than doubled to \$349.5 million in 1999. Nonsectarian not-for-profit hospitals in New York, by way of comparison, received \$2.2 billion in tax exempt bond financing in 1998 and \$389 million in 1999.⁹
- California: In 1998, the California Health Facilities Financing Authority (CHFFA) issued \$502.4 million in tax exempt bond financing for religious hospitals and systems in that state, with the majority of these funds (\$325.1 million) going to the Catholic Healthcare West system, which owns 48 hospitals in the state. By comparison, nonsectarian hospitals received \$1.3 billion in CHFFA financing.

Because tax exempt bond financing can be used to acquire property, religious hospitals and health systems sometimes use it to fund the acquisition of financially ailing competing hospitals. For example, in 2000, Catholic Health Services of Long Island received over \$88 million in tax exempt bond financing from DASNY to help finance the acquisition of St. John's Episcopal Hospital in Suffolk County. Although St. John's had been religiously-affiliated, it had a tradition of providing a full range of reproductive health services, most of which were banned after the facility became Catholic.¹⁰

Religious hospitals also make use of tax-exempt bond financing obtained through local agencies, such as city and county Industrial Development Agencies in New York.

Use of municipal buildings, management of hospital districts

Religiously-sponsored hospitals and health systems enjoy other forms of government support, including use of city-owned buildings and contracts to manage hospitals owned by municipalities or regional hospital districts, some of which collect taxes to support the hospital and pay for care received by indigent patients. For example, the city of Austin, Texas, has contracted with the Catholic Seton Healthcare Network to operate city-owned Brackenridge Hospital. In the western United States, a number of public hospital districts, some of which collect taxes, are now being managed by sectarian health systems.¹¹ The study identified at least five major religious health systems that are managing publicly-owned hospitals. See table 20 in the Appendix.

Summary of findings

The statistical analysis of religiously-sponsored hospitals produced the following key findings:

- **Religious organizations operate a significant proportion of acute-care community hospitals in the United States, with 1 out of every 5 hospital beds.**
- **Religious hospitals rely on Medicare and Medicaid for half their revenues.**
- **Religious hospitals receive almost no operating revenues from religious sources.**
- **Public hospitals, not religious hospitals, provide the most care for the poor. All privately-owned hospitals, including those which are religiously-affiliated, lag far behind.**



II. Restrictions imposed at religious hospitals

Some religiously-affiliated hospitals in the United States, such as those associated with Presbyterian, Methodist, Jewish and Episcopalian denominations, deliver health care services in a nonsectarian manner that has little or no effect on patients' ability to obtain services. Others, however, particularly Roman Catholic hospitals, operate under religious guidelines that restrict patients' treatment options and access to services, and in some cases can affect the terms of employment or admitting privileges for physicians and other caregivers.

Catholic hospitals

The nation's Roman Catholic hospitals have expressed an explicitly religious purpose. The Rev. Michael D. Place, President & CEO of the Catholic Health Association of the United States, explained: "Our fundamental mission is quite straightforward: to serve those in need and to transform society on behalf of Jesus and the Catholic Church."¹²

In recent remarks at Thomas More College, the Rev. Place underscored the importance of this point: "As membership in religious orders has declined, and lay personnel of all faiths have assumed management and staffing roles, and as market pressures threaten to overshadow traditional commitments, attention to first principles is of critical importance. This means recognizing the essentially religious nature of the action of providing health care, one that is an expression of faith..."¹³

Our fundamental mission is quite straightforward: to serve those in need and to transform society on behalf of Jesus and the Catholic Church.

— Rev. Michael D. Place,
President & CEO
of the Catholic Health
Association of the
United States

How does this religious mission manifest itself in the health care delivered at Catholic hospitals? The answer can be found in the Ethical and Religious Directives for Catholic Health Care Services, a set of 72 directives compiled and issued by the U.S. Conference of Catholic Bishops.¹⁴ Catholic health care services "must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff and other personnel," according to the Directives (*DIRECTIVE 5*).

The Directives set forth significant and praiseworthy institutional commitments to social responsibility, care for the poor and respect for individuals. However, they also include a number of restrictions on the health care that can be provided at Catholic hospitals. Some of these restrictions are quite specific, such as the prohibitions on contraception, sterilization and abortion. Others are worded more generally, requiring that treatment be "consistent with Catholic moral principles."

Catholic hospitals interpret these guidelines in consultation with the Bishop in whose diocese a hospital is located, and practices may vary from diocese to

diocese and even from patient to patient. Section IV of this report describes the impact of these restrictions on patients.

Examples of Catholic health care Directives include the following:

Advance directives, surrogates for incapacitated patients

- “The institution...will not honor an advance directive that is contrary to Catholic teaching.” (*DIRECTIVE 24*)
- “Decisions by (a) designated surrogate should be faithful to Catholic moral principles.” (*DIRECTIVE 25*)

The interpretation of what is “contrary to Catholic teaching” is generally made by hospital leadership in consultation with the Bishop in whose diocese the hospital is located. Guided by such interpretations, some Catholic hospitals have challenged decisions by patients or their surrogates to discontinue or refuse artificial nutrition and hydration.

Informed consent

- “Free and informed consent requires that the person or the person’s surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and *morally legitimate alternatives*, including no treatment at all.” (*DIRECTIVE 27, with emphasis added*)
- “The free and informed health care decision of the person or the person’s surrogate is to be followed so long as it does not contradict Catholic principles.” (*DIRECTIVE 28*)

Infertility treatments

- “While we rejoice in the potential for good inherent in many of these “(reproductive) technologies, we cannot assume that what is technically possible is always morally right. Reproductive technologies that substitute for the marriage act are not consistent with human dignity.” (Introduction to “Issues in Care for the Beginning of Life”).
- “Heterologous fertilization (that is, any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses) is prohibited because it is contrary to the covenant of marriage...” (*DIRECTIVE 40*)
- “Homologous artificial fertilization (that is, any technique used to achieve conception using the gametes of the two spouses joined in marriage) is prohibited when it separates procreation from the marriage act...” (*DIRECTIVE 41*) A footnote to the Directives explains that “masturbation, through which the sperm is normally obtained...lacks the sexual relationship called for by the moral order.”

Reproductive health services

- “Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted...an abortion, in its moral context, includes the interval between conception and implantation of the embryo.” (DIRECTIVE 45)
- “In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.” (DIRECTIVE 48)

Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution.

(Directive 53)

- “Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect.” (DIRECTIVE 50)
- “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.” (DIRECTIVE 52)
- “Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution.” (DIRECTIVE 53)
- “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, in accordance with Catholic moral teaching...” (DIRECTIVE 54)

- “A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation or fertilization. It is not permissible, however, to initiate or recommend treatments that have as their purpose or direct effect the removal, destruction or interference with the implantation of a fertilized ovum.” (DIRECTIVE 36)

Issues in care for the dying

- “The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, *unless it is contrary to Catholic moral teaching.*” (DIRECTIVE 59, with emphasis added)
- “Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way.” (DIRECTIVE 60)
- “Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.” (DIRECTIVE 61)

Medical research

- “A Catholic health care institution, especially a teaching hospital, will promote medical research consistent with its mission of providing health care and with concern for the responsible stewardship of health care resources. Such medical research *must adhere to Catholic moral principles.*”
(*DIRECTIVE 4, with emphasis added*)

Size and influence of Catholic health care

These religious directives affect many patients because of the number and size of Catholic hospitals in the United States. Of the 604 acute-care hospitals in the 1999 study database which identified themselves as “religious,” nearly 70 percent were Roman Catholic (according to their listings in the American Hospital Association directory).

The Catholic Health Association reported that as of August 2001, its membership (of all types of hospitals, not just acute-care facilities) included 618 Catholic facilities, which constituted 11 percent of the nation’s total community hospitals and operated 16.1 percent of the hospital beds.¹⁵

Catholic hospitals “constitute the largest single group of the nation’s not-for-profit hospitals,” employing 731,000 full and part-time workers, the association reported. In 1999, Catholic hospitals had 5.4 million inpatient admissions and 88.3 million outpatient visits, according to the association.

For the past decade, Catholic hospitals have been organizing themselves into large regional and national systems with significant economic and political power. A survey of health systems conducted by the hospital industry trade publication *Modern Healthcare* found that in 2000, the 10 largest Catholic health systems owned 355 acute-care hospitals, with more than 71,000 hospital beds. Four of those systems — Catholic Health Initiatives, Ascension Health, Catholic Healthcare West and Catholic Healthcare Partners — made it on to the magazine’s list of the 10 largest healthcare systems in the United States.¹⁶

By comparison, the Veterans Administration system operated 172 hospitals with 20,404 beds in 2000 and the largest for-profit system, HCA-The Healthcare Co., controlled a total of 196 acute-care hospitals with 43,724 beds.

Other religiously-affiliated health care systems

Some other denominations, including Baptists, the Church of Jesus Christ of Latter Day Saints and Seventh-Day Adventists operate hospitals, health systems or health insurance plans that are governed to a certain extent by religious beliefs. Some Baptist hospitals, for example, ban “elective” abortions, as was revealed when a for-profit system seeking to purchase a group of hospitals from the Georgia Baptist Convention agreed to maintain the religiously-based ban.¹⁷

Because of Latter Day Saint teachings discouraging sterilization, the church-affiliated Deseret Mutual Benefit Administrations HMO does not cover sterilizations until a woman has had five children or reached the age of forty.¹⁸

The Adventist Health System, which operated 25 hospitals with 4,677 beds in

2000,¹⁹ explains on its website that “our mission of medical evangelism was originally commissioned by Jesus, the Great Physician.”²⁰ A system spokeswoman told the *St. Petersburg Times* that Adventist Health “is very much a Christian health care organization.”²¹ The extent to which this mission affects patients appears to be not as extensive as the impact of the Catholic Directives and may vary somewhat from hospital to hospital.

The most publicized religious policy of Adventist hospitals, and the one that has drawn it into direct conflict with government agencies, is the religiously motivated proscription against bargaining with employee unions.

The Adventist Health website is silent on the subject of access to reproductive services, but the linked website of the Seventh-Day Adventist Church discourages abortions “for reasons of birth control, gender selection or convenience.” In a section on prevention of AIDS, the church website advises that “Adventists support sex education that includes the concept that human sexuality is God’s gift to humanity.” It goes on to state that “Biblical sexuality clearly limits sexual relationships to one’s spouse and excludes promiscuous and all other sexual relationships and the consequent increased exposure to HIV.”²²

Some religiously-based restrictions at hospitals are unrelated to health services, but are of interest and are noted here because they have attracted community concern and prompted negotiations between residents and hospital officials. Compromises resulting from such negotiations offer models of how religiously-based health policies could also be shaped to meet residents’ needs, if there were advance notification to the community and a willingness on the part of hospital officials to address community concerns.

For example, residents of two communities in which local nonsectarian hospitals were considering business relationships with the Adventist system (Baton Rouge, LA, and Tarpon Springs, FL) were reported to “have expressed concerns about how much the group’s religious convictions might affect the operation of their hospital.” They found, for example, that Adventist hospital cafeterias were vegetarian and did not serve caffeinated beverages because the Church teaches that people should abstain from “unclean foods” and stimulants. The Louisiana residents insisted that contract provisions guaranteed their continued ability to obtain iced tea, pork chops and crawfish at the hospital.²³

The most publicized religious policy of Adventist hospitals, and the one that has drawn it into direct conflict with government agencies, is the religiously motivated proscription against bargaining with employee unions. “Loma Linda University and Medical Center exists to continue the teaching and healing ministry of Jesus Christ,” explains Ken Hansen, general counsel for Loma Linda University Adventist Health Sciences Center. “We do not believe that the unique method of pursuing this sacred mission should be subject to elections, strikes or collective bargaining.”²⁴

The National Labor Relations Board, however has disagreed with such claims of religious freedom, and recently ruled that another Adventist facility, Ukiah Adventist Hospital, must allow its nurses to form a union. The NLRB’s decision held that “the RNs that the Petitioner (the union) seeks to represent do not forfeit their statutory rights simply because of the Employer’s beliefs.”²⁵ See page 52 for a further discussion on NLRB jurisdiction of religious employers.



III. Impact of Religious Restrictions on Patients and Caregivers

The effects of religious restrictions on patients can be very serious, especially when there is a health care crisis. The following examples of the effects of religious restrictions are drawn from cases reported to the MergerWatch Project or documented by other organizations, journalists or scholars. This list is illustrative, but by no means comprehensive.

Denial of emergency care

The consequences of religious health care restrictions were dramatically demonstrated in Manchester, NH, in 1998 when a poor woman needed an emergency termination of a wanted pregnancy.

Dr. Wayne Goldner, an obstetrician/gynecologist, examined the patient after her membranes ruptured at 14 weeks. He advised her there was almost no chance of carrying the pregnancy to term, and explained there was a significant risk she could develop an infection that could jeopardize her ability to become pregnant in the future. She decided to end the pregnancy.

She was crying.

How would you feel? You're a poor woman... you're alone and your doctor says I can't take care of you.

— Dr. Wayne Goldner

When he tried to schedule the procedure at Manchester's historically nonsectarian Elliot Hospital, where he had admitting privileges, Dr. Goldner was refused permission because the hospital had merged with nearby Catholic Medical Center and banned abortions to comply with the Catholic Ethical and Religious Directives. Rather than delaying the procedure and risking his patient's future fertility while trying to overturn the hospital's decision, Dr. Goldner put his patient in a cab and paid for the 80-mile trip to a hospital that would treat her.²⁶

"She was crying," Goldner recalled. "How would you feel? You're a poor woman...you're alone and your doctor says I can't take care of you." What happened in Manchester "is just an example of how people fall through the cracks when you make edicts on political and church decisions, instead of medical facts," he said.²⁷

Refusal to allow sterilization at the time of childbirth

A 34-year-old mother of eight was unable to obtain a medically-advised sterilization when she delivered her ninth child at the only hospital in her rural home town of Gilroy, CA. The formerly nonsectarian South Valley Hospital had just been purchased by the Catholic Healthcare West system, which renamed it St. Louise Regional Medical Center, and eliminated sterilizations, as well as other reproductive services banned under the Catholic Directives.²⁸ The woman's physician had recommended a tubal ligation, advising that a further pregnancy would expose her to potentially-life threatening complications.²⁹

Sterilization is the most common of birth control in the United States, according to a study prepared by statisticians from the federal Centers for Disease Control and Prevention and published in the journal *Family Planning Perspectives*. The study, which analyzed national data from the years 1994 to 1996, found that 28 percent of all women aged 15 to 44 who were using contraception relied on tubal ligation. About half of all tubal ligations are performed post partum (within 48 hours of birth during the hospital stay), and of those, 42 percent take place at the same time as a Cesarean delivery.³⁰

For some women, a tubal ligation is necessary to prevent the recurrence of life-threatening conditions associated with pregnancy, such as the dangerous high blood pressure condition known as preeclampsia or toxemia. A study by the National Institute of Child Health and Human Development found that 21 percent of women undergoing tubal ligations do so for medical reasons, including “medical problems with female reproductive organs” and because “pregnancy would be dangerous to woman’s health.”³¹ The Catholic Directives ban sterilization even when a future pregnancy could harm a woman’s health.³² Other women — typically those in their 30s who already have children — choose sterilization as a reliable form of birth control.

Having a tubal ligation at the time of delivery, especially in the case of a Cesarean delivery, makes good medical and financial sense. “Tubal sterilization at the time of Cesarean section is clearly the safest and least costly way of meeting that patient’s needs,” Dr. Wayne L. Goldner, a New Hampshire obstetrician/gynecologist, said in a review of the issue. Forcing a woman to undergo the sterilization at a later time “requires that the patient undergo two separate surgical procedures with some attendant additional risks. Patients requesting a tubal ligation after vaginal delivery, if denied, would be unnecessarily inconvenienced and exposed to the risk of an unplanned pregnancy. Medically, socially and financially, a post partum tubal ligation makes the most sense for those women desiring immediate sterilization.” He cited social considerations, such as the difficulties a new mother would face in finding care for her baby while she travels to another surgical facility for a tubal ligation.³³

Failure to offer rape victims emergency contraception

Despite the urgency of immediate treatment for rape survivors, and the effectiveness of emergency contraception in preventing pregnancy, several studies have documented policies at some Catholic hospitals that bar staff from offering emergency contraception to rape victims.³⁴

A survey of 58 urban hospitals across the United States, including 28 Catholic facilities, found “some Catholic hospitals have policies that prohibit the discussion of emergency contraceptives with rape victims and in some of these hospitals, a victim would learn about the treatment only by asking.”³⁵

A lawsuit brought by a California woman complained that staff at Daniel Freeman Marina Hospital, a Catholic facility in Los Angeles County, failed

to inform her about emergency contraception after she had been raped. Although she did not become pregnant, she was outraged by what happened at the hospital, where she was taken by police after having been raped. Court papers gave the following account of her treatment:

*Her mother asked for information concerning the “morning-after pill,” a “pregnancy prevention treatment.” Respondent hospital refused to provide information concerning this treatment, despite the fact that appellant was at risk of pregnancy, because it was “a Catholic hospital.” It also allegedly failed to inform appellant that if she chose to receive this treatment she should immediately contact her doctor or another emergency room in order to obtain it within the 72-hour period during which such treatment is effective. Appellant alleged that she did not see her family doctor until more than 72 hours after the rape.*³⁶

An estimated 25,000 American women become pregnant each year as a result of rape, according to the UCSF Center for Reproductive Health Research & Policy and the Office of Population Research at Princeton University. As many as 22,000 of these pregnancies could be prevented if all women who were raped received prompt medical services and were provided with emergency contraception, a recent article in the *American Journal of Preventive Medicine* stated.³⁷

Bans on “safer sex” counseling, including discussion of condom use

In New York, some Catholic facilities treating people with HIV/AIDS have refused to provide counseling on “safer sex” practices, including condom use, because such practices are “morally unacceptable.”³⁸

The U.S. Conference of Catholic Bishops has released a publication on caring for AIDS patients, entitled “Called to Compassion and Responsibility: A Response to the HIV/AIDS Crisis.” In a section entitled “AIDS and the Use of Prophylactics,” the publication rejects the use of condoms, stating:

*The “safe sex” approach to preventing HIV/AIDS, though frequently advocated, compromises human sexuality and can lead to promiscuous sexual behavior... Sexual intercourse is appropriate and morally good only when, in the context of heterosexual marriage, it is a celebration of faithful love and is open to new life. The use of prophylactics to prevent the spread of HIV is technically unreliable. Moreover, advocating this approach means, in effect, promoting behavior that is morally unacceptable... It is not condom use that is the solution to this health problem, but appropriate attitudes and a corresponding behavior regarding human sexuality, integrity and dignity.*³⁹

The U.S. Department of Health and Human Services, by contrast, has recommended condom use to decrease the risk of disease transmission.⁴⁰

Despite the hope of advocates who seek to prevent the spread of AIDS through education on “safer sex” practices, the Catholic Church continues to oppose the

use of condoms as a method to prevent the spread of this fatal disease. For example, at a Vatican conference on AIDS, the undersecretary to the Church's Pontifical Council for Health Care Workers said the use of condoms was unacceptable even for married couples when one partner is HIV positive.⁴¹

Susan Dooha of Gay Men's Health Crisis (GMHC), an advocacy organization for people with HIV/AIDS, is concerned that religious hospitals' restrictions on HIV/AIDS prevention counseling and contraception can mean patients will have to be referred to other facilities for these services. These referrals, she said, "compromise the 'one-stop shopping' principle that has been proven essential to effective healthcare, and creates additional barriers for already overburdened HIV-positive people." Dooha notes that HIV-positive people "don't need single services in a vacuum ... quality HIV care involves the whole ball of wax."⁴²

Refusal to provide requested contraceptive services

Hospital outpatient clinics that become governed by the Catholic Directives through mergers or affiliations have often been forced to discontinue contraceptive services. In one case, in Troy, NY, a low-income teenaged mother trying to avoid additional pregnancies was turned away when she showed up for her regular appointment for a contraceptive injection at a hospital outpatient clinic in her neighborhood. The historically non-sectarian hospital had just merged with a nearby Catholic facility, and was now subject to the Catholic Directives.⁴³

The only method of preventing pregnancy which is permissible under the Catholic Directives is fertility awareness combined with abstinence. The method is commonly known as "natural family planning" and involves tracking changes in the woman's body to determine when ovulation occurs. Abstinence is practiced during the time frames in which pregnancy is predicted to occur. According to a Catholic Healthcare West website, this method has a failure rate of 19 percent, in comparison to a 6 percent failure rate listed for oral contraceptives. The Alan Guttmacher Institute has reported failure rates ranging from 2 to 4 percent for implants and injectable contraceptives to 9 percent for oral contraceptives, 13 percent for diaphragms, 15 percent for condoms and 22 percent for periodic abstinence.⁴⁴

Restrictions on treatment of ectopic pregnancies

Some Catholic hospitals will not allow use of the drug methotrexate to treat life-threatening ectopic pregnancies because theologians believe its use constitutes an abortion. Instead, physicians must use more invasive surgical means, including removal of all or part of a woman's fallopian tube.

Although methotrexate is a simpler means of treatment, especially useful if bleeding has not occurred, the ethical problem is "that the death of the fetus follows upon the action" of administering the drug, according to

Rev. Kevin D. O'Rourke, director of the Center for Health Care Ethics at Saint Louis University. By comparison, he explains, surgical removal of a segment or all of the fallopian tube is undertaken to preserve the mother's life, and "the ensuing death of the fetus is an unintended and unwanted effect."⁴⁵

At a New York State Public Health Council Establishment Committee hearing on a pending hospital affiliation in 1999, Monsignor Dennis Regan, speaking on behalf of Catholic Health Services of Long Island, said the Catholic system would not offer methotrexate for the treatment of ectopic pregnancies unless medical research discovers that the drug attacks only the tissue around the fertilized ovum, as opposed to directly attacking the ovum.⁴⁶

End-of-life care

Catholic hospitals have challenged decisions by patients or their surrogates to discontinue or refuse artificial nutrition and hydration (ANH).

One case involved a patient who was in the end stages of amyotrophic lateral sclerosis (a degenerative, fatal disease commonly known as "Lou Gehrig's disease") and was receiving treatment in a formerly nonsectarian hospital which had merged with a Catholic facility following the date of her hospital admission. The patient informed hospital personnel that she did not want to accept ANH (commonly referred to as a "feeding tube") when her condition worsened to a point where she was no longer able to eat on her own. The hospital refused this request, saying the patient's wishes conflicted with the hospital's "pro-life" position.⁴⁷

Catholic concerns about end-of-life care have also been reflected in amicus briefs filed by Catholic organizations in court cases involving disputes at non-Catholic facilities. The New Jersey Catholic Conference filed such a brief in a case involving a woman in a persistent vegetative state whose family sought to have ANH treatment discontinued. The nursing home in which the woman was a patient refused.⁴⁸ In support of the nursing home's position, the Catholic Conference wrote that "nutrition and hydration, being basic to human life, are aspects of normal care, which are not excessively burdensome, and should always be provided to a patient."⁴⁹

Catholic views on these issues are not unanimous, however. The Rev. Kevin D. O'Rourke, Director of the Center for Health Care Ethics at St. Louis University, expressed disagreement with the New Jersey Catholic Conference's position in an article published in the journal of the Catholic Health Association. He maintained that Catholic doctrine does not always forbid the refusal or removal of ANH, citing language in the Catholic Ethical and Religious Directives (No. 57) allowing hospitals to weigh the "benefits" and "burdens" of such treatment. He acknowledged, however, that "in order to recognize the position of those bishops who opposed withdrawal of ANH, the authors of the ERD added another directive — No. 58 — which confuses the issue." That Directive states that "There should be a presumption in favor of

providing hydration and nutrition to all patients...as long as this is sufficient benefit to outweigh the burdens involved to the patient.”⁵⁰

Because of these variances in interpretation, the policies followed by any particular Catholic health care facility may depend on the views of the local Bishop. Thus, at Catholic facilities, the normal review of difficult end-of-life cases by hospital ethics committees must include special consideration of religious policies.

The right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged.

— California Court

A patient at an Adventist hospital encountered religious objections to his request to be removed from a ventilator. The patient was suffering from arteriosclerosis, an abdominal aneurysm, a malignant tumor of the lung and respiratory failure. When he asked to be removed from a ventilator, the hospital refused to honor his wishes, stating that the facility was “a Christian, prolife-oriented hospital.” When the patient attempted to remove the medical device himself, the hospital restrained his hands. Attempts to find another hospital where the patient could be transferred were unsuccessful, so the patient and his family resorted to legal action. A California court resolved the dispute in favor of the patient, stating, “if the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient’s hospital and doctors. The right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged.”⁵¹

Disproportionate effect on low-income women and rural residents

Poor women are disproportionately affected by these religious health care restrictions because they tend to be more dependent on hospitals and hospital outpatient clinics for their health care than are more affluent women. Rural women are also especially affected, as they may not have an easily accessible alternative provider of health care.

Forty-eight of the religious hospitals in the study database were also found to be on the list of facilities recognized by the federal Centers for Medicare and Medicare Services as being the “sole providers” of hospital care in their immediate region. This designation means the hospital is either located more than 35 miles from any similar hospital, or is the exclusive provider for more than 75 percent of the population in its service area.⁵²

About 28 percent of Catholic acute care hospitals are located in rural areas, according to Rev. Michael Place, President and Chief Executive Officer of the Catholic Health Association of the United States.⁵³ While such institutions play a vital role in serving the overall health care needs of rural residents, they typically deliver this care within strict sectarian boundaries, leaving no other choice for patients when their health care needs conflict with the hospital’s doctrine.

For example, the planned merger of the only two hospitals in Batavia, a rural western New York State community, threatened to leave residents with only a merged facility that followed Catholic doctrine. As the merger was being debated, a 34-year-old pregnant woman was told that she would have to deliver her baby in a hospital 40 miles away in Rochester or Buffalo if she wanted to have a tubal ligation performed immediately following a Cesarean delivery.⁵⁴

Effect on physicians and other caregivers

Religious doctrine governing hospital policies also directly affects hospital employees and physicians with admitting privileges. Caregivers may be barred from even discussing with patients those treatment options proscribed by hospital religious policies, or providing referrals to alternative providers. Physicians and employees can be asked to sign statements promising to adhere to religious doctrine in the delivery of health care, potentially posing conflicts with professional standards of care.

Dr. William van Druten and other physicians were required to sign a form that included an agreement "to respect and abide by the Ethical and Religious Directives."

Dr. William van Druten was a psychiatrist at the Duluth Clinic in Minnesota when the nonsectarian facility announced plans to merge with St. Mary's, a Catholic hospital. He and other physicians were required to sign a form that included an agreement "to respect and abide by the Ethical and Religious Directives." Dr. van Druten refused because he did not feel these restrictions should be placed on a physician's practice or allowed to interfere with a patient's ability to make medical choices in accordance with his or her own religious beliefs. His admitting privileges were not renewed.⁵⁵

Dr. David Mesches lost his position as chair of the Roman Catholic-affiliated New York Medical College's family medicine program, for expressing a view that was not in conformance with the Catholic Church's position on abortion. In a newspaper article about his decision to lease space in an unrelated medical building he owned to a clinic that would provide abortions, Dr. Mesches commented, "It's the law of the land, and the right thing to do."⁵⁶ Not long after publication of the article, the Dean of the Medical College's School of Medicine told Dr. Mesches, "It would not be possible for him to hold this public position on abortion and to continue to be the chair of our department."⁵⁷

Hospital employees also can be denied health insurance coverage for services deemed immoral by their employer, such as contraception and sterilization. Such policies may be found to constitute discrimination. A federal court in the state of Washington found that an employer's failure to include insurance coverage for contraceptives when it covers other prescription drugs and preventative care, constitutes discrimination against women. Although the case did not involve a religiously-affiliated employer, this principle may be applicable to such an employer.⁵⁸

Anti-choice policies at religiously-sponsored teaching hospitals can also prevent medical students and residents from obtaining training in abortion and sterilization procedures, as well as family planning services and counseling.

Future medical advances, including treatments derived from embryonic stem cells

A likely future effect of church policies will be the prohibition at Catholic hospitals and their nonsectarian partner hospitals of any treatments derived from embryonic stem cells, which may be found useful for Parkinsons' disease, juvenile diabetes and other conditions.

President George W. Bush's approval of even limited use of federal funds for stem cell research was "morally wrong" because such research "relies on the destruction of some defenseless human beings for the possible benefit to others," said Bishop Joseph A. Fiorenza, President of the U.S. Conference of Catholic Bishops, in a public statement released on August 9, 2001.⁵⁹

The Catholic Church's opposition to fetal or embryonic stem cell research is not shared by all religious denominations. While some religious groups (including the Southern Baptist Convention, the Greek Orthodox Church and many evangelical Christians) agree with the Catholic Church's opposition to such research, other denominations, including many Jewish groups, Muslims, the United Church of Christ and the Presbyterian Church (USA) favor further scientific research into potential cures and treatments.⁶⁰



IV. Special Government Accommodations for Religious Hospitals

Many religiously-sponsored hospitals in the United States were founded to serve the spiritual needs of members of a particular faith. Catholic hospitals, for example, could ensure the provision of last rites to critically-ill Catholic patients, while Jewish hospitals offered kosher foods and Sabbath observances. These hospitals also served an important role in providing admitting privileges at a time when physicians faced religious discrimination at other established hospitals. Because of this appeal to patients and physicians of the same faith, and the frequent availability of alternative hospitals for other patients, these religious institutions were able to maintain sectarian principles with little or no burden on those who were not of the same faith.

Religious hospitals in the secular world

Since the mid-twentieth century, however, religiously-sponsored hospitals have been drawn more and more into the secular world. They serve an increasingly diverse population of patients and employ physicians and other personnel who are not of the same faith as the hospital sponsors. The participation of religious hospitals in the secular world has been further promoted through consolidation in the hospital industry, which has brought nearby hospitals together in mergers and other forms of business partnerships.

Some hospitals with sectarian origins have adapted to these changes by becoming more nonsectarian in nature and making the delivery of health care a “neutral” activity. Others, however, are clearly fighting to maintain a religious identity, while serving the general public.

In a 1972 article, Catholic moral theologian Richard A. McCormick, S.J., provided a remarkably prescient forecast of the dilemma facing Catholic hospitals:

Catholic health facilities themselves have undergone subtle but discernible changes in their self-image. Increasingly they have become community hospitals, often with heavy non-Catholic staff and clientele. They were frequently financed through public funds or by appeal to the whole community, and still often enough the only health facility reasonably available to a community. In this climate, the concept itself of a “Catholic hospital” becomes problematic.⁶¹

The United States Conference of Catholic Bishops acknowledged this conflict in drafting the Ethical and Religious Directives, which note that “within a pluralistic society, Catholic health care services will encounter requests for medical procedures contrary to the moral teachings of the Church.” The Bishops’ answer to the problem was to firmly instruct Catholic health care providers that they must uphold the teachings of the Church, even when they conflict with patients’ individual religious and ethical beliefs (or the advice of physicians). The Ethical Directives assert that “Catholic health care does not

offend the rights of individual conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority of the Church.”⁶²

This determined stance has raised a significant question in communities where Catholic facilities have become the dominant or only providers of hospital care: Can a hospital that holds a state license to serve the general public and relies on public funding for about half of its revenues be permitted to place its religious beliefs above the medical needs and individual conscience rights of its patients?

Can a hospital that holds a state license to serve the general public and relies on public funding for about half of its revenues be permitted to place its religious beliefs above the medical needs and individual conscience rights of its patients?

To ensure their continued right to do just this, Catholic and other sectarian health care providers have sought and obtained special government accommodations that have permitted these institutions to refuse to provide services they deem morally objectionable, while remaining eligible for public funding.

Establishing special rights: The Church amendment

The first such special accommodation for religious institutions was the Church Amendment, named after Sen. Frank Church, R-Idaho, who sponsored its enactment as part of the Health Programs Extension Act of 1973.⁶³

The Church Amendment was adopted in response to a 1972 court decision in *Taylor v. St. Vincent's Hospital* which required a Catholic hospital to perform a tubal ligation for a woman at the time she delivered a baby by a planned cesarean section.⁶⁴ The court action came about when the only two local hospitals in rural Billings, Montana, (nonsectarian Billings Deaconess Hospital and St. Vincent's, a Catholic hospital) combined their maternity services in 1972 at St. Vincent's, which did not permit sterilizations. Gloria Taylor, together with her husband, had decided that she wished to be sterilized by tubal ligation at the time she delivered their second child. They were refused by St. Vincent's and brought suit.

The district court issued an order requiring the hospital to perform the sterilization, having determined that the facility had acted “under color of state law” — in effect, was acting on behalf of the state — because of its advantageous state tax position (tax-exempt), state licensing and its receipt of Hill-Burton Funds.⁶⁵

But, Congress responded quickly when the Catholic Health Association raised an outcry about the Taylor decision. Using language that would be echoed again and again in subsequent decades when similar situations arose, the Bishops said Catholic hospitals might have to close their maternity wards, rather than allow procedures contrary to their religious policies. Senator Church, in comments reflected in the Congressional Record, reported that “the Catholic Bishop of Spokane has spoken of civil disobedience. There is open conjecture in the press that obstetrics divisions of Catholic hospitals might be closed ...”⁶⁶

The Church Amendment stated that “the receipt of any grant contract, loan or loan guarantee” under several specified federal funding programs “does not authorize any court or public official... to require such entity to make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions.”⁶⁷ Language specifically exempting abortion, as well sterilization services, was included in response to the 1973 *Roe v. Wade* decision, which legalized abortion.

As recognized by the Ninth Circuit, the Church Amendment prevents a court from finding that a hospital acts under the color of state law, or is the equivalent of a “state actor,” (and thus, can be compelled to provide sterilizations) because of its receipt of Hill-Burton funds. Such a finding had been a key factor in the lower court’s basis for asserting jurisdiction over St. Vincent’s Hospital and issuing the injunction which required the hospital to perform the sterilization procedure.

This first legislated special accommodation for religious hospitals effectively eliminated the underpinnings of the Taylor decision and the court order was dissolved. The following year (1974), the religious exemption was extended to apply to recipients of funds under any program administered by the Secretary of Health and Human Services.⁶⁸

By 1978, most states had adopted their own versions of these religious provider exemption laws.⁶⁹

Expanding religious exemptions

In recent years, The Alan Guttmacher Institute has reported, religious exemptions have been broadened to go beyond abortion and sterilization to encompass “any health services about which an ethical, religious or moral objection is raised,” as well as counseling and providing information about those services. Exemptions have also been extended to those institutions that pay for health care, including insurance plans and employers, not just those which actually provide it, such as hospitals.⁷⁰

In the Balanced Budget Act of 1997, Congress enacted the first religious exemption language specific to the Medicaid program, allowing Medicaid managed care plans to refuse to “provide, reimburse for, provide coverage of a counseling or referral service if the organization objects to the provision of such services on moral or religious grounds.”⁷¹ One such Catholic-sponsored plan, Fidelis Care New York, now the largest Medicaid managed care program in New York State, refuses to provide coverage for contraceptive counseling. It also bars coverage for birth control, sterilizations and abortions. The plan is owned by the Roman Catholic dioceses and hospitals of New York.⁷²

The effect of this exemption is that religiously-sponsored Medicaid managed care plans can refuse to pay for birth control counseling or referrals when provided at any hospital (Catholic or not), outpatient clinic or doctor’s office, thus adding another layer of religious review to existing sectarian health policies.

In 1996, Congress enacted yet another government accommodation that benefited religiously-sponsored medical schools (as well as nonsectarian medical schools with ethical policies opposed to abortion). The Congressional move came in response to an action taken the previous year by the Accreditation Council for Graduate Medical Education (ACGME), which had issued new curriculum guidelines for Ob-Gyn programs. These guidelines were meant to address the growing problem of medical programs failing to train residents on abortion procedures.⁷³

Under the ACGME's guidelines, medical schools were explicitly required to provide or arrange for training on abortion for Ob-Gyn students in residency programs. The requirement included an exemption that allows individual students with religious or moral objections to opt out of the requirement. Medical schools with religious or moral objections to abortion were not exempted from the training requirement, but were permitted to arrange for the training to take place at alternate locations.⁷⁴

Catholic leaders have urged the defeat of proposed laws requiring hospital emergency rooms to offer emergency contraception to rape survivors.

Training in abortion procedures is an important part of the medical education of residents who will care for women. Statistics show that 43 percent of all women will have an abortion at some point in their lives, so many physicians, even those who choose not to perform the procedure, will encounter questions on the procedure from their patients. Physicians also need training in abortion methods in order to treat women who have experienced incomplete spontaneous miscarriages or fetal demise.⁷⁵

In response to the ACGME standard, Congress passed a law protecting residency programs that did not provide the required abortion training from many adverse consequences. The law prevents the federal government (or any state or local government that receives federal money) from acting to withhold any form of financial assistance, licensing or other benefits from those medical training programs that do not offer or refer students for training in abortion and from those physicians who have not received such training.⁷⁶

Demands for such religious accommodations are also frequently voiced when state legislatures propose new health care mandates for all hospitals. For example, Catholic leaders in New York, Illinois, Maryland and other states have urged the defeat of proposed laws requiring hospital emergency rooms to offer emergency contraception to rape survivors. Alternatively, these leaders have insisted that Catholic hospitals must be exempted from the law.

"This legislation would force Catholic and other religious health care institutions to violate their religious and ethical teachings by mandating a protocol which can destroy human life at its earliest stage of development," wrote John M. Kerry, former Executive Director of the New York State Catholic Conference, in a memo to state lawmakers opposing the emergency contraception bill. "As such, it would strike a serious blow to freedom of conscience and religious liberties in this state."⁷⁷

Catholic officials also have objected to mandates that would apply to hospitals as employers, such as proposed laws requiring that all employee prescription drug plans cover contraception. Such a requirement would be “un-American,” suggested New York Cardinal Edward Egan, during a lobbying trip to the state Capitol in Albany. “Government must not interfere in matters of religious faith.”⁷⁸

Individual hospitals and health systems have also requested and been granted case by case accommodations. For example, Seton Health System in Austin, Texas, told city officials in June 2001 that it could no longer allow sterilizations to take place in Brackenridge Hospital, a city-owned facility it leases and manages under contract. The change came as the U.S. Conference of Catholic Bishops voted to condemn sterilization as “intrinsically immoral.”⁷⁹

“We want to do whatever we can to serve society, especially those in need, but as a church, we must be faithful to our teachings. We would hope others would understand that,” explained Austin Diocese Bishop Gregory Aymond.⁸⁰

Advocates for the poor women served by Brackenridge Hospital suggested it might be time to seek a nonsectarian management company that would have no problem with providing a full range of reproductive health services. However, city officials instead began to pursue a complicated and expensive “city hospital-within-a-religious hospital” solution to legally separate the Catholic managers from provision of services they deem morally objectionable.

Under this plan, the city would resume management of the fifth floor of Brackenridge Hospital, where staff would provide sterilizations for maternity patients, emergency contraception for rape survivors and other services prohibited in the rest of the hospital. In October of 2001, the city was considering issuing \$7 million in tax-exempt bonds to help pay for the expenses of creating this accommodation for Seton Health System.⁸¹

Approval of the plan was delayed in late October when Seton officials announced yet another requirement, that emergency contraception provided in the city-managed fifth floor be conducted in accordance with Catholic-promulgated procedures requiring that an ovulation test be conducted, and that emergency contraception be denied if the rape victim was found to be ovulating. Peggy Romberg, CEO of the Women’s Health and Family Planning Association of Texas, criticized the new requirement, saying, “That protocol is bad because they’re denying emergency contraception to the very people who might become pregnant.”⁸²

In response to Seton’s attempt to impose restraints on the availability of emergency contraception for those rape victims most at risk of pregnancy, the city withdrew consideration of the revised lease agreement from the city council’s schedule. Approximately two weeks later, the Austin diocese withdrew its opposition to the city providing emergency contraception to rape victims treated at the proposed city-operated hospital floor. “In moral theology, a ‘hospital within a hospital’ is owned, operated and licensed by a different entity, which is not associated with the church,” said Bishop Aymond.⁸³

Resisting policy attempts to address the problem

Recent legislative attempts in several states to ensure that patients' access to health care services is not compromised by special accommodations for sectarian providers have provoked a new chorus of protests from religious leaders. For example, New York legislators introduced several bills designed to ensure that consumers are notified, and the impact on their access to health care is considered, when state health regulators review applications for hospital mergers. Such provisions would apply to all mergers, but would be especially useful in ensuring that patients are not left without access to reproductive services as the result of a religious/nonsectarian hospital merger.

In a striking reprise of the religious lobbying efforts that led to enactment of the Church amendment, New York Cardinal John O'Connor (since deceased) held a press conference in the State Capitol, claiming "There are those in the state of New York trying very, very hard to insist, to demand, that either we reject our principles or we will be driven out of business." ⁸⁴

An even more starkly worded statement appeared in the headline over an article in Catholic Health World concerning the proposed New York legislation. "NY Providers May Face Hobson's Choice: Compromise Ethics or Abandon the Poor," the headline said. The article contended that if the bills were approved, Catholic hospitals would be faced with "withdrawing from the healthcare ministry and abandoning the poor." ⁸⁵

Case Comparison

New York City foster care system and Catholic foster homes

A similar conflict with religiously-sponsored agencies erupted in the New York City foster care system in the 1970s and 80s. The city has a long history of relying on religious agencies that run group homes and institutions to care for children in the city's foster care system. The homes receive taxpayer funds to care for these children.

Extensive litigation (known as the Wilder case) exposed discriminatory placement criteria and policies at religious foster homes. Placement at those homes also resulted in the denial of access to contraceptives. ⁸⁶

Catholic foster homes refused to allow sexually-active teens in their care to have access to family planning counseling, contraception or abortion. Although access to contraception was not the primary focus of the Wilder litigation, the case provided a striking example of how accommodations of institutional religious policies were detrimental to the well-being and health care needs of clients receiving government-funded services.

Shirley Wilder, the named plaintiff in the litigation, experienced this refusal first-hand. While in the foster system, she had given birth at age 14 (this child grew up in the foster system). After giving birth, she was placed in a Catholic home, with the understanding that she would be fitted with an IUD. After her placement, however, the agency told her probation officer that the understanding had been vetoed by the Archdiocese. At one point, the Catholic home confiscated condoms Shirley had obtained herself. Shirley, who was sexually active, had again requested contraception; this request was also denied, and she was simply told that her behavior was unacceptable.⁸⁷

Marcia Lowry, the attorney who first filed the Wilder litigation, is described in a history of the case as arguing with New York City attorneys over whether Catholic homes should be required to provide family planning counseling:

*Lowry argued that no one was forcing the Catholic agencies to contract with the city. If they accepted public money, they would have to accept the government's rules, too. If they chose to forgo \$50 million or so, the money and children should go to agencies willing to do the job the way the city wanted it done.*⁸⁸

However, city officials wanted to keep the religious agencies in the foster care system, and so came up with a compromise. The resulting settlement required the city to ensure that all clients in the foster system “have ‘meaningful access to the full range of family planning information, services and counseling’ through the (foster care) agency or an outside source or both.”⁸⁹ While the religious foster care homes did not actually have to provide the family planning services themselves, they were required to make adolescents in their custody available for instruction and family planning services that would be arranged by the city.⁹⁰

Even this agreement was nearly derailed by John Cardinal O'Connor, who had been installed as the Archbishop of the New York Diocese just as the settlement was being finalized. Just as religious hospitals threaten to close if they are made to provide services deemed immoral by the Church hierarchy, O'Connor (since deceased) threatened to shut down Catholic foster homes if made to comply with the agreement that required all foster agencies to allow foster children access to reproductive services.⁹¹ Ultimately, however, the settlement stood and received court approval.



V. Restoring patients' rights

The findings of this study raise a number of challenging public policy questions about the role of sectarian hospitals in the American health care system and the appropriate relationships between and among:

- Government, which regulates health care and funds the delivery of health services through Medicare, Medicaid and other appropriations;
- The hundreds of sectarian hospitals in the United States which receive public funds and hold government licenses to serve community residents;
- The patients who rely on those hospitals for medical care and indirectly supply those institutions with public funding through tax payments.

Until now, government policymakers have focused largely on accommodating the religiously-based policies of these hospitals. Responding to pleas from the Catholic Health Association and religious leaders, lawmakers have granted sectarian institutions what amount to institutional “conscience rights,” allowing these hospitals to refuse to provide services they deem morally objectionable, while remaining eligible to receive public funds.

Already struggling with HMO “gatekeepers” who restrict their access to care for financial reasons, patients and their caregivers in many communities are now facing equally powerful religious gatekeepers who deny medical care on moral and ethical grounds.

But in the rush to protect the religious freedom of the sponsors of these institutions, Congress and state legislatures have ignored the rights and concerns of some important third parties who are directly affected: patients, physicians and hospital employees. Already struggling with HMO “gatekeepers” who restrict their access to care for financial reasons, patients and their caregivers in many communities are now facing equally powerful religious gatekeepers who deny medical care on moral and ethical grounds.

While public officials have been quick to attack physician “gag clauses” (which prohibit physicians from talking about treatment options that managed care companies do not want to pay for), they have been silent about the similar effects on patients of restrictive religious health care doctrine. It is striking that in the debate on Capitol Hill about patients’ rights, this issue has never been raised.

How should the public policy be crafted so that the rights of patients and their caregivers are not sacrificed in order to protect the religious principles of sectarian hospitals?

Kathleen M. Boozang, a professor at Seton Hall University Law School, was one of the first legal scholars to address this issue in a pioneering 1995 law review article, “Deciding the Fate of Religious Hospitals in the Emerging Health Care Market.”⁹²

While noting that “currently, the law does not compel religious institutions to provide care that does not comport with their beliefs,” she predicted that “the continual evolution of health care delivery...threatens to diminish, if not completely erode, the ability of sectarian hospitals and nursing homes to maintain

control over the kinds of medical care they provide.” She specifically cited increased government financing of health care as one of the factors that will “pressure religious providers to give care that is inconsistent with their philosophical traditions or risk going out of business.”⁹³

Although sympathetic to the concerns of religious hospitals, Boozang flatly and firmly rejected government’s “historic reliance on conscience clauses... to avoid and resolve conflicts between state and church law” because it “undermines the goal of patient access to care.”⁹⁴ In an article published the following year concerning mergers of sectarian and nonsectarian hospitals, Boozang asserted that the state “should not indulge religious beliefs at the expense of patient care.”⁹⁵

Other legal scholars, bioethicists, public health experts, civil libertarians and religious leaders have raised a number of specific concerns about the extent to which patients’ individual rights have been violated, and physicians’ professional responsibilities compromised, when sectarian hospitals are allowed to refuse to provide services.

Protecting patients’ right to informed consent

From a patient’s perspective, the refusal of sectarian hospitals to provide or even discuss services they deem immoral “violates principles of autonomy, bodily integrity and patient choice that underlie the doctrine of informed consent and right of privacy or 14th Amendment liberty clauses,” Loyola Law School Professor Lisa Ikemoto has written.⁹⁶

University of Pennsylvania School of Medicine bioethicist Jon Merz and two colleagues focused specifically on the issue of informed consent in a recent *American Journal of Public Health* commentary about the policies at some Catholic hospitals that prohibit even the discussion of emergency contraception with rape victims.

“Such policies undermine a victim’s right to information about her treatment options and jeopardize physicians’ fiduciary responsibility to act in their patient’s best interests,” the authors said, asserting that refusal to disclose all treatment options, such as the potential use of emergency contraception, is “tantamount to abandonment” of the patient.⁹⁷

Merz and his colleagues called for reevaluation of such restrictive policies, and of the government accommodations that permit them, within an ethical framework that recognizes the needs and values of patients:

What seems to be missing, is a clear moral analysis of culpability and duty that would help Catholic and other health care providers resolve the dilemmas posed by a conflict of their own beliefs and values with the beliefs, values and, perhaps most important, treatment needs of their patients, including rape victims. The permissive conscience clause laws enacted by several states appear to resolve this conflict purely in favor of the provider. These laws are unreasonable because they create unique, dangerous and insidious exceptions both to the quasi-fiduciary role of physicians and to the obligation of providers to secure informed consent

*to medical care and, most significantly, because they are inconsistent with patients' reasonable expectations that their physicians will act in their best interest.*⁹⁸

Safeguarding physicians' duty to their patients

Allan Rosenfield, M.D., Dean of Columbia University's School of Public Health, has stressed that a physician's duty must be to the patient. "Medical decisions must be based on medical and scientific facts — not on ideology," he told a New York audience in February 2001.⁹⁹ When patients are denied appropriate care, such actions may constitute medical malpractice, Rosenfield suggested, an observation that has been seconded by some legal observers.

Medical decisions must be based on medical and scientific facts — not on ideology.

— Allan Rosenfield, M.D.

"No one has a right to commit malpractice," said Margaret C. Crosby, staff attorney for the ACLU of Northern California. "If we can establish that a standard of care is being violated, the public interest in patient health will clearly outweigh the sectarian hospitals' or insurers' right to limit care."¹⁰⁰

In fact, a California appellate court suggested that a rape victim who was denied information about emergency contraception and became pregnant would have a viable legal claim of malpractice.¹⁰¹

Physicians' responsibilities to their patients are aptly summarized in a document the American Medical Association distributes to member physicians, encouraging them to frame and post it in their offices. The document, entitled "Commitment to My Patients,"¹⁰² lists medical and ethical commitments that AMA members make to their patients, including:

- "To tell you about appropriate treatment options, answer your questions about medical risks and to give you the current and accurate medical facts you need to make an informed decision about your treatment; and
- To respect your wishes in decisions about your health care."

Protecting patients' rights of individual conscience

Some religious leaders have called for the protection of patients' rights to individual conscience — in essence, the right to make medical treatment decisions based on their own religious or ethical beliefs.

"When a hospital prohibits medical services because of religious doctrine, it imposes one set of beliefs on all patients who rely on that hospital and denies them health care they want and need," said the Rev. Carlton W. Veazey, President of the Religious Coalition for Reproductive Choice. "This is fundamentally wrong in a nation founded on — and guided by — religious freedom."¹⁰³

An interfaith group of clergy in the city of Wilmington, Delaware, expressed similar concerns in 1997 to the Delaware Health Resources Board, which was

reviewing a proposal for an outpatient surgery center that would have banned certain reproductive services because one of the sponsoring hospitals was Catholic:

*Our community reflects great religious diversity. Within the larger religious community there is not common agreement on many issues of medical ethics and around certain medical issues. Persons in our community who find themselves in need of medical services also reflect this diversity, holding a rich variety of religious and ethical convictions, as well as no religious convictions at all. Each person should have the right to expect the delivery of medical services unencumbered by any particular religious community's doctrines, teachings or values.*¹⁰⁴

Addressing discrimination against women

Because many of the services which are banned at religiously-affiliated hospitals are reproductive health services, the burden of religious health care exemptions falls disproportionately on women. As a result, some analysts have suggested these exemptions are equivalent to government permission for discrimination against women.

No longer would anyone seriously discuss religious objections to a race discrimination claim. But they are certainly prepared to discuss it in the context of gay rights and reproductive rights.

— Ira Glasser, former
ACLU President

“To exclude services that pertain ‘only’ to women is to debase the ethical ground of the process of providing community medical services,” a group of 26 Dutchess County, NY, clergy wrote in a 1995 letter of concern to a nonsectarian hospital considering a merger with a religiously-affiliated hospital. “Why should women’s diverse medical needs be relegated to an inferior, and even negotiable, status?”¹⁰⁵

Religiously-motivated discrimination is not a new thing, former ACLU President Ira Glasser has noted, recalling religious justifications for segregation. He cites a 1967 Virginia Supreme Court decision that upheld an anti-miscegenation statute by asserting that God did not intend the mixing of races.

“No longer would anyone seriously discuss religious objections to a race discrimination claim,” Glasser said, “But they are certainly prepared to discuss it in the context of gay rights and reproductive rights.”¹⁰⁶

Marcia Greenberger, Co-President of the National Women’s Law Center, has underscored the importance of using existing anti-discrimination laws and court decisions to fight the erosion of access to women’s reproductive health care.¹⁰⁷

A December 2000 ruling by the federal Equal Employment Opportunity Commission and a subsequent court decision in the state of Washington both held that refusal of employers to include contraception in employee health insurance plans constituted sex discrimination. Those rulings have yet to be tested against “conscience” claims by religiously-affiliated employers, such as religiously-sponsored hospitals.¹⁰⁸



VI. Re-examining religious hospital exemptions: some pertinent questions

Several public opinion surveys have found that Americans disapprove of religiously-based limits on the health care they can receive at local hospitals.

For example, a national survey of 1,000 women conducted by the firm of Belden, Russonello & Stewart in 2000 found that 79 percent opposed any legislation giving hospitals the right to refuse to provide medical services that conflict with a religious belief. Significantly, an even higher proportion (85 percent) rejected the idea that Catholic hospitals that take government money should be allowed to bar certain procedures because of religious beliefs.¹⁰⁹

Given this public opposition to sweeping religious health care exemptions, the identified concerns about violations of patients' rights at religious hospitals and the findings of this study concerning public funding of these hospitals, a number of questions must be raised about such accommodations, including:

Are religious exemptions constitutionally required?

Representatives of religious hospitals often insist that government accommodation of their restrictive policies is constitutionally required. In making such assertions, they cite the First Amendment's language protecting Americans' free exercise of religion.

For example, at a forum sponsored by the New York City Bar Association, Kathleen Gallagher, a spokeswoman for the New York State Catholic Conference, asserted "there is no overriding or compelling government interest or need which warrants an infringement on (sectarian) health facilities' free exercise of religion."¹¹⁰

But, such assertions do not reflect the current state of constitutional jurisprudence. In a 1990 case, *Employment Division v. Smith*, the U.S. Supreme Court held that the free exercise clause does not require religious exemptions from generally applicable laws. In fact, the court held, the government may enact a law that infringes on religious practices, so long as the law has a valid, non-discriminatory purpose and it applies to all.¹¹¹

The court reasoned that such a principle is necessary in a pluralistic society that includes a wide variety of religious beliefs: "Because we value and protect that religious divergence, we cannot afford the luxury of deeming presumptively invalid, as applied to the religious objector, every regulation of conduct that does not protect an interest of the highest order."¹¹²

If religious objectors were granted exemptions from neutral, generally applicable laws, each objector would become "a law unto himself," the judges held.¹¹³ In a footnote to the case, Justice Antonin Scalia commented, "it is hard to see any reason in principle or practicality why the government should have to tailor its health or safety laws to conform to the diversity of religious belief."¹¹⁴

Another case showing that exemptions are not invariably required was a lawsuit brought by a Catholic teaching hospital against the Accreditation Council for Graduate Medical Education (ACGME). St. Agnes Hospital's obstetrics-gynecology program lost its accreditation in 1986 after ACGME refused to exempt the hospital from a requirement that obstetrics-gynecology programs provide clinical training in a full range of reproductive health procedures, including abortion, sterilization and contraception, among other procedures. Not only did the hospital refuse to provide training, or arrange for it to occur at another location, but it also forbade residents from obtaining training in those reproductive procedures on their own time.

St. Agnes Hospital went to court, challenging the ACGME action as violating the hospital's right to free exercise of religion under the First Amendment. But a U.S. District Court in Maryland upheld the ACGME standards in 1990. Finding that the ACGME was a "state actor," because training at an ACGME accredited program was a requirement for physicians to be licensed in Maryland, the Court said that the state had a compelling interest in requiring Ob-Gyn residents to receive a "satisfactory medical education." Noting that "the development and maintenance of standards for medical training requires specialized knowledge and expertise," the court gave deference to the ACGME's expert witness who testified that training in abortion, sterilization and contraception is essential in any obstetrics-gynecology residency program. The court stated that granting an exemption from these training requirements would impair the state's compelling interest in adequate training of Ob-Gyn residents.¹¹⁵

Besides hospitals, what other organizations are seeking religious exemptions?

Although the Smith case strongly indicates that accommodation of religious tenets is not mandatory, Congress and state legislatures have often granted such accommodations.

Both conservative Congressional leaders and the Bush administration have been explicitly advocating accommodation of religious or "faith-based" organizations in order to increase their participation in government-funded programs.

This policy trend has been exemplified on the Congressional level by inclusion of "Charitable Choice" provisions in welfare reform laws, community service block grants and substance abuse programs, allowing states to contract with religious organizations to provide these services. These religious entities may accept government funds, while maintaining their religious character. They can continue to display religious symbols (such as icons or art) and can use their own money (not public funds) and staff to preach to clients who are receiving government-funded services.

Further, under Charitable Choice, such religious groups are exempted from anti-discrimination employment laws. They can use religious criteria for

hiring and firing of people to fill government-funded positions, and they can require these employees to adhere to religious tenets and teachings.¹¹⁶

The White House's August 2001 report on faith-based delivery of government services termed the right to take religion into account in hiring decisions a "vital civil rights safeguard."¹¹⁷ In fact, the *Washington Post* reported that

The Bush faith-based initiative is a plan through which "a religious group will be able to receive public tax dollars to pay for a job, but still be free to hang up a sign that says 'Jews And Catholics Need Not Apply'."

—Barry Lynn, Director of Americans United for Separation of Church and State

the White House had promised the Salvation Army that under the President's faith-based funding plan, it could maintain policies of refusing to hire gay people, regardless of state or local anti-discrimination laws.¹¹⁸ The White House backed away from this pledge after unfavorable press coverage and warnings from Democratic Senate leaders that the provision could imperil Bush's faith based funding plan. Although White House officials backed off from their alleged commitment to the Salvation Army, they did note that existing law, and proposals before Congress would insulate religious charities from complying with laws that ban discrimination against lesbians and gays.¹¹⁹

Barry Lynn, Director of Americans United for Separation of Church and State, called this practice "federally-funded employment discrimination." He described the Bush faith-based initiative as a plan through which "a religious group will be able to receive public tax dollars to pay for a job, but still be free to hang up a sign that says 'Jews And Catholics Need Not Apply'."¹²⁰

Americans United has taken the position that the U.S. Constitution prohibits the government from funding positions at private places of employment when those positions are filled using discriminatory religiously-based criteria. The organization also contends it is unconstitutional for the government to provide cash aid to a social service program that includes religious worship, instruction or proselytization, even if the program purports not to use the government money for the religious activities.¹²¹

Is there a difference between individual and institutional exemptions?

There is a crucial difference between religious exemptions for individual health care providers, such as physicians, and those for institutions, such as hospitals or managed care plans.

Laws that allow individuals to claim a conscience right to refuse to provide certain health care services are based on a tradition that honors individual beliefs. Even in these situations, it is important to note that a physician's primary duty is to the patient. A health care practitioner's objection to providing a particular medical service should not result in a patient's being denied information about treatment options or access to needed services. An alternate provider — such as a different physician on duty at a hospital — should be found to serve the patient's needs.

When an entire institution is granted “conscience” rights, the result can be very real limitations on an entire community’s access to medical care — effectively making basic, legal health care services inaccessible and forcing one religion’s perspective on everyone’s health care. Catherine Weiss, director of the ACLU Reproductive Freedom Project, has suggested that the creation of

Institutional conscience exemptions have “transformed what used to be shields for individuals from the coercive power of government into what amount to weapons to make people who don’t share the views of a religious organization abide by them anyway.”

— Catherine Weiss, director of the ACLU Reproductive Freedom Project

institutional conscience exemptions has “transformed what used to be shields for religious and conscientious individuals from the coercive power of government into what amount to weapons to make people who don’t share the views of the religious organization abide by them anyway.” ¹²²

In a review of the evolution of religious provider exemptions, journalist Angela Bonavoglia concluded that “the granting of exemptions to corporate entities based on ‘conscience’ poses one of the greatest threats to health care delivery in America today.” ¹²³

Can religious exemptions be unreasonable?

While it is permissible to accommodate religious beliefs, government cannot abandon secular goals to give preferential treatment to religion. There is a point at which a policy meant to protect the free exercise of religion can become an impermissible accommodation that favors or “establishes” religion over secular concerns. The First Amendment, while protecting the free exercise of religion, also has a clause prohibiting government establishment of religion.

In striking down a Connecticut statute that gave employees the absolute right to not work on their chosen day of religious observance, the U.S. Supreme Court noted that under the statute, “religious concerns automatically control ...all secular interests at the workplace. . .” ¹²⁴ Because the statute’s primary effect was to advance a particular religious practice, it was ruled a violation of the First Amendment’s Establishment Clause.

Although accommodations that allow religious hospitals to refuse to provide abortion or sterilization have, to date, been accepted as constitutionally permissible, there could be a point at which accommodations cross the line of permissibility.

How can religious exemptions be limited?

While most exemptions that accommodate religious health care providers are not seen as unconstitutional, that fact does not make them desirable. Since, as a general rule, exemptions are permitted, but not constitutionally required, the key policy question is how to balance the beliefs of religious health care providers (particularly institutions, such as hospitals) with the competing needs of patients and the professional responsibilities of doctors and other health care practitioners.

Because of the serious impact of institutional religious exemptions on patients' access to reproductive health care, a number of civil liberties, pro-choice and women's legal rights organizations have been working to propose limits on the use of these government accommodations.

A national meeting on "Conscientious Exemptions and Reproductive Rights" was organized in Washington, D.C., in December 1999 by the Reproductive Freedom Project of the American Civil Liberties Union (ACLU) and the ProChoice Resource Center, under the sponsorship of the George Gund Foundation.¹²⁵ Followup sessions involving representatives of a wide array of organizations have examined religious exemptions from legal, medical and public policy standpoints.

Out of these discussions have come proposals to limit the future granting of religious exemptions. The ACLU has developed a framework of limiting such exemptions based on two key criteria: the impact of the exemption on others in society, such as patients; and the nature of the organization seeking the exemption, such as whether its primary purpose is the inculcation of religious values. A guiding principle of this framework is that exemptions are not appropriate "when the practices that are subject to such laws are secular in nature, and allowing an exemption would result in the imposition of religious tenets on others in civil society."¹²⁶

What is the impact on patients?

The likelihood that patients would be affected is greater, of course, when the exemption goes to an institution, such as a hospital, instead of to an individual health practitioner. The burden on patients from institutional exemptions is also increased when the sectarian hospital in question is the primary or only source of health care in a region, or when patients' choices of hospitals are limited by managed care provider networks. The impact of religious exemptions may be especially great in cases of emergency, when patients are transported by ambulance to the nearest hospital, with no consideration of whether that facility might have sectarian policies that could limit the patient's choice of services or end-of-life care.

*Are you practicing medicine or are you practicing religion?
Make a choice.*

As patients' choices have become limited by managed care restrictions and consolidation in the health care marketplace, patients injured by religiously-motivated denial of care have begun to go to court. Some judges have taken a skeptical view and narrowly interpreted legislated "conscience" exemptions for sectarian health care providers, explained ACLU staff attorney Margaret Crosby. "Their attitude is: 'Are you practicing medicine or are you practicing religion? Make a choice.'" ¹²⁷

Do hospitals operate in a religious or a public sphere?

The second criterion proposed for deciding whether or not to grant an exemption has to do with the nature of the organization seeking the accommodation.

An important determination is whether an organization operates in a public sphere or a religious sphere. Key questions for this analysis are:

- Can religiously-sponsored hospitals really claim to operate in a religious sphere when they rely on a combination of government and commercial insurance reimbursements, serve the general public, employ many people of other faiths and do not (as demonstrated by the findings of this report) perform a special religious mission to serve the poor?
- Is there a distinction which should be drawn between two groups of religiously-affiliated agencies: 1) religious entities, such as parishes, dioceses and parochial schools, which serve primarily people of the same faith and have as a primary purpose the inculcation of religious values and 2) religiously-sponsored hospitals, nursing homes and social service agencies, which serve and employ people of many faiths?

While the parish, school and diocese have a public presence, only the hospital is inherently a public place.

Christopher J. Kauffman, author of a history of Catholic health care in the United States, has observed that “while the parish, school and diocese have a public presence, only the hospital is inherently a public place; here Catholics ministered to the physical, mental, emotional and spiritual needs of people representing the entire spectrum of religious and secular traditions.”¹²⁸

In trying to draw these distinctions for public policy purposes, the ACLU framework for analysis draws on the concept of “pervasively sectarian” institutions (as described by the Supreme Court in several Establishment Clause cases). It suggests that it is appropriate to grant “pervasively sectarian” institutions — typically churches and diocese offices — exemptions permitting them to carry out religious functions without being subject to anti-discrimination and other civil laws.¹²⁹ In order to fall within the definition of a “pervasively sectarian” institution, and thus be eligible for a religious exemption, the ACLU has suggested that an institution must:

- Have as its primary purpose the inculcation of religious values;
- Employ primarily those who share the same religious tenets;
- Serve primarily those who share the same religious tenets; and
- Operate without government funds or government employees.

So, for example, a sectarian hospital would not qualify for an exemption if it employs and treats people of all faiths and backgrounds.

These criteria were used, in large part, in a California statute that became effective in 2000.¹³⁰ The law — requiring employers to provide equitable coverage for birth control in employee health insurance — contained a very narrowly-drawn religious exemption. In order to qualify, an employer must meet the following criteria:

- The inculcation of religious values is the purpose of the entity;

- The entity primarily employs persons who share the religious tenets of the entity;
- The entity serves primarily persons who share the religious tenets of the entity; and
- The entity is a nonprofit organization as defined in § 6033(a)(2)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended. (Under this section of the IRS code, “churches, their integrated auxiliaries, and conventions or associations of churches,” and “the exclusively religious activities of any religious order” are exempt from certain tax filings.)

This statute was challenged by Catholic Charities of Sacramento, a provider of social services that met none of the criteria for exemption, since it served and employed many people of different faiths, provided secular services and was not a nonprofit organization as defined in §-6033(a)(2)(A)(i) or (iii) of the IRS code.

We believe that agencies that receive government funding, provide social services to the general public and employ people of all religions are not entitled to a religiously-based exemption from providing services mandated by law.

— Frances Kissling,
Catholics for a Free Choice

Catholic Charities contended the law violated its religious liberty by forcing it to provide insurance coverage for contraception, when Catholic doctrine teaches that contraceptives are “intrinsically evil.”¹³¹

However, the California Court of Appeals in July 2001 rejected Catholic Charities’ claim, holding that the law did not violate either the Establishment or Free Exercise clauses of the federal or state constitutions. The Court stated that the legislature permissibly accommodated religious beliefs “without significantly undermining the anti-discrimination and public welfare goals of the prescription contraceptive coverage statutes, and without imposing the employers’ religious beliefs on employees who did not share those beliefs.”¹³²

Frances Kissling, President of Catholics for a Free Choice, a national organization of Catholics who disagree with the church hierarchy’s positions on reproductive rights, applauded the court’s decision. “We believe that agencies that receive government funding, provide social services to the general public and employ people of all religions are not entitled to a religiously-based exemption from providing services mandated by law,” she said. “In the face of increasing demands by Catholic hospitals, HMOs and other health care institutions for exemptions from providing services ranging from contraception to

sterilization to assisted reproduction, we hope this decision will serve as a precedent in ensuring that it is a patient’s conscience that must be respected above all.”¹³³

In September of 2001, the California Supreme Court agreed to review the Court of Appeals decision. Catholic Charities continued to maintain that the statute unconstitutionally infringes on its “right to religious freedom and liberty of conscience.”¹³⁴ Numerous groups opposed to granting broad exemptions were preparing amicus briefs urging the California Supreme Court to affirm the lower court’s ruling.

Exemptions Denied: Religious Hospitals Subject to NLRB Jurisdiction

The area of collective bargaining provides a fascinating contrast to the trend toward governmental exemptions for religiously-sponsored hospitals.

When Congress acted in 1974 to give the National Labor Relations Board (NLRB) jurisdiction over nonprofit hospitals, legislators rejected calls by the Seventh-Day Adventist Church — which operates many health care institutions — to exempt religiously-sponsored hospitals whose religious tenets opposed unionization of workers. Adventist officials pointed out Congress' previous accommodations for Catholic hospitals, which allowed them to refuse to provide abortion and sterilization services, and urged Congress to create an exemption to accommodate Adventist hospitals' policies against unions.¹³⁵

The NLRB is an independent agency that was created by an act of Congress in 1935. Its functions include remedying and preventing unfair labor practices and conducting secret ballot elections for employees considering unionization.

In testimony before Congress, Adventist officials explained that the Adventist church “has taught and is teaching its members not to belong to or contribute to a labor organization, and has based this teaching on passages in the Bible, thereby making this teaching part of the religious doctrine of the Church.”¹³⁶ Adventist leaders also testified that if the exemption were not enacted, the Church would “give serious consideration to not operating any hospitals at all.”¹³⁷

During the Congressional debate on the Adventist request, Senator Alan Cranston (a California Democrat) opposed such an exemption, noting that religious hospitals “were supported by a variety of governmental subsidies and grants...”¹³⁸ Congress agreed, denying the exemption.

In fact, the reliance of religious health care institutions on public funding has been a factor taken into consideration in several cases in which courts have found NLRB jurisdiction over religious entities constitutional. In one case, *St. Elizabeth Community Hospital v. NLRB*, the court noted, “Although the hospital is owned and operated by the Sisters of Mercy, neither their order nor the Catholic Church contribute financial support.”¹³⁹

Adventist leaders testified that if the exemption were not enacted, the Church would “give serious consideration to not operating any hospitals at all.”

Public funding was also mentioned in *Tressler Lutheran Home v. NLRB*, with the court noting that the facility's operating funds "currently come from the patients, the majority of whom are eligible for Medicare and Medicaid."¹⁴⁰

Similarly, in *NLRB v. St. Louis Christian Home*, the court noted that the majority of the home's funding came from federal, state and local governments. In a footnote to the case, the court again noted that the home "depends heavily on state funding."¹⁴¹ These cases are indications that reliance on government funding can be an important factor in determining that a religiously affiliated institution must comply with generally applicable laws and regulations, even when the institution claims such requirements infringe on its religious liberty.

By contrast, courts have tended to allow limited exemptions from NLRB jurisdiction for religious schools. In 1979, the Supreme Court in *NLRB v. Catholic Bishop* found that Congress did not intend to give the NLRB jurisdiction over the employment conditions of parochial school teachers. The Court noted that constitutional concerns raised by NLRB assertion of jurisdiction because of the "critical and unique role of the teacher in fulfilling the mission of a church-operated school" and declined to address these constitutional issues without a clear expression that Congress intended to give the NLRB such jurisdiction.¹⁴²

The NLRB maintained that the services provided were not religious in nature, and thus there were no entanglement issues that would prevent NLRB jurisdiction.

In subsequent cases involving other types of religious employers, courts have looked to the activities or purposes of the employers challenging NLRB jurisdiction to determine if regulation by the NLRB would violate the First Amendment. Courts have found that "where the institution's primary activity is secular, assertion of NLRB jurisdiction does not violate the First Amendment."¹⁴³ In these cases, courts have applied the *Catholic Bishop* holding only to teachers at parochial schools, because such teachers have a unique role in transmitting and teaching a religion's faith and values.

For example, when a Lutheran nursing home resisted attempts by the NLRB to assert jurisdiction, the NLRB maintained that the services provided were not religious in nature, and thus there were no entanglement issues that would prevent NLRB jurisdiction. In upholding NLRB jurisdiction over the religiously affiliated nursing home, the court noted the differences between religious schools — whose purpose is the teaching of religious doctrine — and the nursing home, whose purpose was to care for

the infirm, finding that “the actual physical care given is comparable to that furnished by secular facilities.”¹⁴⁴

Similarly, in upholding NLRB jurisdiction over a church-operated home for abused children, the court said: “The Home’s activities relate only tangentially to the religious mission of the Christian Church, and inquiry into the operation of the Home should not intrude on any activity substantially religious in character.”¹⁴⁵

The NLRB’s assertion of jurisdiction over religious hospitals has been upheld in several court challenges brought by religious hospitals, which claimed the asserted jurisdiction violated either the Establishment and/or the Free Exercise clauses of the constitution. In all of these challenges, courts have upheld NLRB jurisdiction, finding the interests of the employees would not be met if the employers were exempt.

For example, in *St. Elizabeth Community Hospital v. NLRB*, the court rejected the Catholic hospital’s claims that both clauses of the First Amendment were violated by its being subject to NLRB jurisdiction. In deciding the case, the court said:

“Unlike a church school, however, St. Elizabeth does not have a substantial religious character. Its primary purpose, like that of any secular hospital, is rather humanitarian, devoted to medical care for the sick. St. Elizabeth’s principal function, unlike a parochial school, is to care and heal, not to indoctrinate and propagate Catholicism.”¹⁴⁶

As discussed in a recent NLRB decision on a challenge by an Adventist Hospital to NLRB jurisdiction, an exemption for church-operated health facilities would deny “many thousands of employees the opportunity to self-organize and choose bargaining representation, as well as by putting vital health care services in jeopardy.”¹⁴⁷

Although Congress declined to create an exemption for religious hospitals, it did act to protect the consciences of individuals who held religious tenets against belonging to a union. The act that gave the NLRB jurisdiction over all non-profit health care institutions included a narrow exemption for individual employees who adhere to tenets that oppose joining or supporting labor organizations. Those individuals cannot be compelled to join a labor union as a condition of employment, although any amount they would have paid in dues to the union must be paid to a non-religious charitable organization.



VII. A framework for public policy action

When patients' access to care is being threatened by religious health care restrictions, government intervention may be necessary. The public policy challenge is to fashion such intervention in a way that is effective and places the least possible burden on religious freedom. Appropriate first steps can include attempts to encourage voluntary solutions with policy "carrots" or "sticks."

In her 1995 and 1996 law review articles, Kathleen Boozang advocated a strategy of graduated public policies that first attempt to accommodate sectarian hospitals' restrictions on services, but ultimately lead to government intervention when patients' access to health care is threatened. Those policy stages can be summarized as follows:

- First, government officials should "acknowledge the current pluralistic system of health care delivery in the United States by considering sectarian facilities' limitations in carrying out health planning." So, when conducting health planning for a community, officials should make sure there are alternative providers of services not available at religious facilities. When reviewing proposed mergers of religious and nonsectarian hospitals, regulators should encourage creative corporate structuring and cooperative ventures that allow the nonsectarian hospitals to continue providing needed services.
- Second, in those communities where there is a choice of providers, the planning agency "should require sectarian facilities that restrict their services to advise patients of the treatment options they do not provide and to refer and transfer patients who desire treatment to an alternative provider."
- Finally, "in those instances in which an accommodation cannot be achieved between the religious precepts of the provider and patient access to health care, the state should either compel the religious institution to provide the desired care or license an alternative facility to render the service."

Commenting on the specific challenges posed by mergers of religious and nonsectarian hospitals, Boozang suggested that "the state should honor the community's right to basic health care services by refusing to approve merger proposals that interfere with access to those services," thus encouraging what she called "negotiated accommodation."¹⁴⁸

First steps: Encouraging voluntary solutions

In the years since Boozang's articles were published, there have been a number of attempts to achieve this sort of negotiated accommodation, producing a variety of creative approaches and some clumsy compromises.

The demand for these solutions has come primarily from those third parties that have seen themselves as unprotected by government policy:

- Health care consumers — organized into grassroots groups with names like "Save Our Services" and "Preserve Medical Secularity" — have voiced

objections to proposed hospital mergers that would impose religious doctrine on historically nonsectarian hospitals, forcing the elimination of reproductive services.¹⁴⁹

- Physicians and other caregivers have objected to proposed hospital policies that require their adherence to religious doctrine and threaten their freedom to discuss all treatment options with patients and provide appropriate care.¹⁵⁰

The kinds of solutions achieved have included:

- Loose partnerships (affiliations and joint ventures, instead of full-asset mergers) that permit nonsectarian hospitals to continue to provide reproductive services in their own facilities, while forming limited business relationships with Catholic facilities;

This may shock you, but the Catholic church is very keen on finding practical solutions to complicated problems. We certainly will not do immoral acts, but we certainly can come to arrangements.

— Rev. Gerard Magill

- The creation of separately-incorporated “hospitals within hospitals” that use non-religious staff and money to provide reproductive services not permitted on the other floors of the facility;
- The creation of separate women’s health centers at other locations, to which some reproductive services are transferred. This approach is generally not favored by consumer groups, since it can segregate women’s health care from other hospital services, produce fragmented care, and expose patients to the risk of encountering violent anti-choice protesters;
- Agreements on the part of Catholic health systems to disclose to patients the new religious affiliation and service restrictions (including potential limitations on end-of-life choices) being introduced at previously non-Catholic hospitals they are acquiring;¹⁵¹
- Agreements on the part of Catholic health systems not to interfere with the doctor-patient relationships (and all conversations about treatment options) at previously non-Catholic hospitals they are acquiring.¹⁵²

Some Catholic health systems have embraced these approaches out of a pragmatic desire to form financially advantageous business partnerships with nonsectarian institutions. Surveying such developments, the *Wall Street Journal* reported that some national Catholic health systems are employing special ethicists to help find ways to resolve such moral conflicts and permit partnerships with nonsectarian hospitals. One such ethicist, Rev. Gerard Magill, told the newspaper, “This may shock you, but the Catholic church is very keen on finding practical solutions to complicated problems. We certainly will not do immoral acts, but we certainly can come to arrangements.”¹⁵³

However, these promising approaches are threatened by a strong backlash from conservative members of the church hierarchy. In September of 1999, the Vatican intervened to overturn a creative solution that permitted tubal

ligations to continue at Doctor's Hospital in Little Rock, Arkansas, after it was purchased by the St. Vincent Health System. The solution, under which the Arkansas Women's Health Center leased space in Doctor's Hospital to provide the sterilization services, had been approved by the local Bishop, who was then forced to revoke his permission.¹⁵⁴

In June of 2001, the U.S. Conference of Catholic Bishops made its opposition to such creative solutions official. The Bishops voted to approve revisions to the Ethical and Religious Directives that condemn sterilization and are likely to significantly restrict Catholic hospitals' ability to form partnerships with nonsectarian facilities that provide sterilizations.¹⁵⁵ As a result, voluntary solutions may become more difficult.

When compromise fails: stronger measures

Such indications of growing ecclesiastical resistance may signal the need for stronger measures on the part of government officials at both the federal and state levels. While most regulation of hospitals — such as approval or disapproval of proposed hospital mergers — occurs at the state level, the federal government has significant levers of policy control through its management of the Medicare and Medicaid programs.

When the government decides to fund an activity, such as medical care, it can choose to attach conditions (or policy “strings”) within the funded program or to the expenditure of funds that are rationally related to the purpose of the funding. For example, as a condition of public funding from Medicare, Medicaid and other government programs, the federal government could require acute care hospitals to assure patients' timely access (either on site or at an alternate facility) to a full range of reproductive health services, HIV prevention counseling and legal end-of-life care choices.

Medicare and Medicaid conditions of participation

In fact, hospitals must meet many requirements — termed “Conditions of Participation” — in order to participate in the federal Medicare program, and to be reimbursed under the Medicaid program. These regulations are extensive and cover such areas as hospital governance, administration, and staff credentialing.

These conditions of participation are meant to ensure that patients' rights are respected and they receive medically appropriate care. For example, hospitals are required to:

- “Honor a patient's right to make informed decisions regarding his or her medical care.”¹⁵⁶
- “Meet the emergency needs of patients in accordance with acceptable standards of practice.”¹⁵⁷
- “Have pharmaceutical services that meet the needs of the patients.”¹⁵⁸

Religiously-sponsored hospitals have been able to receive public funding while maintaining practices that appear to violate all three of the above conditions. For instance, when a hospital emergency room does not inform a rape survivor about emergency contraception and fails to dispense it immediately, if she wants it, the hospital arguably is failing to honor the woman's right to make an informed decision, and is not meeting her emergency or pharmaceutical needs.

One of the possible avenues of action for protecting patients' access to reproductive services might be to seek enforcement by the federal government of these three existing provisions, as well as any others which might apply. Where language of the conditions is vague — such as “meet the needs of patients in accordance with acceptable standards of practice” — patient advocates may need to work with medical associations to establish appropriate practice standards that are specific. Another action might be to address the current lack of conditions explicitly guaranteeing patients' access to a full range of reproductive services.

Sample state and federal policies

Some examples of potential public policies can be drawn from existing federal and state laws and regulations that prevent providers of government-funded services from imposing their religious beliefs on their clients. Under some of these policies, the agency or institution must provide the service desired by the patient, regardless of religious concerns. In others, the institution must at least disclose its restrictive policies and/or refer the patient elsewhere. Other policies place an obligation on public officials to protect patients' rights and access to services.

Requirements that publicly-financed services be free of religious influence

Federal Housing and Urban Development regulations impose restrictions on the use of any grants awarded to housing programs for persons with AIDS, as well as community development programs for Indian tribes and Alaskan natives. Under these regulations, money can go to religious organizations, but they must agree to provide all eligible activities free from religious influence. Furthermore, religious organizations participating in these programs must agree that they will not provide religious instruction or engage in proselytizing and will exert no religious influence on the provision of eligible activities.

Religious entities must also agree that they will not discriminate against their employees on the basis of religion and will not give preference in employment on the basis of religion, as these organizations would otherwise be permitted to do under Title VII of the Civil Rights Act.¹⁵⁹

Requirements that protect patients' rights to services

In New York, the Office of Mental Retardation and Developmental Disabilities (OMRDD), contracts with private care providers (including those run by

Catholic charities and other religious entities) to deliver services to eligible clients. The rights of clients of OMRDD are protected by a set of regulations that ensure clients will receive all services to which they are entitled without discrimination or interference from those who have contracted with the state to be providers.¹⁶⁰

These regulations give clients the right to be free from discrimination — including discrimination due to gender, religion or sexual orientation. These client safeguards include the right to express sexuality and the right to make decisions about contraception and pregnancy.

Care providers cannot deny clients “access to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medications or devices to regulate conception, when clinically indicated.”¹⁶¹ There are no provisions allowing providers to opt out of offering or arranging for services to which the provider has moral or religious objections.

Required referrals for services not provided

If public policy stops short of requiring the provision of services, the provider can be required to refer patients to alternate providers for services they do not offer. An example of such an approach is found in the New York Child/Teen Health Plan, a health plan for children and adolescents up to age 21 who are eligible for Medicaid. Covered services include family planning services and supplies, and abortion. Although providers are not required to offer all covered services, they must give clients referrals to other providers for needed services.

The regulations define referral as the process of: “(1) directing an eligible person to a provider for a needed service after it has been confirmed that the provider is accessible and can provide the needed service to that person without undue delay, and (2) conducting a follow-up in a timely manner to determine whether the service was obtained and to provide an alternative referral if necessary.” Although providers may not be required to provide all covered services under this program, they cannot cite religious beliefs as a reason to deny patients referrals.¹⁶²

Required disclosure of restrictive religious policies

Some existing laws require hospitals to disclose that some treatment requests may not be honored if the hospital has a religious or moral objection.

For example, New York’s health care proxy law (which enables patients to designate an agent to make medical decisions if the patient is unable to do so) allows hospitals to refuse to honor the decision of a patient’s designated agent if “the decision is contrary to a formally adopted policy of the hospital that is expressly based on religious beliefs or sincerely held moral convictions central to the facility’s operating principles and the hospital would be permitted by law to refuse the decision if made by the principal (the patient).”¹⁶³

To exercise this refusal clause, the hospital must have informed the patient or the patient's agent of the policy upon admission, if possible. In addition, the hospital must transfer the patient to another facility that is reasonably accessible under the circumstances and is willing to honor the request or, if the transfer can not be arranged, the hospital must honor the request or seek judicial approval to refuse the request.¹⁶⁴

The Patient Self-Determination Act is a federal law that requires all states to recognize a patient's advance directives. The law imposes additional requirements, or 'strings,' on all institutions that receive payments from the

Hospitals must inform patients, through written materials, which services or treatments may be limited by the institution based on religious or ethical policies.

Medicare and Medicaid programs. These additional requirements are implemented in regulations termed Conditions of Participation. Under these regulations, hospitals must inform patients, through written materials, which services or treatments may be limited by the institution based on religious or ethical policies. Like the New York law, these regulations allow hospitals to refuse to honor advance directives to which the hospital has a moral or religious objection. In order to exercise this right of refusal, hospitals must include in their written materials a "clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience." This statement of limitation must include, at a minimum, a clarification of "any differences between institution-wide conscience objections and those that may be raised by individual physicians," and most importantly, "describe the range of medical conditions or procedures affected by the conscience objection."¹⁶⁵

In the regulatory arena, the Connecticut Attorney General has proposed a policy for the disclosure of religious health care restrictions to patients being referred from a nonsectarian hospital to a religiously-sponsored one. The policy was spelled out in a regulatory decision issued on a pending hospital acquisition.

Under the acquisition plan, rural Sharon Hospital, which is a nonsectarian not-for-profit facility, would be acquired by the for-profit Essent Health chain, which would in turn establish a tertiary care referral agreement to send patients from Sharon Hospital to St. Francis Hospital, a large Catholic facility in Hartford.

At public hearings on the transaction, the Connecticut Commission on the Status of Women, the Connecticut Coalition for Choice and the MergerWatch Project all had raised concerns about how this referral agreement would affect patients' access to reproductive health services, since St. Francis Hospital is governed by the Ethical and Religious Directives for Catholic Health Services.

The Attorney General issued a decision that requires the hospital to ensure that patients who are referred to St. Francis or any other hospital, are "appropriately and fully informed regarding limitations on the scope and range of medical services and end-of-life care available to the patient at the hospital

or health care institution. The disclosure shall include a discussion of any limitations on the scope of services created by the institution's secular or religious mission, strategic plan, medical staffing, financial resources and internal ethical policies or directives." ¹⁶⁶

Prohibitions on the use of government bond proceeds for religious purposes

Other policy examples can be drawn from conditions attached to the use of proceeds from issuance of government bonds. The New York State Dormitory Authority, for example, has a section entitled "Restrictions on Religious Use" in the loan agreements it executes with institutions benefiting from issuance of the Authority's bonds.

According to these restrictions, the bond proceeds "shall not be used for sectarian religious instruction or as a place of religious worship or in connection with any part of a program of a school or department of divinity for any religious denomination." The restriction was obviously written to apply to colleges, which were the original beneficiaries of Dormitory Authority bonds.

As the Authority's portfolio of activities has expanded to include low-cost financing for hospitals, the religious exclusions clause has not been updated. The consumer group Save Our Services-Long Island requested a review of the clause's language, with an eye to wording applicable to hospital bonds, after Catholic Health Services of Long Island began using Dormitory Authority bond proceeds to acquire non-Catholic health providers, which became subject to the Ethical and Religious Directives for Catholic Healthcare Services.

Other policy approaches for protecting patients

Some policymakers seeking to protect the public's access to reproductive and other health care services have taken a different approach. Instead of attaching conditions to public funding, they have focused on giving state regulatory authorities the responsibility and power to ensure that hospital consolidations and transactions do not result in a loss of needed health care services.

Sample state statutes

California, for example, has acted to prevent the potential loss of services caused by affiliations between religious and nonsectarian hospitals. The state has enacted a law giving the state Attorney General oversight over transactions involving not-for-profit hospitals, including those that are religiously-sponsored. Implementing regulations specify that hospitals contemplating transactions covered by the law must submit to the attorney general an assessment of "how the proposed transaction will affect the availability and accessibility of health care in the affected communities," and a description of any proposals to "mitigate or eliminate any significant adverse effect on

the availability or accessibility of healthcare services to the affected community.”¹⁶⁷ The regulations also provide for notice to the public and allow for public comment.

Under the law, in determining whether to approve a proposed transaction, the Attorney General must consider several factors, including whether the proposal would have a “significant effect on the availability or accessibility of health care services,” and whether the proposal is in the public interest. The regulations also require the Attorney General to monitor a transaction after approval for compliance with any terms and conditions.

The state of Massachusetts has also acted to protect access to services by enacting a statute that requires hospitals to seek approval from the health department before eliminating an “essential health service.”

A similar New Jersey statute requires not-for-profit corporations to seek Attorney General review and court approval for any acquisition of a hospital. The statute defines acquisition as “the purchase, lease, exchange, conversion, restructuring, merger, division, consolidation, transfer of control or other disposition of a substantial amount of assets or operations...”¹⁶⁸

In consultation with the state’s Commissioner of Health, the New Jersey Attorney General can approve an application with specific modifications, or can deny an application if it is not in the public interest. An application will not be deemed in the public interest unless the Commissioner of Health determines the proposal “is not likely to result in the deterioration of quality, availability or accessibility of health care services in the affected communities.”¹⁶⁹

The state of Massachusetts has also acted to protect access to services by enacting a statute that requires hospitals to seek approval from the health department before eliminating an “essential health service.” In regulations that implement the statute, reproductive health services are considered essential.¹⁷⁰ If the department of health determines the essential health service is necessary for preserving access and health in the affected community, the hospital must submit a plan for assuring continued access to the services proposed to be eliminated.¹⁷¹

Charitable assets laws

When a nonsectarian hospital agrees to follow religious rules and thus ban services in order to affiliate with a sectarian hospital, its conduct could be a violation of charitable trust laws. In many states, charitable entities such as not-for-profit hospitals are subject to these laws, which are based on the theory that charitable assets are held for the good of the public. Members of the public have a right to expect that charitable assets (such as the charitable donations made to a hospital) will be applied to their intended purpose, which is reflected in a charitable institution’s mission. A not-for-profit hospital’s decision to change from a nonsectarian to a religious mission therefore could be

viewed as a change that violates charitable trust laws. Several recent cases have demonstrated this potential application of charitable trust law by judges and state Attorneys General.¹⁷²

The National Women's Law Center has published a guide on how community activists and lawyers can utilize charitable trust laws to protect access to reproductive health care services that are threatened by, or have been lost to, an affiliation between a non-sectarian and a religious hospital. To obtain the guide, contact the National Women's Law Center (see Resources section).

APHA Recommendations

The 30,000-member American Public Health Association (APHA) has addressed the issue of patients' rights and consumers' access to services in the context of proposed religious/secular hospital mergers. Terming the problem an "emerging health access issue," the APHA in November 2000 adopted an official policy statement¹⁷³ which:

- Encourages "creative solutions" to preserve access to vital health services in communities facing mergers of religious and secular institutions;
- Recommends that state and local agencies, in regulating health care facilities, exercise their authority to ensure the availability of comprehensive reproductive health services and end-of-life choices;
- Urges that health care facilities receiving public funding assure the availability of comprehensive reproductive health services and end-of-life choices.

Case study

Anti-choice "strings" attached to public funding

Many of the same anti-choice conservatives who are decrying "unfair barriers" to religious organizations' participation in government programs have previously advocated attaching "strings" to Title X funds for family planning, which had the effect of creating burdens on organizations receiving those funds.

During the administration of Ronald Reagan, the Secretary of Health and Human Services imposed a "gag" rule on projects receiving Title X funds, banning abortion counseling within the project. (The regulations did not require organizations receiving Title X funds to give up abortion related speech, although they did have to keep such activities separate and distinct from Title X funded activities.) This rule was strenuously opposed by civil liberties and pro-choice organizations.

Dr. Irving Rust, medical director of the HUB, a Planned Parenthood of New York City clinic, was among the physicians who counseled women about unplanned pregnancy and were affected by the restriction. Dr. Rust, along with other medical providers, brought suit, claiming infringement of the rights to free speech and reproductive choice. When the case reached the U.S. Supreme Court as *Rust v. Sullivan*, the justices ruled against the plaintiffs, 5-4.¹⁷⁴

In response to public outrage over the Rust decision, both the U.S. House and the Senate voted to overturn the rule. George H. W. Bush, who had by then been elected president, vetoed the bill. An effort to override the veto failed by only 12 votes.¹⁷⁵



VIII. Conclusions and Recommendations

As this study has documented, religiously-sponsored hospitals in the United States receive billions of dollars in public funding and use a variety of other forms of government support, including tax-exempt bonds. These hospitals have enjoyed the kind of “level playing field” that the Bush administration is advocating for faith-based social services agencies seeking to compete for federal funding. Far from facing what the Bush administration and many religious agencies call “unfair barriers,” religiously-sponsored hospitals have received a variety of special legislative and regulatory accommodations of their restrictive policies.

The consequence of this reality — public funding and support with few or no “strings” attached — has been the establishment and growth of a significant sector of the American health care system that can and does refuse to honor the needs and wishes of its patients. Nearly one in five acute care hospital beds in the United States is now controlled by a religiously-sponsored entity that is legally permitted to restrict patient care, based on religious principles, while remaining eligible to receive public money.

It would be unwise and impractical to suggest that religiously-sponsored hospitals should simply be considered ineligible for receipt of public funds. Such a remedy would be unduly harsh and would fail to recognize the important role of religious hospitals in providing health care for many Americans.

However, it would be equally improper to continue to allow religiously-sponsored hospitals to receive billions in public funds and hold licenses to serve the general public, while operating in a manner that imposes one religious perspective on the health care available for everyone in a community. Such a situation is particularly egregious when it serves to violate patients’ rights, restrict access to needed services and interfere with physicians’ ability to serve their patients.

In fact, there is ample precedent for requiring that recipients of public funding (whether religious or not) adhere to conditions that are designed to promote public health and well-being. Grants-in-aid have traditionally been conditioned on the recipients maintaining certain standards within the funded program. Further, there are examples of state policies designed to ensure that patients’ access to a full range of health care services does not become eroded when hospitals merger or form other types of business partnerships.

The following specific recommendations to achieve this goal are based on the findings of this study and the public policy discussion presented in previous sections. Some of these recommendations suggest action by the federal government or the states. Others can be carried out through voluntary action by hospitals and medical associations.

1. Patients' right to informed consent must be protected

Patients must be informed of the recommended course of treatment and all alternative treatments, including the risks and potential benefits of each, regardless of whether those alternatives are permitted at the hospital.

Discussion

Patients must be informed of all treatment options so that they are able to give fully informed consent, based on medical recommendations and their own individual ethical and religious beliefs. It should not be considered an acceptable hospital practice to withhold information about some treatment options because of a hospital's ethical or religious policies.

This report recommends that hospitals serving the general public and receiving public funding adopt policies that explicitly ensure patients' right to be informed of all treatment options, including those not offered at the hospital. Such policies should be prominently posted within the hospital, incorporated into employee training and enforced through quality assurance and other internal review programs.

Further, hospital licensing and accreditation authorities should incorporate into licensing and accreditation requirements the assurance of fully informed patient consent. Compliance should be documented in hospital records and reviewed periodically by licensing and accreditation authorities.

Finally, compliance with fully-informed consent requirements should be a condition of hospital participation in the federal Medicare and Medicaid programs. The existing informed consent language for those programs should be strengthened to explicitly state that information about treatment options may not be withheld from patients because of hospital ethical or religious policies.

2. Physicians' and other caregivers' ability to fulfill their duty to their patients must be safeguarded

Physicians and other caregivers must be guaranteed the right to discuss all treatment options with patients, regardless of whether those options are permitted at the hospital, and to assist patients in obtaining desired treatment at alternate facilities.

Discussion

It is unacceptable for hospitals that serve the general public and receive public funding to impose "gag orders" on physicians and other caregivers. Hospital policies must explicitly spell out protection of caregivers' rights to discuss all treatment options with patients. These protections must not be countermanded by the conditioning of admitting privileges or staff positions on caregivers' adherence to religious or ethical health care policies in order to retain admitting privileges or staff positions.

In addition, physicians and other caregivers must be free to recommend courses of treatment not permitted at the hospital and to assist patients in obtaining such care elsewhere. Further, caregivers must be permitted to provide such alternate treatments at other locations, without jeopardy to their hospital admitting privileges.

Such protections for physicians and caregivers should be extended not only at hospitals, but also in any associated outpatient facilities and medical office buildings. It should not be permissible, for example, to incorporate into the lease for a medical office a clause that bars a physician from discussing all treatment options with patients.

As with recommendation 1, these protections for caregivers should be incorporated into hospital policies, medical staff by-laws, rules and regulations. These policies should be transmitted in employee training and enforced through quality assurance and other internal review processes. Further, such policies should be required and enforced by state hospital licensing and accrediting bodies and should be conditions of participation in the federal Medicare and Medicaid programs. Finally, states and the federal government should adopt regulations or enact laws that prohibit any entity — including hospitals, managed care companies, insurers and other entities — from placing restrictions or limits on physician/patient communications.

3. Hospitals must disclose treatment restrictions

Hospitals must disclose to their patients any religious or ethically-based policies which restrict treatment options.

Discussion

Disclosure of restrictive hospital policies should be carried out prior to admission, and repeated following admission in the event of a conflict between hospital policy and the patient's desired course of medical treatment. Disclosure procedures should be documented in hospital policies, incorporated into employee training and enforced by hospital administration.

Further, disclosure of restrictive ethical or religious policies should be required and enforced by hospital licensing and accrediting bodies and should be conditions of participation in the Medicare and Medicaid programs. The current Medicare Condition of Participation regarding disclosure of end-of-life policies can serve as a model for disclosure of other restrictive policies, such as those prohibiting certain reproductive services. That model could be strengthened by more specific language explaining how and when disclosure should be made (such as in written materials provided at the time of admission, and in advance directive forms made available in the hospital).

In addition, disclosure of hospitals' restrictive policies and bans on provision of certain services should be made in prospective enrollment materials distributed by health insurance plans and government health coverage programs, such as Medicare, Medicaid and subsidized child/family health plans for low-income working families. A California statute enacted in 2000 provides one model of how such disclosure could be required.¹⁷⁶ Disclosure of religious/ethical restrictions at participating providers is essential to ensure that health insurance enrollees are able to choose plans that include providers of desired services or exercise freedom of choice options under Medicaid. Any changes to hospital policies, including the addition of new service restrictions, should also be disclosed to enrollees.

The requirement for disclosure should also encompass hospital communications and advertising. For example, hospital advertisements should be prohibited from claiming to offer "comprehensive women's health care," if some reproductive health options are barred by hospital ethical or religious policies. Some state consumer protection laws concerning misleading advertising may already prohibit such advertisements, and therefore might offer an avenue for enforcement.

4. Provision of emergency services must be required

When emergency care is needed, such as for an ectopic pregnancy or rape, hospitals must be required to provide the emergency care immediately on site.

Discussion

When a patient needs time-sensitive care, such as treatment of ectopic pregnancy or the provision of emergency contraception following a rape, a hospital should not be permitted to refuse the care and attempt to send the patient elsewhere. The patient's need for emergency care must take precedence.

When a hospital has an emergency department, it should be required to provide such emergency care as a condition of Medicare and Medicaid participation, as well as licensing and accreditation. Compliance with such policies should be enforced by internal review and outside auditing agencies.

New or enhanced language under the Emergency Medical Treatment and Labor Act should specify that all hospitals are required to provide treatment on site when time is of the essence for the patient's health, regardless of religious or ethical objections. Hospitals should be prohibited from transferring the patient in such instances.

5. For non-emergency care, referrals to alternate facilities must be required if treatment is being refused

Patients must be given referrals to alternate hospitals when a desired course of treatment is being denied, except in emergency situations, as described in recommendation number 4.

Discussion

Referrals to alternate providers are essential to ensure that patients are fully able to exercise their right to pursue courses of treatments not offered at the hospital. Acceptable referral practices must include, at minimum, reviewing all the patient's health care treatment options with him or her; explaining which of those options are available at the hospital and which are not; providing the patient with the names, addresses and phone numbers of alternative providers; and ensuring that the patient is able to travel to at least one of these alternative providers and has insurance coverage (including Medicaid) which will be accepted there.

Additional assistance must be given when a patient is at risk of not receiving care at an alternative provider for reasons such as transportation problems, lack of financial resources, physical or emotional instability, youthful status or diminished capacity. In such cases, the hospital must take active steps to ensure that the patient is able to receive treatment at an alternate provider.

Such referral procedures should be incorporated into hospital policies, transmitted in employee training sessions and enforced through internal review and quality assurance processes. Further, referrals to alternate facilities when treatment is being refused should be required and enforced by hospital licensing and accrediting bodies and should become conditions of participation in the Medicare and Medicaid programs.

6. "Sole community hospitals" must ensure their patients' access to care

When a hospital is the sole or primary provider of health care for a region, it should have a special responsibility to ensure patients' access to needed care. Such a hospital should be expected to provide the needed health care service when no other appropriate provider is practically accessible.

Discussion

Those hospitals designated by the federal government as "sole community hospitals" — in other words, the sole or primary providers of health care for their region — have a special responsibility to ensure that patients have access to needed care and are fully informed of all treatment options. Such hospitals should be required either to meet patients' needs on site, or take special steps to assist those patients

who cannot travel outside the region without hardship or threat to their health. Such steps might include facilitating transfer of the patient to an alternate facility outside the region.

Such responsibilities should be articulated by the federal government as conditions for receipt of the special payment considerations that accrue to sole community hospitals.

7. Standards of care must be strengthened and enforced

Medical associations, hospital accrediting organizations, managed care quality assurance programs and state health officials should be encouraged to more clearly articulate and, where applicable, enforce standards of care.

Discussion

Clearly-articulated standards of care can establish the expected responsibilities of caregivers and hospitals to their patients. When such standards are vague, nonexistent or not enforced, patients' needs can easily be subordinated to institutional religious or ethical policies.

Professional medical associations, such as the American Medical Association, the American College of Obstetricians and Gynecologists, the American Medical Women's Association, the Association of Reproductive Health Professionals, the American College of Emergency Physicians, the International Association of Forensic Nurse Examiners, should be encouraged to review their existing practice guidelines and strengthen them, as appropriate.

Hospital accrediting organizations, managed care quality assurance programs and state health officials should also review standards of care to ensure that patients' rights to informed consent and access to needed health care services are not subordinated to hospital ethical or religious policies. Enforcement of such standards should be strengthened, where necessary, and efforts undertaken to educate consumers about appropriate complaint processes.

8. Governments must act to ensure patients' access to care through oversight of hospital transactions

Prior to approving a sale, merger or other transaction between a religiously-affiliated and a nonsectarian health facility, government regulators should ensure that the affected community will continue to have access to a full range of reproductive health services and end-of-life choices.

Discussion

Government regulators should not approve religious/nonsectarian hospital transactions that impose religious or ethical restrictions on both

or all hospitals and will result in a deterioration in the availability or affordability of health care services, such as reproductive health care, or end-of-life choices, in the community. Instead, regulators should ensure that access will continue to be available, either at the existing nonsectarian hospital, through creative corporate structures, or at alternate providers in the community.

Because hospital oversight usually occurs at the state level, and processes vary from state to state, the mechanism for ensuring continued community access will vary. In some states, this goal can be accomplished through a Certificate of Need process, under which hospitals are granted operating licenses and permitted to merge or affiliate with other hospitals. In other states, the responsibility may lie with Attorneys General. Legislatures or executive branch agencies might also contribute to the process by offering incentives, such as enhanced reimbursements, to hospitals that provide services not available elsewhere in the community.

In order to ensure such protection of patients' access to care, the following elements must be included in any state government approval process for hospital transactions:

- Advance notice to the affected community, through information provided to local newspapers, distributed at public libraries and posted on government internet sites;
- Opportunity for public comment, through at least one public hearing in the affected community and through the solicitation of written comments;
- Assessment, by the appropriate state regulatory body, of the present hospital services offered in the community and the likely impact the proposed transaction would have on essential services;
- Approval standards which reflect public comment and take into account the availability of health care services before and following the transaction.

9. Proposed governmental exemptions for religious hospitals must be carefully evaluated in light of their impact on patients

Special government exemptions for religious hospitals should not override patients' rights to informed consent and access to needed health care services. Any new proposals for such exemptions should be carefully scrutinized to assess their likely impact on patients and to take into account community hospitals' role in serving the general public.

Discussion

In the rush to exempt religiously-sponsored hospitals from mandates that they provide services contrary to religious policies, federal and state policymakers have ignored the concerns of patients who need those

services. In today's health care marketplace, religiously-sponsored hospitals serve the general public and rely heavily on public funding. Accordingly, policymakers should take care not to sacrifice patients' rights when considering new requests by religiously-sponsored hospitals for exemptions from health care mandates.

As a general rule, policymakers considering exemptions can be guided by frameworks such as that articulated by the American Civil Liberties Union. We recommend that religious exemptions be granted only when an institution meets all four of these criteria:

- Serves primarily those who share the same religious tenets;
- Employs primarily those who share the same religious tenets;
- Has as its primary purpose the inculcation of religious values; and
- Operates without government funds or government employees.

10. Litigation should be considered as one method of establishing standards of care

Patients whose rights to informed consent and quality care have been violated should be informed about the possibility of malpractice litigation as one method of establishing standards of care when other approaches (voluntary, regulatory or legislative) have proved inadequate.

Discussion

With consumer awareness of patients' rights and the impact of religious and ethical health restrictions will come the potential to use litigation to establish standards of care. Patients who have been harmed by hospitals' refusal to provide information about treatment options (such as emergency contraception) or to provide needed care (especially in emergency situations) can be informed of the possibility of malpractice lawsuits.

Litigation approaches to improving standards of care may prove effective in instances in which voluntary approaches to hospitals have been rebuffed and regulation or legislation is stalled because of powerful lobbying efforts by organizations representing religiously-affiliated hospitals, such as the Catholic Health Association of the United States. Some of the organizations listed in the resources section of this guide have legal staff capable of undertaking such litigation.

11. Tax-exempt bond financing for hospitals should be used to preserve and enhance consumer access to a full range of health services

State and local agencies providing tax-exempt bond financing for hospitals should establish guidelines favoring projects that preserve and enhance consumer access to a full range of health services and treatment options.

Discussion

Although it would not be appropriate to bar religiously-affiliated health care providers from access to government-issued tax exempt bond financing, state and local bonding authorities should recognize that the public purpose of this form of financing is to provide communities with needed health care services. Accordingly, bond-issuing agencies should review their guidelines and establish priorities favoring projects that preserve and enhance consumer access to health care services and do not contribute to the elimination or diminution of services.

For example, state and local bonding agencies might establish guidelines giving priority to hospital projects that enhance consumer access to comprehensive reproductive health services, including full-service maternity departments. Bonding authorities should also review their current “religious exclusions” clauses to ensure that recipients of tax-exempt financing are not permitted to use such financing to impose religious health care values or restrictions on people of other faiths.

12. Health care consumers should be educated about religious restrictions and patients’ rights

Consumer education is essential to ensure that patients are aware of the restrictions at some religiously-affiliated hospitals, are able to make appropriate choices of health care providers and are able to advocate for themselves.

Discussion

In addition to the policy approaches outlined above, consumer education must be undertaken to inform patients about religious health care restrictions and ensure that they are equipped to ask questions about hospital policies and make the best decisions about where to seek health care.

Because of religious hospitals’ failure to disclose their restrictive policies, their frequent use of nonsectarian-sounding names and their use of advertisements which offer “comprehensive women’s health care,” many health care consumers are completely unaware of the ethical and religious restrictions in place at these hospitals.

Even if all of the other recommendations of this report — including mandatory disclosure of restrictive policies and truthful advertising —

were adopted, such consumer education would be essential. Consumers need to be aware of potential religious restrictions on health care, educated about their rights and equipped with questions they need to ask of their health providers, so they will be able to protect themselves when faced with restrictive hospital policies.

Health care consumer groups, with assistance from interested foundations, should undertake educational campaigns to improve the level of public awareness about ethical and religious health care restrictions. Such informational campaigns could also be undertaken by large membership organizations, such as unions and associations of retired persons, and by organizations such as the American Public Health Association, as well as by state health departments. In addition, the development of such educational efforts should be one focus of programs in public health, women's studies, patient advocacy and other health disciplines at American colleges and universities.



End Notes

1. See, for example, the history of hospitals in the United States presented in Paul Starr's *The Social Transformation of American Medicine*, New York, Basic Books, 1982, which notes that "discrimination was a principle reason for the creation of separate religious and ethnic hospitals.", p. 173.
2. The hospital self-designations are made in their institutional cost reports to the federal Centers for Medicare and Medicaid Services (CMS), formerly known as Health Care Financing Administration (HCFA).
3. See, "Principles and Practices Board Statement Number 15," Healthcare Financial Management Association, available at: www.hfma.org/kn/statement15.htm. The statement says the following about the difference between charity care and bad debt: "Bad debts result from the unwillingness of a patient to pay, whereas charity service is provided to a patient with demonstrated inability to pay. The charity care write-off results as accounting standards dictate that hospital services rendered be recorded at the full established charges in revenue and receivables. Revenue and receivables are then adjusted to the amount that the payer has an obligation to pay. When determined that an amount qualifies as charity service, it is written off. "
4. For a discussion of these differing definitions and standards, see numerous articles in *Modern Healthcare* magazine, including David Burda's June 15, 1992, article, "Charity Care: Are hospitals giving their fair share? Misleading data, disparities in definitions muddy the debate over how much charity care is provided." That article reported on several different national surveys (including one by the magazine) showing that hospitals spent 1 to 2 percent of their gross patient revenues on charity care (without bad debt added in).
5. For example, studies in the early 1980s showed that public hospitals provided uncompensated care (the sum of charity care and bad debts) at a level about twice as high as private hospitals. See *Hospitals and the Uninsured Poor: Measuring and Paying for Uncompensated Care*, published by the United Hospital Fund of New York, 1985. Other studies have showed that large public teaching hospitals have the highest level of uncompensated care of any type of hospital. See *Uncompensated Hospital Care: Rights and Responsibilities*, John Hopkins University Press, 1986. The Commonwealth Fund reported that in 1996, public teaching hospitals provided 30.7 percent of uncompensated care in a given community, while private teaching hospitals provided 13.5 percent. See *A Shared Responsibility: Academic Health Centers and the Provision of Care to the Poor and Uninsured*, April 18, 2001.
6. Bellandi, D., and Kirchheimer, B., "For-profits report decline in acute-care hospitals," *Modern Healthcare* annual multi-unit providers survey, May 24, 1999, pp. 23-42.
7. *Broken Promises: How Declining Charity Care at Catholic Healthcare West is Costing all Californians*, Service Employees International Union, June 1999. The study and comments on it from SEIU officials were reported in the *National Catholic Reporter* ("Catholic hospitals faulted for decline in care of poor" by William Bole).
8. Bole, W., "Catholic hospital faulted for decline in care of poor," *National Catholic Reporter*, June 30, 1999. For further comments on Catholic hospitals and service to the poor, see also a letter to the editor of the *Modern Healthcare* from Catholic Health Association President and CEO Rev. Michael D. Place, sent on August 27, 1999, and posted on the Catholic Health Association's website at: www.chausa.org/PRESPAGE/990827NCR.ASP.
9. In New York, and other states, both religious and nonsectarian hospitals take advantage of the opportunity to obtain tax-exempt bond financing, which is available at a lower cost than other forms of financing because the interest paid to bond-holders is exempt from federal, and for the most part, state income taxes. Because of this savings, tax-exempt bonds carry an interest rate that is lower than financing that is obtained through commercial lending sources. The activities of the New York State Dormitory Authority (DASNY) were examined for 1998 and

1999. Through state legislation enacted in 1995, DASNY was given responsibility for issuing bonds on behalf of hospitals and other medical facilities, a task previously carried out by the Medical Care Facilities Finance Agency.

10. Ambro, D. "Abortions, Reproductive Procedures Are Only Services To Be Discontinued," *The Smithtown News*, Mar. 2, 2000, p. 3.

11. See Table 21 in the Appendix, which includes a listing of hospital systems, some of which manage public hospitals. The chart lists the portion of all hospitals in each system that are publicly owned. Some examples of public hospitals that are managed or leased by religious entities include health-district owned Oak Valley Hospital in California, which is managed by Catholic Healthcare West (CHW). Physicians leasing space in district-owned medical office buildings must adhere to the Directives. Also in California, the Beach Cities Health District leases space to the Little Company of Mary, a Catholic system, which runs a woman's health center that bans many reproductive services. In Oregon, tax-supported Central Oregon District Hospital (renamed Central Oregon Community Hospital), located in Redmond, Oregon, merged with St. Charles Medical Center, which adheres to the Ethical and Religious Directives for Catholic Health Care Services. The merger was accomplished with both hospitals transferring their assets to a new corporation named Cascade Health Services. The district hospital was not required to drop services or adhere to the Ethical Directives.

12. Place, Rev. M., "Toward a Common Vision for the Catholic Health Ministry," *Health Progress* (the magazine of the Catholic Health Association of the United States), Jan.-Feb. 1998.

13. Place, Rev. M., "The Graying of America: Ethical and Policy Implications for the Church and the Nation," lecture text for remarks given at Thomas More College, Apr. 23, 2001.

14. U.S. Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," 4th ed., U.S. Catholic Conference, Jan. 2001. A copy can be downloaded from: www.usccb.org/bishops/directives.htm.

15. "Facts About The Catholic Health Association of the United States," Catholic Health Association, downloaded 6/1/01, from <http://www.chausa.org/aboutcha/chafacts.asp>.

16. Bellandi, D., Kirchheimer, B., and Galloro, V., "Overall, Not So Bad: Survey Finds Hospital Systems Posted a Modest Operating Profit in 2000," *Modern Healthcare*, June 4, 2001, pp. 36 to 58.

17. See, for example, "Columbia to Do No Abortions in Georgia," Louisville, Ky., *Courier*, May 18, 1995, regarding the Columbia/HCA system's decision to continue a no-abortion policy at hospitals it purchased from the Georgia Baptist Convention.

18. White, K., "Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patients' Rights," *Stanford Law Review*, 51:1703 (1999).

19. 10 Largest Non-Catholic Religious Healthcare Systems, in "Overall, Not So Bad: Survey Finds Hospital Systems Posted a Moderate Operating Profit in 2000," *Modern Healthcare*, June 4, 2001, p. 38

20. *Adventist Health*, "About Us," downloaded 9/1/01 from: www.adventisthealth.org/doc.asp?ID=81.

21. Gilmer, B., "Hospital Deal Raises Questions About Religion," *St. Petersburg Times*, Nov. 29, 1999.

22. Seventh-Day Adventist Church website, downloaded 8/28/01 from [www: adventist.org/beliefs/guidelines.html](http://www.adventist.org/beliefs/guidelines.html).

23. Gilmer, B., "Hospital Deal Raises Questions About Religion," *St. Petersburg Times*, Nov. 29, 1999.

24. Adventist News Network dispatch, downloaded 8/28/01, from: www.adventist.org/news.

25. Ukiah Adventist Hospital d/b/a Ukiah Valley Medical Center and California Nurses Association, 332 NLRB No. 59 (2000).
26. Jimenez, R., "Abortion Dispute Hits N.H. Hospital: Woman Transferred During Emergency," *The Boston Globe*, May 23, 1998, p. B1.
27. Uttley, L. "How Merging Religious and Secular Hospitals Can Threaten Health Care Services," *Social Policy*, Spring 2000, pp. 4-5.
28. Labi, N., "Holy Owned: Is It Fair for a Catholic Hospital to Impose its Morals on Patients?" *Time*, Nov. 15, 1999, pp. 85-96.
29. Laurence, L., "The Hidden Health Threat That Puts Every Woman at Risk," *Redbook*, July 2000. After this story aired, physicians with admitting privileges at St. Louise threatened to send their patients to alternative hospitals that did not ban the procedure. Concerned about the loss of income that St. Louise would have incurred, the hospital modified its policy to allow the procedure in limited and rare circumstances. Doctors must now submit applications to a committee of the Archdiocese to determine if a tubal ligation will be approved.
30. MacKay, A., Kieke, B., Jr., Koonin, L., & Beattie, K., "Tubal Sterilization in the United States, 1994-1996," *Family Planning Perspectives*, 33(4):161-165 (2001).
31. *Surgical Sterilization in the United States: Prevalence and Characteristics, 1965-95*, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, updated 6/25/98.
32. deBlois, Sr. J., & O'Rourke, Rev. K., "Introducing the Revised Directives," *Health Progress*, Apr. 1995. Also available online at: <http://www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9504&ARTICLE=D>. The article describes a sterilization performed to prevent predictable renal failure in a women if she should become pregnant, as an example of an impermissible contraceptive procedure that cannot be performed in a Catholic hospital.
33. Goldner, W., M.D., personal communication on file with the MergerWatch Project.
34. See, for example, Smugar, S., Spina, B., & Merz, J., "Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims," *American Journal of Public Health*, 90:1372 (2000); Simons, R., M.D., "Emergency Contraception for Sexual Assault Survivors: A Survey of Hospital Emergency Rooms in Pennsylvania," a master's thesis supervised by the faculty of the Johns Hopkins School of Hygiene and Public Health, May 2000; Bucar, L., *Caution: Catholic Health Care Restrictions May Be Hazardous to Your Health*, Catholics for a Free Choice (1999); and *Preventing Pregnancy After Rape: Does Your Hospital Provide Emergency Contraception to Rape Survivors?*, NARAL/NY Foundation (1999).
35. Smugar, S., Spina, B., & Merz, J., "Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims," *American Journal of Public Health*, 90:1372 (2000).
36. *Brownfield v. Daniel Freeman Marina Hospital*, 208 Cal. App. 3rd 405 (1989).
37. Stewart, F., & Trussell, J., "Prevention of Pregnancy Resulting From Rape: A Neglected Preventive Health Measure," *American Journal of Preventive Medicine*, 19(4):228-229 (2000).
38. Navarro, M., "Ethics of Giving AIDS Advice Troubles Catholic Hospitals," *New York Times*, Jan. 3, 1993.
39. National Conference of Catholic Bishops, *Called to Compassion and Responsibility: A Response to the HIV/AIDS Crisis*, United States Catholic Conference, p. 20 (1997).
40. *HIV Counseling, Testing, and Referral Standards and Guidelines*, U.S. Department of Health and Human Services, May 1994.
41. Miller, P., "The Lesser Evil: The Catholic Church and the AIDS Epidemic," *Conscience*, Catholics for a Free Choice, vol. XXII, no. 3, Autumn 2001.

42. Harmon, K., "When Conscience Limits Care," *Treatment Issues*, GMHC, vol. 15, no. 9, Sept. 2001.
43. Nelson, S., "Cutting Family Planning Service Hurts Poor, Says Client," *Troy Record*, May 16, 1996, p. C1; and Complaint, *Amelia E. v. Public Health Council* (N.Y. Supreme Ct., Albany Cnty, 1994).
44. See, "Birth Control for Moms," downloaded 10/15/01 from the Catholic Healthcare West website, at: www.chw.healththinkonline.com/dohealth/member/vitSelfCare.asp?scID=236. See also, Fu, H., Darroch, J., Haas, T., & Ranjit, N., "Contraceptive Failure Rates: New Estimates From the 1995 National Survey of Family Growth," *Family Planning Perspectives*, vol 31, no. 2, March/April 1999, available online at: www.agi-usa.org/pubs/journals/3105699.html.
45. O'Rourke, Rev. K., "Applying the Directives," *Health Progress*, July-Aug. 1998.
46. Transcript of New York State Public Health Council Establishment Committee, March 2, 1999, p. 194. Monsignor Regan is now a member of the New York State Public Health Council.
47. See, *Requena*, 517 A.2d 886 (N.J. Superior Ct. Ch. Div. 1986).
48. *Matter of Jobes*, 108 N.J. 394 (1987).
49. O'Rourke, Rev. K., "Development of Church Teaching on Prolonging Life," *Health Progress*, Jan.-Feb. 1988, and, "Applying the Directives," *Health Progress*, July-Aug. 1998. The article is available online at: www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9807&ARTICLE=E.
50. O'Rourke, Rev. K., "Applying the Directives," *Health Progress*, Jul.-Aug. 1998, The article is available online at: www.chausa.org/PUBS/PUBSART.ASP?ISSUE=HP9807&ARTICLE=E.
51. *Bartling v. Gendale Adventist Medical Center*, 163 Cal. App.3d 186 (1984).
52. 42 C.F.R. § 412.92. A hospital can be designated a sole community hospital if it meets certain other statutory criteria, including being located in an area where weather conditions make other hospitals inaccessible at least 30 days in each 2 out of 3 years, or local road conditions make the travel time to another like facility at least 45 minutes.
53. "Hospitals Help Put a Face on Rural Health," *Catholic Health World*, posted 9/4/01, downloaded from: www.chausa.org/PUBS/PUBSART.ASP?Issue=W010901&ARTICLE=C.
54. Mandelbaum-Schmid, J., "Their Religion, Your Rights," *Self*, May, 1999.
55. Correspondence with Dr. William van Druten, on file with MergerWatch.
56. Werthamer, C., "Controversial Clinic Not His Legacy," *Freeman*, Feb. 8, 1998.
57. Durkin, B. "Abortion View Gets Official in Trouble," *The Reporter Dispatch*, Mar. 6, 1998.
58. *Erickson v. The Bartell Drug Co.*, 2001 WL 649651 (W.D. Wash. 2001). The case can be downloaded from the National Women's Law Center website at: www.nwlc.org/pdf/erickson-case.pdf.
59. "Catholic Bishops Criticize Bush Policy on Embryo Research," Office of Communications, United States Conference of Catholic Bishops, Washington, D.C., downloaded 9/1/01 from the conference's website, at: www.nccbuscc.org/comm/archives/2001/01-142.htm.
60. See for example, *Ethical Issues in Human Stem Cell Research, Volume III: Religious Perspectives*, National Bioethics Advisory Commission (June 2000); Wolfe, K., "Stem Cell Research Poses Spiritual Quandary," *Baptist Standard*, Sept. 22, 1999, downloaded 11/6/01 from: www.baptiststandard.com/1999/9_22/pages/stemcell.html; and Evans, J., "Religious Communities and Stem Cell Research: Creating Meaningful Debate," downloaded 11/6/01 from the Pew Forum website at: <http://pewforum.org/projects/stemcell/bushanalysis.htm>.
61. McCormick, R., "Not What Catholic Hospitals Ordered," *Linacre Quarterly*, 39:21-25 (Feb. 1972).

62. U.S. Conference of Catholic Bishops, "Ethical and Religious Directives for Catholic Health Care Services," 4th ed., U.S. Catholic Conference, Jan. 2001.
63. Gold, R., "Conscience Makes a Comeback In the Age of Managed Care," *The Guttmacher Report on Public Policy*, vol. 1, no. 1, Feb., 1998. This article is available online at: www.agi-usa.org/pubs/journals/gr010101.html.
64. Boozang, K., "Deciding the Fate of Religious Hospitals in the Emerging Health Care Market," *Houston Law Review*, 31:1429 at 1481 (1995).
65. See, *Taylor v. St. Vincent's Hospital*, 369 F.Supp. 948 (D. Montana 1978).
66. Boozang, K., "Deciding the Fate of Religious Hospitals in the Emerging Health Care Market," at footnote 252.
67. Church amendment to the Health Programs Extension Act of 1973, Pub. L. No. 93-45 (enacted June 18, 1973).
68. Boozang, K., "Deciding the Fate of Religious Hospitals in the Emerging Health Care Market," at 1481.
69. Gold, R., "Conscience Makes a Comeback In the Age of Managed Care," *The Guttmacher Report on Public Policy*, vol. 1, no. 1, Feb., 1998. This article is available online at: www.agi-usa.org/pubs/journals/gr010101.html.
70. *Ibid.*
71. Balanced Budget Act of 1997, § 1396u-2(b)(3)(B).
72. *When Religion Compromises Women's Health Care*, NARAL/NY Foundation, March 2001.
73. See, for example, Platt, L., "Making Choice Real," *The American Prospect*, vol. 12, issue 17, Sept. 24, 2001 - Oct. 8, 2001; and *St. Agnes Hospital v. Riddick*, 748 F.Supp. 319 (D. Md. 1990). See also, Cook-Mac, B., "Abortion Training in Ob-Gyn Programs," downloaded 10/15/01 from: www.haverford.edu/wmbweb/writings/rcabortion.html.
74. ACGME Program Requirements for Residency Education in Obstetrics and Gynecology, ACGME, 2000. The requirements are available online at: www.acgme.org/req/220pr999.asp.
75. For an excellent discussion on the medical necessity for doctors to be trained in abortion procedures, see *St. Agnes Hospital v. Riddick*, 748 F.Supp. 319 (D. Md. 1990); see also, "Induced Abortion," *Facts in Brief*, The Alan Guttmacher Institute, 2/2000. The fact sheet is available online at: www.agi-usa.org/pubs/fb_induced_abortion.html.
76. 42 U.S.C. §238n.
77. June 7, 2000 memo in relation to A9359/S6253-A; downloaded 4/9/01 from: www.nyscatholicconference.org/budget/ltr000607-a9359.htm.
78. Lovett, K., "Egan: N.Y.'s Birth-Control Legislation 'Un-American'," *New York Post*, Mar. 14, 2001, p. 5.
79. Roser, M., "Seton to Limit Services at Brack," *Austin American-Statesman*, June 8, 2001.
80. Roser, M., Perkes, L., "City May Run Birth Control at Brack," *Austin American-Statesman*, Aug., 22, 2001.
81. Albanese, E., "Austin Council Weighs Plan to Allow A Separation of Church and Hospital," *The Bond Buyer*, Oct., 10, 2001.
82. Roser, M., "Brack Birth Control Plan is Put on Hold," *Austin American- Statesman*, Oct. 26, 2001.
83. Roser, M. "City, Seton are Close to a Final Agreement," *Austin American- Statesman*, Nov. 10, 2001.

84. Cunningham, N. "Cardinal: Church will Maintain Moral, Medical Principles," *Legislative Gazette*, Mar. 15, 1999.
85. NY Providers May Face Hobson's Choice: Compromise Ethics Or Abandon The Poor," *Catholic Health World*, June 9, 1998, downloaded 6/10/98 from: www.chausa.org/PUBS/PUBSART.ASP?PUB=VHW&ARTICLE=E.
86. Bernstein, Nina, *The Lost Children of Wilder*, New York, Pantheon Books, 2001.
87. *The Lost Children of Wilder*, at 124-130.
88. *The Lost Children of Wilder*, at 322.
89. See, *Wilder v. Bernstein*, 645 F.Supp. 1292 at 1307, (S.D. N.Y. 1986).
90. *The Lost Children of Wilder*, at 323, 331.
91. *The Lost Children of Wilder*, at 332.
92. Boozang, K., "Deciding the Fate of Religious Hospitals in the Emerging Health Care Market," *Houston Law Review*, 31:1429 (1995).
93. Boozang, K., "Deciding the Fate of Religious Hospitals in the Emerging Health Care Market," at 1430.
94. Boozang, K., "Deciding the Fate of Religious Hospitals in the Emerging Health Care Market," at 1446.
95. Boozang, K., "Developing Public Policy for Sectarian Providers: Accommodating Religious Beliefs and Obtaining Access to Care," *Journal of Law, Medicine & Ethics*, 24:90-98 (1996).
96. Ikemoto, L., "When a Hospital Becomes Catholic," *Mercer Law Review* 47:1087 (1996).
97. Smugar, S., Spina, B., & Merz, J., "Informed Consent for Emergency Contraception: Variability in Hospital Care of Rape Victims," *American Journal of Public Health*, 90:1372 (2000).
98. *Ibid.*
99. "The Spotlight Campaign: Exposing Non-Compliance Provisions, Northeast Regional Meeting, February 26-27, 2001," on file with MergerWatch.
100. *Ibid.*
101. *Brownfield v. Daniel Freeman Marina Hospital*, 208 Cal. App.3d 405 (1989). In this decision the California court stated that "When a rape victim can allege that a skilled practitioner of good standing would have provided her with information concerning and access to estrogen pregnancy prophylaxis under similar circumstances; that if such information had been provided to her she would have elected such treatment; and that damages have proximately resulted from the failure to provide her with information concerning this treatment option said rape victim can state a cause of action for damages for medical malpractice."
102. "Commitment to My Patients," American Medical Association, a copy of the publication can be downloaded at: www.infectioncenter.com/about/ourpatients.htm. For further information on physician responsibilities and medical ethics, see the American Medical Association's website (www.ama-assn.org/ama/pub/category/5280.html), which has a searchable database of ethical opinions and policies.
103. "Religious Coalition Launches Campaign to Fight Elimination of Reproductive Health Services," The Religious Coalition for Reproductive Choice, downloaded 9/14/01 from: www.rccrc.org/new/campaign.html.
104. September 3, 1997 letter to the Delaware Health Resources Board, from Clergy Concerned for Health Care in The City, on file with MergerWatch.

105. Excerpt from an April 24, 1995 statement of 26 Dutchess County clergy to the Vassar Brothers Hospital Trustees, excerpted in "Clergy and Theological Hospital Mergers," *Clergy Voices*, newsletter of the Planned Parenthood Federation of America Clergy Advisory Board, August 1995.
106. "Conscientious Exemptions and Reproductive Rights: Executive Summary, National Meeting," The Gund Foundation, ProChoice Resource Center, Reproductive Freedom Project of the American Civil Liberties Union, Aug., 2000.
107. "The Spotlight Campaign: Exposing Non-Compliance Provisions, Northeast Regional Meeting, February 26-27, 2001," on file with MergerWatch.
108. See, EEOC Decision, 12/14/00, and *Erickson v. Bartell Drug Company*, 2001 WL 649651 (W.D. Wash.).
109. "National Survey Finds Women Oppose Religious Control of Reproductive Health Services," Catholics For A Free Choice News Release, April 25, 2000, on file with MergerWatch.
110. Remarks at October 5, 1998 symposium "Mergers and Affiliations Between Religious and Non-Religious Health Care Institutions: Balancing the Competing Concerns," sponsored by the Association of the Bar of the City of New York.
111. *Employment Division v. Smith*, 494 U.S. 872.
112. *Smith* at 888.
113. *Smith* at 885.
114. *Smith*, at footnote 2.
115. *St. Agnes Hospital v. Riddick*, 748 F.Supp 319 (D. Md. 1990).
116. See, 42 USC § 290kk-1, 42 USC §300x-65 and 42 USC § 604(a).
117. "*Unlevel Playing Field*," p. 16. In litigation over this "vital civil rights safeguard," which is found in a religious employer exemption in Title VII of the Civil Rights Act, courts have interpreted the exemption as allowing a qualifying institution to not only give hiring preferences to those of the same faith as the religious employer, but to also allow the employer to make hiring and firing decisions based on an employee's conduct in his or her personal life. Courts have interpreted the exemption as allowing practices such as the following: the firing of unmarried, pregnant parochial school teachers because their pregnancies indicated they had engaged in nonmarital intercourse in violation of Church teachings (*Cline v. Catholic Diocese of Toledo*, 206 F.3d 651 (6th Cir. 2000) and *Ganzy v. Allen Christian School*, 995 F.Supp. 340 (E.D.N.Y. 1998)); the firing of a non-Catholic parochial school teacher by a Catholic school because her marriage was invalid under Church teachings (*Little v. Wuerl*, 929 F.2d 944 (3rd Cir. 1991), and the firing of a counselor because she is homosexual by a Baptist-affiliated home for children who are wards of the state (*Pedreira v. Kentucky Baptist Homes for Children*, 2001 U.S. Dist. LEXIS 10283; 86 Fair Empl. Prac. Cas. (BNA) 417 (W.D. Ky. 2001)).
118. See, Milbank, D., "Charity Cites Bush Help in Fight Against Gays: Salvation Army Wants Exemption from Laws," *Washington Post*, July 10, 2001, p. A1, and Rosin, H., "Charity's Image Shaken by Bias Flap," *Washington Post*, July 15, 2001, p. A5.
119. Milbank, D., "Bush Drops Rule On Hiring of Gays," *Washington Post*, July 11, 2001, p. A1.
120. "President Bush and 'Faith-Based' Initiatives: AU Report and Answers to Frequently Asked Questions," Americans United for Separation of Church and State, downloaded 9/10/01 from www.au.org/press/pr12601.htm.
121. Communication from Alex Luchenitser, Litigation Counsel, Americans United for Separation of Church and State, to Lois Utley (Oct., 5, 2001) on file with MergerWatch.

122. "Conscientious Exemptions and Reproductive Rights: Executive Summary, National Meeting," The Gund Foundation, ProChoice Resource Center, Reproductive Freedom Project of the American Civil Liberties Union, Aug., 2000.
123. Bonavoglia, A., "Co-Opting Conscience," *ProChoice Matters*, ProChoice Resource Center, Jan. 1999.
124. Estate of Thornton v. Caldor, 472 U.S. 703 (1985).
125. "Conscientious Exemptions and Reproductive Rights: Executive Summary, National Meeting," The Gund Foundation, ProChoice Resource Center, Reproductive Freedom Project of the American Civil Liberties Union, Aug., 2000.
126. "Religious or Conscientious Exemptions from Anti-Discrimination Laws: A Framework for Analysis," American Civil Liberties Union, Oct., 1999.
127. The Spotlight Campaign: Exposing Non-Compliance Provisions, Northeast Regional Meeting, February 26-27, 2001," on file with MergerWatch.
128. Kauffman, C. J., *Ministry & Meaning, A Religious History of Catholic Health Care in the United States*. Crossroad Publishing Company, (1995), p. 1.
129. "Religious or Conscientious Exemptions from Anti-Discrimination Laws: A Framework for Analysis," American Civil Liberties Union, Oct., 1999. Available online at: www.aclu.org/issues/reproduct/conscien-exemptions.htm.
130. California Health & Safety Code § 1367.25 and California Insurance Code § 10123.196.
131. Verified Complaint for Declaratory and Injunctive Relief, Catholic Charities of Sacramento v. State of California, filed July 20, 2000 in Superior Court of the State of California, Sacramento County.
132. Catholic Charities of Sacramento, Inc. v. Superior Court, 90 Cal. App. 4th 425 (2001).
133. "Prochoice Catholics Applaud Court Victory on Access to Contraception," Catholics for a Free Choice press release, July 2, 2001. Available online at: www.catholicsforchoice.org/new/pressrelease/070201CatholicCharities.htm.
134. Petition for Review from an Opinion of the Court of Appeal, Third Appellate District, in Catholic Charities of Sacramento, Inc. v. Superior Court, filed by Catholic Charities September, 2001.
135. 120 Cong. Rec. 12950-12954.
136. 120 Cong. Rec.12950.
137. 120 Cong. Rec. 12951.
138. 120 Cong. Rec. 12956.
139. See, for example, St. Elizabeth Community Hospital v. NLRB, 708 F.2d 1436 (9th Cir. 1983).
140. Tressler Lutheran Home v. NLRB, 677 F.2d 302 (3rd Cir. 1982).
141. NLRB v. St. Louis Christian Home, 663 F.2d 60 (8th Cir. 1981).
142. NLRB v. Catholic Bishop, 440 U.S. 490 (1979).
143. St. Elizabeth Hospital v. NLRB, 715 F.2d 1193 (7th Cir. 1983).
144. Tressler Lutheran Home v. NLRB, 677 F.2d 302 (3rd Cir. 1982).
145. NLRB v. St. Louis Christian Home, 663 F.2d 60 (8th Cir. 1981).
146. St. Elizabeth Community Hospital v. NLRB (708 F.2d 1436 (9th Cir. 1983).
147. Ukiah Valley Medical Center, 332 NLRB No. 59 (2000).

148. Boozang, K., "Developing Public Policy for Sectarian Providers: Accommodating Religious Beliefs and Obtaining Access to Care," *Journal of Law, Medicine & Ethics*, 24:90-98 (1996).
149. See, for example, Voolke Studolska, J., "An Unhealthy Alliance," *The Minnesota Women's Press*, Feb., 14, 2001, available online at: www.womenspress.com/newspaper/2001/16-24duluth.html; Weiss, B., "Did Women's Health Issues Kill This Hospital Merger?," *Medical Economics*, May 1999; Bellandi, D., "The People Strike Back," *Modern Healthcare*, Aug., 31, 1998 p. 60; Dinsmore, C., "Women's Health; A Casualty of Hospital Merger Mania," *Ms.*, July-Aug. 1998; Rather, J., "Saving Hospitals, But Not All Their Parts," *The New York Times*, Aug., 9, 1998; for more information, see the MergerWatch website at: www.mergerwatch.org.
150. See for example, Poppe, D., "Hospital Backs Off Abortion Rule," *Miami Herald*, May 30, 1998; "Physician Decisions and Catholic Directives: Who Will Decide What's Best for the Patients?," *Choice Notes*, Physicians for Reproductive Choice and Health, Vol. 3 No. 2, Spring 1998; and Bellandi, D., "The People Strike Back," *Modern Healthcare*, Aug., 31, 1998, p. 60.
151. Pearl, K., "Long Island Coalition Saves Services, Wins Disclosure," *ProChoice Ideas!*, ProChoice Resource Center, Winter 1999-2000.
152. *Ibid.*
153. Lagnado, L., "Religious Practice: Their Role Growing, Catholic Hospitals Juggle Doctrine and Medicine," *The Wall Street Journal*, Feb., 4, 1999, p. A1.
154. Bellandi, D., "Women's Service Cut: Rome's Scrutiny Ends Hospital Arrangement on Tubal Ligations," *Modern Healthcare*, Oct., 4, 1999 p. 17.
155. Bellandi, D., "Bishops Get Strict on Sterilizations," *Modern Healthcare*, June 18, 2001, p. 6. See also, McDonald, M., "The Limits of Cooperation," *The Catholic World Report*, Dec., 2000, p. 40.
156. 42 C.F.R. § 482.13.
157. 42 C.F.R. § 482.55.
158. 42 C.F.R. § 482.25.
159. See 24 C.F.R. § 1003.600, 24 C.F.R. § 574.300. Similar requirements are found in many HUD regulations, including section 202 and 811 programs that fund supportive residences for the elderly and disabled. These regulations were harshly criticized in the Office of Faith Based Initiatives' August, 2001 report, "*Unlevel Playing Field*," as barriers to faith-based organizations participating in federal social service programs.
160. 14 N.Y.C.R.R. § 633.4.
161. 14 N.Y.C.R.R. § 633.4(4)(xi).
162. 18 N.Y.C.R.R. § 508.1(h).
163. N.Y. Pub. Health Law § 2984(3).
164. N.Y. Pub. Health Law § 2984(a) and (b).
165. 42 C.F.R. § 489.102.
166. Final Decision, In re: The Purchase of Sharon Hospital, Inc. by Essent Healthcare, of Connecticut, Inc., Docket No. 01-486-01, State of Connecticut Office of the Attorney General, Nov. 26, 2001. The decision can be downloaded from: www.cslib.org/attygenl/mainlinks/tabin-dex12.htm.
167. 11 C.C.R. § 999.5.
168. N.J. Stat. Ann. 26:2H-7.11.
169. N.J. Stat. Ann. 26:2H-7.11.

170. 105 C.M.R. 130.020.

171. 105 C.M.R. 130.122(G).

172. Cohen, E., Morrison, J., *Hospital Mergers and the Threat to Women's Reproductive Health Services: Using Charitable Assets Laws to Fight Back*, National Women's Law Center, 2001.

173. "Preserving Consumer Choice in an Era of Religious/Secular Hospital Mergers," Official Policy Statement of the American Public Health Association, adopted Nov. 15, 2000.

174. *Rust v. Sullivan*, 500 U.S. 173 (1991). See also, *Legal Services Corp. v. Velazquez*, 121 S. Ct. 1043 (2001), where the Court further explained *Rust*, noting that "when the government establishes a subsidy for specified ends," the inclusion of restrictions, or strings, "may be necessary to define the limits and purposes of the program."

175. Melich, Tanya, *The Republican War Against Women: An Insider's Report From Behind the Lines*, Bantam Books, 1996.

176. California AB 525 codified at sections 1339.80, 1339.81 and 1363.02 of the state's Health and Safety Code, section 10604.1 of the state's Insurance Code and section 14016.8 of the state's Welfare and Institutions Code. The bill text is available online at: www.leginfo.ca.gov/pub/99-00/bill/asm/ab_0501-0550/



Organizations & Internet Resources

ACLU Reproductive Freedom Project

125 Broad Street, 18th Floor
New York NY 10004
Phone: 212-549-2633
Fax: 212-549-2652
www.aclu.org

Alan Gutmacher Institute

1120 Connecticut Avenue, Suite 460
Washington, DC 20036
Phone: 202-296-4012
Fax: 202-223-5756
www.agi-usa.org

Americans United for Separation of Church & State

518 C. Street NE
Washington, DC 20002
Phone: 202-466-3234
Fax: 202-466-2587
www.au.org

Catholics for a Free Choice

1436 U Street NW, Suite 301
Washington DC 20009-3997
Phone: 202-986-6093
Fax: 202-332-7995
www.cath4choice.org

California Women's Law Center

3460 Wilshire Blvd. Suite 1102
Los Angeles, CA 90010
Phone: 213-637-9900
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www.cwlc.org

Center for Reproductive Law and Policy

120 Wall Street, 14th Floor
New York NY 10005
Phone: 917-637-3600
Fax: 917-637-3666
www.crlp.org

Death with Dignity

11 Dupont Circle NW, Suite 202
Washington, DC 20036
Phone: 202-969-1669
Fax: 202-969-1668
www.deathwithdignity.org

MergerWatch

Education Fund of Family Planning Advocates of NYS

17 Elk Street
Albany NY 12207
Phone: 518-436-8408
Fax: 518-436-1048
www.mergerwatch.org

Medical Students for Choice

2041 Bancroft Way, Suite 201
Berkeley, CA 94704
Phone: 510-540-1195
Fax: 510-540-1199
www.ms4c.org

National Health Law Program

2639 S. La Cienega Blvd.
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**Physicians for Reproductive
Choice and Health**
55 W. 39th Street, 10th Floor
New York NY 10018
Phone: 646-366-1890
Fax: 646-366-1897
www.prch.org

**Planned Parenthood
Federation of America**
810 Seventh Avenue
New York, NY 10011
www.plannedparenthood.org
Phone: 212-541-7800

Prochoice Resource Center

16 Willett Avenue
Port Chester, NY 10573
Phone: 1-800-733-1973
Fax: 914-690-0958
www.ProChoiceResource.org

**Religious Coalition for
Reproductive Choice**
1025 Vermont Avenue NW, Suite 1130
Washington DC 20005
Phone: 202-628-7700
Fax: 202-628-7716
www.rcrc.com

Internet Resources

Adventist Health
www.adventisthealth.org

**Catholic Health Association
of the United States**
www.chausa.org

**MergerWatch
Education Fund of
Family Planning Advocates of NYS**
www.mergerwatch.org

**The Henry J. Kaiser
Family Foundation**
www.kaisernetwork.org

**United States Conference
of Catholic Bishops**
www.nccbuscc.org



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Data Table 1

Community Hospitals and Beds* by Sponsorship Type — National 1998

| | <i>Number of Hospitals</i> | <i>Number of Hospital Beds</i> | <i>Percent of Total Hospitals</i> | <i>Percent of Total Hospital Beds</i> |
|-----------------------------|----------------------------|--------------------------------|-----------------------------------|---------------------------------------|
| Religious | 585 | 115,830 | 13.41% | 17.80% |
| Nonsectarian Not-For-Profit | 1,966 | 327,259 | 45.06% | 50.28% |
| Public | 1,087 | 106,583 | 24.91% | 16.38% |
| For-Profit | 725 | 101,190 | 16.62% | 15.55% |
| Total | 4,363 | 650,862 | 100.00% | 100.01% |

*Beds in service

Data Table 2

Community Hospitals and Beds* by Sponsorship Type — National 1999

| | <i>Number of Hospitals</i> | <i>Number of Hospital Beds</i> | <i>Percent of Total Hospitals</i> | <i>Percent of Total Hospital Beds</i> |
|-----------------------------|----------------------------|--------------------------------|-----------------------------------|---------------------------------------|
| Religious | 604 | 126,662 | 13.21% | 17.93% |
| Nonsectarian Not-for-Profit | 2,111 | 357,782 | 46.16% | 50.63% |
| Public | 1,149 | 114,813 | 25.13% | 16.25% |
| For-Profit | 709 | 107,362 | 15.50% | 15.19% |
| Total | 4,573 | 706,619 | 100.00% | 100.00% |

*Beds in service

Data Table 3 *Community Hospitals and Beds* by Sponsorship Type — Six-State Study 1998*

| | <i>Number of Hospitals</i> | <i>Number of Beds</i> | <i>Hospitals by Sponsorship Type as Percent Total Hospitals</i> | <i>Beds by Sponsorship Type as Percent of Total Beds</i> |
|-----------------------------------|----------------------------|-----------------------|---|--|
| California | | | | |
| Religious | 56 | 11,222 | 14.66% | 16.80% |
| Nonsectarian Not-For-Profit | 157 | 33,467 | 41.10% | 50.11% |
| Public | 67 | 8,940 | 17.54% | 13.39% |
| For-Profit | 102 | 13,160 | 26.70% | 19.70% |
| Total | 382 | 66,789 | | |
| Florida | | | | |
| Religious | 16 | 5,544 | 9.30% | 12.95% |
| Nonsectarian Not-For-Profit | 55 | 15,315 | 31.98% | 35.78% |
| Public | 19 | 5,472 | 11.05% | 12.78% |
| For-Profit | 82 | 16,478 | 47.67% | 38.49% |
| Total | 172 | 42,809 | | |
| Maryland | | | | |
| Religious | 5 | 1,533 | 15.63% | 17.13% |
| Nonsectarian Not-For-Profit | 26 | 7,032 | 81.25% | 78.60% |
| Public | 0 | 0 | 0.00% | 0.00% |
| For-Profit | 1 | 382 | 3.13% | 4.27% |
| Total | 32 | 8,947 | | |
| Minnesota | | | | |
| Religious | 4 | 575 | 7.69% | 11.76% |
| Nonsectarian Not-For-Profit | 27 | 2,786 | 51.92% | 57.00% |
| Public | 19 | 1,383 | 36.54% | 28.29% |
| For-Profit | 2 | 144 | 3.85% | 2.95% |
| Total | 52 | 4,888 | | |
| New Jersey | | | | |
| Religious | 16 | 4,745 | 19.75% | 20.24% |
| Nonsectarian Not-For-Profit | 60 | 17,545 | 74.07% | 74.83% |
| Public | 2 | 646 | 2.47% | 2.76% |
| For-Profit | 3 | 509 | 3.70% | 2.17% |
| Total | 81 | 23,445 | | |
| New York | | | | |
| Religious | 29 | 7,915 | 16.20% | 16.88% |
| Nonsectarian Not-For-Profit | 134 | 36,156 | 74.86% | 77.13% |
| Public | 11 | 2,041 | 6.15% | 4.35% |
| For-Profit | 5 | 766 | 2.79% | 1.63% |
| Total | 179 | 46,878 | | |
| Total for Six-State Sample | | | | |
| Religious | 126 | 31,534 | 14.03% | 16.28% |
| Nonsectarian Not-For-Profit | 459 | 112,301 | 51.11% | 57.96% |
| Public | 118 | 18,482 | 13.14% | 9.54% |
| For-Profit | 195 | 31,439 | 21.71% | 16.23% |
| Total | 898 | 193,756 | | |

*Beds in service

Religious Hospital Sole Community Provider List 1998

| Hospital Name | State | Beds |
|---|--------------|-------------|
| Providence Kodiak Island Medical Center | AK | 30 |
| South Peninsula Hospital | AK | 16 |
| Baptist Medical Center Dekalb | AL | 134 |
| Carondelet Holy Cross Hospital Inc | AZ | 41 |
| Mercy Medical Center Mt Shasta | CA | 37 |
| Redbud Community Hospital | CA | 43 |
| St Elizabeth Community Hospital | CA | 82 |
| Centura Hlth-St Thomas More Hospital | CO | 63 |
| Mercy Medical Center Of Durango | CO | 96 |
| St Mary's Hospital And Medical Center | CO | 227 |
| St Vincent General Hospital District | CO | 37 |
| Mercy Medical Center - North Iowa | IA | 226 |
| Clearwater Valley Hospital | ID | 23 |
| Saint James Hospital | IL | 77 |
| Central Kansas Medical Center | KS | 288 |
| Mt Carmel Medical Center | KS | 167 |
| St Catherine Hospital | KS | 90 |
| Pikeville Methodist Hospital | KY | 221 |
| Mercy Hospital | MI | 57 |
| St Francis Hospital | MI | 80 |
| Tawas St Joseph Hospital | MI | 54 |
| Breech Regional Medical Center | MO | 49 |
| Benefis Healthcare | MT | 387 |
| Holy Rosary Health Center | MT | 57 |
| St James Community Hospital | MT | 173 |
| Carrington Health Center | ND | 38 |
| Heart Of America Medical Center | ND | 42 |
| Mercy Hospital | ND | 89 |
| Mercy Hospital, | ND | 57 |
| The Mercy Medical Center | ND | 99 |
| Oakes Community Hospital | ND | 34 |
| St Andrew's Health Center | ND | 40 |
| St Joseph's Hospital/Health Center | ND | 126 |
| Good Shepherd Community Hospital | OR | 59 |
| St Anthony Hospital | OR | 55 |
| St Elizabeth Health Services, Inc | OR | 42 |
| Tillamook County General Hospital | OR | 56 |
| Avera Sacred Heart Hospital | SD | 162 |
| Avera St Luke's | SD | 134 |
| St Mary's Hospital | SD | 106 |
| Jellico Community Hospital | TN | 62 |
| Christus Spohn Hospital Beeville | TX | 81 |
| Christus Spohn Hospital Kleberg | TX | 100 |
| Madison St Joseph Health Center | TX | 31 |
| Providence Centralia Hospital | WA | 84 |
| St John Medical Center | WA | 198 |
| Langlade Memorial Hospital | WI | 55 |
| St Agnes Hospital | WI | 150 |

** some hospitals are religious through affiliation and have names that may appear non-sectarian*

Data Table 5

Government Funding of Hospitals — National 1998

| | <i>Number of Hospitals</i> | <i>Gross Patient Revenue</i> | | | <i>Other Revenue</i> | |
|------------------------------|----------------------------|------------------------------|-----------------|------------------------------------|---------------------------------------|----------------------------------|
| | | <i>Medicare</i> | <i>Medicaid</i> | <i>Total Gross Patient Revenue</i> | <i>Disproportionate Share Payment</i> | <i>Government Appropriations</i> |
| Total - All 50 States | | | | | | |
| Religious | 585 | \$35,666,664,612 | N/A | \$91,251,436,926 | \$682,991,980 | \$149,067,954 |
| Nonsectarian Not-For-Profit | 1,966 | \$92,525,620,411 | N/A | \$247,366,495,561 | \$1,841,096,532 | \$627,160,827 |
| Public | 1,087 | \$19,526,205,264 | N/A | \$64,939,199,712 | \$713,250,040 | \$2,617,383,428 |
| For-Profit | 725 | \$30,366,595,014 | N/A | \$76,795,423,740 | \$620,829,552 | \$380,930,363 |
| Total | 4,363 | \$178,085,085,302 | N/A | \$480,352,555,939 | \$3,858,168,103 | \$3,774,542,573 |

Data Table 6

Government Funding of Hospitals — National 1999

| | <i>Number of Hospitals</i> | <i>Gross Patient Revenue</i> | | | <i>Other Revenue</i> | |
|------------------------------|----------------------------|------------------------------|-----------------|------------------------------------|---------------------------------------|----------------------------------|
| | | <i>Medicare</i> | <i>Medicaid</i> | <i>Total Gross Patient Revenue</i> | <i>Disproportionate Share Payment</i> | <i>Government Appropriations</i> |
| Total - All 50 States | | | | | | |
| Religious | 604 | \$41,310,981,072 | N/A | \$114,893,895,258 | \$759,598,814 | \$119,939,528 |
| Nonsectarian Not-For-Profit | 2,111 | \$110,881,309,159 | N/A | \$317,587,774,762 | \$2,070,838,183 | \$569,467,669 |
| Public | 1,149 | \$23,183,995,099 | N/A | \$84,507,889,352 | \$824,855,529 | \$2,881,118,922 |
| For-Profit | 709 | \$32,072,895,344 | N/A | \$92,161,023,117 | \$685,159,858 | \$278,487,186 |
| Total | 4,573 | \$207,449,180,674 | N/A | \$609,150,582,489 | \$4,340,452,384 | \$3,849,013,306 |

Data Table 7

Government Funding of Hospitals — Six-State Study 1998

| | Number of Hospitals | Gross Patient Revenue | | | Other Revenue | |
|-----------------------------------|---------------------|-------------------------|-------------------------|-----------------------------|--------------------------------|---------------------------|
| | | Medicare | Medicaid | Total Gross Patient Revenue | Disproportionate Share Payment | Government Appropriations |
| California | | | | | | |
| Religious | 56 | \$4,138,639,528 | \$1,821,729,232 | \$12,435,710,365 | \$160,013,756 | \$476,626 |
| Nonsectarian Not-For-Profit | 157 | \$10,637,343,520 | \$4,060,424,722 | \$32,678,095,003 | \$287,588,448 | \$70,583,393 |
| Public | 67 | \$1,896,816,287 | \$3,431,660,337 | \$9,331,768,084 | \$116,604,854 | \$493,879,622 |
| For-Profit | 102 | \$4,726,183,711 | \$2,592,953,029 | \$13,724,879,439 | \$170,293,660 | \$349,636,435 |
| Total | 382 | \$21,398,983,045 | \$11,906,767,320 | \$68,170,452,891 | \$734,500,718 | \$914,576,076 |
| Florida | | | | | | |
| Religious | 16 | \$1,812,828,062 | \$393,755,122 | \$5,254,698,189 | \$38,891,156 | \$5,445,221 |
| Nonsectarian Not-For-Profit | 55 | \$5,133,724,731 | \$1,271,007,879 | \$13,096,898,057 | \$87,428,324 | \$14,706,013 |
| Public | 19 | \$1,229,673,511 | \$752,043,745 | \$5,112,015,982 | \$36,722,740 | \$269,813,826 |
| For-Profit | 82 | \$6,190,056,098 | \$964,141,446 | \$14,387,061,746 | \$92,035,625 | \$8,974,986 |
| Total | 172 | \$14,366,282,402 | \$3,380,948,192 | \$37,850,673,974 | \$255,077,846 | \$298,940,046 |
| Maryland | | | | | | |
| Religious | 5 | \$206,169,091 | \$43,297,700 | \$626,425,943 | \$9,039,156 | \$0 |
| Nonsectarian Not-For-Profit | 26 | \$1,098,630,020 | \$252,135,300 | \$3,162,832,703 | \$17,785,415 | \$1,864,774 |
| Public | 0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| For-Profit | 1 | \$37,238,736 | \$12,291,100 | \$113,970,050 | \$0 | \$0 |
| Total | 32 | \$1,342,037,848 | \$307,724,100 | \$3,903,228,696 | \$26,824,571 | \$1,864,774 |
| Minnesota | | | | | | |
| Religious | 4 | \$164,074,937 | \$36,424,737 | \$362,172,000 | \$1,902,278 | \$0 |
| Nonsectarian Not-For-Profit | 27 | \$752,713,993 | \$135,844,185 | \$2,129,257,375 | \$5,895,125 | \$0 |
| Public | 19 | \$257,650,444 | \$218,274,812 | \$821,937,465 | \$9,002,724 | \$18,361,625 |
| For-Profit | 2 | \$16,693,949 | \$16,693,344 | \$47,813,574 | \$0 | \$0 |
| Total | 52 | \$1,191,133,323 | \$407,237,078 | \$3,361,180,414 | \$16,800,127 | \$18,361,625 |
| New Jersey | | | | | | |
| Religious | 16 | \$1,977,664,521 | \$390,554,000 | \$4,078,174,119 | \$37,414,832 | \$55,021,496 |
| Nonsectarian Not-For-Profit | 60 | \$7,478,007,310 | \$1,162,620,000 | \$16,468,196,248 | \$63,549,185 | \$13,900,955 |
| Public | 2 | \$110,802,007 | \$200,887,000 | \$570,800,463 | \$10,125,147 | \$70,389,234 |
| For-Profit | 3 | \$168,497,053 | \$18,673,000 | \$377,999,845 | \$342,308 | \$0 |
| Total | 81 | \$9,734,970,891 | \$1,772,734,000 | \$21,495,170,675 | \$111,431,472 | \$139,311,685 |
| New York | | | | | | |
| Religious | 29 | \$2,072,010,767 | \$685,186,488 | \$5,088,820,427 | \$59,330,220 | \$28,944,381 |
| Nonsectarian Not-For-Profit | 134 | \$9,706,316,067 | \$5,373,633,578 | \$26,185,781,308 | \$384,205,595 | \$80,562,071 |
| Public | 11 | \$396,669,226 | \$238,649,531 | \$1,403,877,846 | \$19,366,847 | \$44,623,243 |
| For-Profit | 5 | \$149,946,970 | \$51,110,719 | \$375,856,630 | \$5,271,033 | \$0 |
| Total | 179 | \$12,324,943,030 | \$6,348,580,316 | \$33,054,336,211 | \$468,173,695 | \$154,129,695 |
| Total for Six-State Sample | | | | | | |
| Religious | 126 | \$10,371,386,906 | \$3,370,947,279 | \$27,846,001,043 | \$306,591,398 | \$89,887,724 |
| Nonsectarian Not-For-Profit | 459 | \$34,806,735,641 | \$12,255,665,664 | \$93,721,060,694 | \$846,452,092 | \$181,617,206 |
| Public | 118 | \$3,891,611,474 | \$4,841,515,425 | \$17,240,399,840 | \$191,822,312 | \$897,067,550 |
| For-Profit | 195 | \$11,288,616,518 | \$3,655,862,638 | \$29,027,581,284 | \$267,942,626 | \$358,611,420 |
| Total | 898 | \$60,358,350,539 | \$24,123,991,006 | \$167,835,042,861 | \$1,612,808,428 | \$1,527,183,900 |

Data Table 8

Government Funding of Hospitals as Percentage of Total Gross Patient Revenue — National 1998

| | <i>Number of Hospitals</i> | <i>Gross Patient Revenue</i> | | <i>Gross Patient Revenue</i> | |
|------------------------------|----------------------------|------------------------------|-------------------|---------------------------------------|----------------------------------|
| | | <i>Medicare</i> | <i>All Other*</i> | <i>Disproportionate Share Payment</i> | <i>Government Appropriations</i> |
| Total - All 50 States | | | | | |
| Religious | 585 | 39.09% | 60.91% | 0.75% | 0.16% |
| Nonsectarian Not-For-Profit | 1,966 | 37.40% | 62.60% | 0.74% | 0.25% |
| Public | 1,087 | 30.07% | 69.93% | 1.10% | 4.03% |
| For-Profit | 725 | 39.54% | 60.46% | 0.81% | 0.50% |
| Total | 4,363 | 37.07% | 62.93% | 0.80% | 0.79% |

* Includes commercial insurance, private pay, and other third party payors, including Medicaid.

Data Table 9

Government Funding of Hospitals as Percentage of Total Gross Patient Revenue — National 1999

| | <i>Number of Hospitals</i> | <i>Gross Patient Revenue</i> | | <i>Gross Patient Revenue</i> | |
|------------------------------|----------------------------|------------------------------|-------------------|---------------------------------------|----------------------------------|
| | | <i>Medicare</i> | <i>All Other*</i> | <i>Disproportionate Share Payment</i> | <i>Government Appropriations</i> |
| Total - All 50 States | | | | | |
| Religious | 604 | 35.96% | 64.04% | 0.66% | 0.10% |
| Nonsectarian Not-For-Profit | 2,111 | 34.91% | 65.09% | 0.65% | 0.18% |
| Public | 1,149 | 27.43% | 72.57% | 0.98% | 3.41% |
| For-Profit | 709 | 34.80% | 65.20% | 0.74% | 0.30% |
| Total | 4,573 | 34.06% | 65.94% | 0.71% | 0.63% |

* Includes commercial insurance, private pay, and other third party payors, including Medicaid.

Data Table 10

Government Funding of Hospitals as Percentage of Total Gross Patient Revenue — Six-State Study 1998

| | Number of Hospitals | Gross Patient Revenue | | | Other Revenue | |
|-----------------------------------|---------------------|-----------------------|---------------|---------------|--------------------------------|---------------------------|
| | | Medicare | Medicaid | All Other* | Disproportionate Share Payment | Government Appropriations |
| California | | | | | | |
| Religious | 56 | 33.28% | 14.65% | 52.07% | 1.29% | 0.00% |
| Nonsectarian Not-For-Profit | 157 | 32.55% | 12.43% | 55.02% | 0.88% | 0.22% |
| Public | 67 | 20.33% | 36.77% | 42.90% | 1.25% | 5.29% |
| For-Profit | 102 | 34.44% | 18.89% | 46.67% | 1.24% | 2.55% |
| Total | 382 | 31.39% | 17.47% | 51.14% | 1.08% | 1.34% |
| Florida | | | | | | |
| Religious | 16 | 34.50% | 7.49% | 58.01% | 0.74% | 0.10% |
| Nonsectarian Not-For-Profit | 55 | 39.20% | 9.70% | 51.10% | 0.67% | 0.11% |
| Public | 19 | 24.05% | 14.71% | 61.23% | 0.72% | 5.28% |
| For-Profit | 82 | 43.03% | 6.70% | 50.27% | 0.64% | 0.06% |
| Total | 172 | 37.96% | 8.93% | 53.11% | 0.67% | 0.79% |
| Maryland | | | | | | |
| Religious | 5 | 32.91% | 6.91% | 60.18% | 1.44% | 0.00% |
| Nonsectarian Not-For-Profit | 26 | 34.74% | 7.97% | 57.29% | 0.56% | 0.06% |
| Public | 0 | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| For-Profit | 1 | 32.67% | 10.78% | 56.54% | 0.00% | 0.00% |
| Total | 32 | 34.38% | 7.88% | 57.73% | 0.69% | 0.05% |
| Minnesota | | | | | | |
| Religious | 4 | 45.30% | 10.06% | 44.64% | 0.53% | 0.00% |
| Nonsectarian Not-For-Profit | 27 | 35.35% | 6.38% | 58.27% | 0.28% | 0.00% |
| Public | 19 | 31.35% | 26.56% | 42.10% | 1.10% | 2.23% |
| For-Profit | 2 | 34.91% | 34.91% | 30.17% | 0.00% | 0.00% |
| Total | 52 | 35.44% | 12.12% | 52.45% | 0.50% | 0.55% |
| New Jersey | | | | | | |
| Religious | 16 | 48.49% | 9.58% | 41.93% | 0.92% | 1.35% |
| Nonsectarian Not-For-Profit | 60 | 45.41% | 7.06% | 47.53% | 0.39% | 0.08% |
| Public | 2 | 19.41% | 35.19% | 45.39% | 1.77% | 12.33% |
| For-Profit | 3 | 44.58% | 4.94% | 50.48% | 0.09% | 0.00% |
| Total | 81 | 45.29% | 8.25% | 46.46% | 0.52% | 0.65% |
| New York | | | | | | |
| Religious | 29 | 40.72% | 13.46% | 45.82% | 1.17% | 0.57% |
| Nonsectarian Not-For-Profit | 134 | 37.07% | 20.52% | 42.41% | 1.47% | 0.31% |
| Public | 11 | 28.26% | 17.00% | 54.75% | 1.38% | 3.18% |
| For-Profit | 5 | 39.89% | 13.60% | 46.51% | 1.40% | 0.00% |
| Total | 179 | 37.29% | 19.21% | 43.51% | 1.42% | 0.47% |
| Total for Six-State Sample | | | | | | |
| Religious | 126 | 37.25% | 12.11% | 50.65% | 1.10% | 0.32% |
| Nonsectarian Not-For-Profit | 459 | 37.14% | 13.08% | 49.78% | 0.90% | 0.19% |
| Public | 118 | 22.57% | 28.08% | 49.34% | 1.11% | 5.20% |
| For-Profit | 195 | 38.89% | 12.59% | 48.52% | 0.92% | 1.24% |
| Total | 898 | 35.96% | 14.37% | 49.66% | 0.96% | 0.91% |

* Includes commercial insurance, private pay, and other third party payors.

Data Table 11

Inpatient Days by Payor — National 1998

| | <i>Number of Hospitals</i> | <i>Inpatient Days</i> | | | <i>Inpatient Days by Payor as % of Total</i> | | | |
|------------------------------|----------------------------|-----------------------|-------------------|---------------------------|--|-------------------|---------------------------------|--------------------------------|
| | | <i>Medicare</i> | <i>Medicaid</i> | <i>Total Patient Days</i> | <i>Medicare %</i> | <i>Medicaid %</i> | <i>Total Gov't*</i> <i>%</i> | <i>Non Gov't**</i> <i>%</i> |
| Total - All 50 States | | | | | | | | |
| Religious | 585 | 10,739,328 | 2,838,264 | 23,447,888 | 45.80% | 12.10% | 57.91% | 42.09% |
| Nonsectarian Not-For-Profit | 1,966 | 28,416,268 | 9,158,856 | 65,981,603 | 43.07% | 13.88% | 56.95% | 43.05% |
| Public | 1,087 | 7,184,102 | 4,092,312 | 19,261,290 | 37.30% | 21.25% | 58.54% | 41.46% |
| For-Profit | 725 | 7,664,704 | 2,381,313 | 16,915,781 | 45.31% | 14.08% | 59.39% | 40.61% |
| Total | 4,363 | 54,004,402 | 18,470,746 | 125,606,563 | 42.99% | 14.71% | 57.70% | 42.30% |

* Medicare and Medicaid.

** Includes commercial insurance, private pay, and other third party payors.

Data Table 12

Inpatient Days by Payor — National 1999

| | <i>Number of Hospitals</i> | <i>Inpatient Days</i> | | | <i>Inpatient Days by Payor as % of Total</i> | | | |
|------------------------------|----------------------------|-----------------------|-------------------|---------------------------|--|-------------------|---------------------------------|--------------------------------|
| | | <i>Medicare</i> | <i>Medicaid</i> | <i>Total Patient Days</i> | <i>Medicare %</i> | <i>Medicaid %</i> | <i>Total Gov't*</i> <i>%</i> | <i>Non Gov't**</i> <i>%</i> |
| Total - All 50 States | | | | | | | | |
| Religious | 604 | 11,521,828 | 3,001,232 | 25,951,987 | 44.40% | 11.56% | 55.96% | 44.04% |
| Nonsectarian Not-For-Profit | 2,111 | 31,588,458 | 8,863,967 | 73,399,377 | 43.04% | 12.08% | 55.11% | 44.89% |
| Public | 1,149 | 7,819,323 | 4,431,604 | 20,847,928 | 37.51% | 21.26% | 58.76% | 41.24% |
| For-Profit | 709 | 7,753,639 | 2,551,047 | 18,209,497 | 42.58% | 14.01% | 56.59% | 43.41% |
| Total | 4,573 | 58,683,249 | 18,847,850 | 138,408,789 | 42.40% | 13.62% | 56.02% | 43.98% |

* Medicare and Medicaid.

** Includes commercial insurance, private pay, and other third party payors.

Data Table 13

Inpatient Days by Payor — Six-State Study 1998

| | Number of Hospitals | Inpatient Days | | | Inpatient Days by Payor as % of Total | | | |
|-----------------------------------|---------------------|-------------------|------------------|--------------------|---------------------------------------|---------------|----------------|---------------|
| | | Medicare | Medicaid | Total Patient Days | Medicare % | Medicaid % | Total Gov't* % | Non Gov't** % |
| California | | | | | | | | |
| Religious | 62 | 826,524 | 452,246 | 2,310,074 | 35.78% | 19.58% | 55.36% | 44.64% |
| Nonsectarian Not-For-Profit | 163 | 1,705,776 | 969,051 | 6,611,363 | 25.80% | 14.66% | 40.46% | 59.54% |
| Public | 80 | 433,987 | 729,885 | 2,074,800 | 20.92% | 35.18% | 56.10% | 43.90% |
| For-Profit | 105 | 822,559 | 520,842 | 2,248,765 | 36.58% | 23.16% | 59.74% | 40.26% |
| Total | 410 | 3,788,846 | 2,672,024 | 13,245,003 | 28.61% | 20.17% | 48.78% | 51.22% |
| Florida | | | | | | | | |
| Religious | 19 | 459,085 | 129,809 | 1,156,538 | 39.69% | 11.22% | 50.92% | 49.08% |
| Nonsectarian Not-For-Profit | 61 | 1,388,338 | 386,815 | 3,183,525 | 43.61% | 12.15% | 55.76% | 44.24% |
| Public | 22 | 306,747 | 240,299 | 1,131,872 | 27.10% | 21.23% | 48.33% | 51.67% |
| For-Profit | 86 | 1,461,849 | 281,182 | 3,011,910 | 48.54% | 9.34% | 57.87% | 42.13% |
| Total | 188 | 3,616,019 | 1,038,105 | 8,483,844 | 42.62% | 12.24% | 54.86% | 45.14% |
| Maryland | | | | | | | | |
| Religious | 5 | 135,386 | 34,486 | 328,979 | 41.15% | 10.48% | 51.64% | 48.36% |
| Nonsectarian Not-For-Profit | 29 | 609,397 | 203,551 | 1,581,683 | 38.53% | 12.87% | 51.40% | 48.60% |
| Public | 2 | 3,914 | 10,901 | 20,236 | 19.34% | 53.87% | 73.21% | 26.79% |
| For-Profit | 1 | 27,691 | 7,509 | 57,717 | 47.98% | 13.01% | 60.99% | 39.01% |
| Total | 37 | 776,388 | 256,447 | 1,988,615 | 39.04% | 12.90% | 51.94% | 48.06% |
| Minnesota | | | | | | | | |
| Religious | 5 | 60,601 | 14,844 | 113,950 | 53.18% | 13.03% | 66.21% | 33.79% |
| Nonsectarian Not-For-Profit | 28 | 215,771 | 50,540 | 546,702 | 39.47% | 9.24% | 48.71% | 51.29% |
| Public | 19 | 81,824 | 38,037 | 191,146 | 42.81% | 19.90% | 62.71% | 37.29% |
| For-Profit | 2 | 8,929 | 2,406 | 16,946 | 52.69% | 14.20% | 66.89% | 33.11% |
| Total | 54 | 367,125 | 105,827 | 868,744 | 42.26% | 12.18% | 54.44% | 45.56% |
| New Jersey | | | | | | | | |
| Religious | 17 | 541,731 | 87,290 | 1,115,705 | 48.56% | 7.82% | 56.38% | 43.62% |
| Nonsectarian Not-For-Profit | 61 | 2,017,038 | 244,147 | 4,092,685 | 49.28% | 5.97% | 55.25% | 44.75% |
| Public | 2 | 31,110 | 56,819 | 153,831 | 20.22% | 36.94% | 57.16% | 42.84% |
| For-Profit | 3 | 54,429 | 3,235 | 106,832 | 50.95% | 3.03% | 53.98% | 46.02% |
| Total | 83 | 2,644,308 | 391,491 | 5,469,053 | 48.35% | 7.16% | 55.51% | 44.49% |
| New York | | | | | | | | |
| Religious | 31 | 967,674 | 346,298 | 2,002,438 | 48.32% | 17.29% | 65.62% | 34.38% |
| Nonsectarian Not-For-Profit | 139 | 3,804,356 | 1,847,337 | 8,970,623 | 42.41% | 20.59% | 63.00% | 37.00% |
| Public | 11 | 154,770 | 88,043 | 439,980 | 35.18% | 20.01% | 55.19% | 44.81% |
| For-Profit | 6 | 113,235 | 43,791 | 223,997 | 50.55% | 19.55% | 70.10% | 29.90% |
| Total | 187 | 5,040,035 | 2,325,469 | 11,637,038 | 43.31% | 19.98% | 63.29% | 36.71% |
| Total for Six-State Sample | | | | | | | | |
| Religious | 139 | 2,991,001 | 1,064,973 | 7,027,684 | 42.56% | 15.15% | 57.71% | 42.29% |
| Nonsectarian Not-For-Profit | 481 | 9,740,677 | 3,701,441 | 24,986,581 | 38.98% | 14.81% | 53.80% | 46.20% |
| Public | 136 | 1,012,352 | 1,163,984 | 4,011,865 | 25.23% | 29.01% | 54.25% | 45.75% |
| For-Profit | 203 | 2,488,691 | 858,965 | 5,666,167 | 43.92% | 15.16% | 59.08% | 40.92% |
| Total | 959 | 16,232,722 | 6,789,363 | 41,692,297 | 38.93% | 16.28% | 55.22% | 44.78% |

* Medicare and Medicaid.

** Includes commercial insurance, private pay, and other third party payors.

Data Table 14

Inpatient Discharges by Payor — National 1998

| | <i>Number of Hospitals</i> | <i>Inpatient Discharges</i> | | | <i>Inpatient Discharges by Payor as % of Total</i> | | | |
|------------------------------|----------------------------|-----------------------------|------------------|---------------------------------|--|-------------------|---------------------------------|--------------------------------|
| | | <i>Medicare</i> | <i>Medicaid</i> | <i>Total Patient Discharges</i> | <i>Medicare %</i> | <i>Medicaid %</i> | <i>Total Gov't*</i> <i>%</i> | <i>Non Gov't**</i> <i>%</i> |
| Total - All 50 States | | | | | | | | |
| Religious | 585 | 1,758,502 | 575,765 | 4,758,473 | 36.96% | 12.10% | 49.05% | 50.95% |
| Nonsectarian Not-For-Profit | 1,966 | 4,653,386 | 1,762,604 | 13,254,698 | 35.11% | 13.30% | 48.41% | 51.59% |
| Public | 1,087 | 1,229,987 | 802,479 | 3,739,829 | 32.89% | 21.46% | 54.35% | 45.65% |
| For-Profit | 725 | 1,231,548 | 535,509 | 3,444,166 | 35.76% | 15.55% | 51.31% | 48.69% |
| Total | 4,363 | 8,873,423 | 3,676,358 | 25,197,167 | 35.22% | 14.59% | 49.81% | 50.19% |

* Medicare and Medicaid.

** Includes commercial insurance, private pay, and other third party payers.

Data Table 15

Inpatient Discharges by Payor — National 1999

| | <i>Number of Hospitals</i> | <i>Inpatient Discharges</i> | | | <i>Inpatient Discharges by Payor as % of Total</i> | | | |
|------------------------------|----------------------------|-----------------------------|------------------|---------------------------------|--|-------------------|---------------------------------|--------------------------------|
| | | <i>Medicare</i> | <i>Medicaid</i> | <i>Total Patient Discharges</i> | <i>Medicare %</i> | <i>Medicaid %</i> | <i>Total Gov't*</i> <i>%</i> | <i>Non Gov't**</i> <i>%</i> |
| Total - All 50 States | | | | | | | | |
| Religious | 604 | 1,940,760 | 644,468 | 5,355,633 | 36.24% | 12.03% | 48.27% | 51.73% |
| Nonsectarian Not-For-Profit | 2,111 | 5,285,777 | 1,888,863 | 15,013,963 | 35.21% | 12.58% | 47.79% | 52.21% |
| Public | 1,149 | 1,352,616 | 890,128 | 4,216,189 | 32.08% | 21.11% | 53.19% | 46.81% |
| For-Profit | 709 | 1,385,689 | 586,989 | 3,960,635 | 34.99% | 14.82% | 49.81% | 50.19% |
| Total | 4,573 | 9,964,844 | 4,010,447 | 28,546,420 | 34.91% | 14.05% | 48.96% | 51.04% |

* Medicare and Medicaid.

** Includes commercial insurance, private pay, and other third party payers.

Data Table 16

Inpatient Discharges by Payor — Six State Study 1998

| | Number of Hospitals | Inpatient Discharges | | | Inpatient Discharges by Payor as % of Total | | | |
|-----------------------------------|---------------------|----------------------|------------------|--------------------------|---|---------------|----------------|---------------|
| | | Medicare | Medicaid | Total Patient Discharges | Medicare % | Medicaid % | Total Gov't* % | Non Gov't** % |
| California | | | | | | | | |
| Religious | 62 | 147,459 | 93,644 | 515,981 | 28.58% | 18.15% | 46.73% | 53.27% |
| Nonsectarian Not-For-Profit | 163 | 312,087 | 191,460 | 1,461,406 | 21.36% | 13.10% | 34.46% | 65.54% |
| Public | 80 | 81,359 | 132,798 | 442,974 | 18.37% | 29.98% | 48.35% | 51.65% |
| For-Profit | 105 | 128,464 | 115,389 | 487,886 | 26.33% | 23.65% | 49.98% | 50.02% |
| Total | 410 | 669,369 | 533,292 | 2,908,247 | 23.02% | 18.34% | 41.35% | 58.65% |
| Florida | | | | | | | | |
| Religious | 19 | 77,452 | 26,748 | 228,443 | 33.90% | 11.71% | 45.61% | 54.39% |
| Nonsectarian Not-For-Profit | 61 | 250,795 | 81,008 | 675,502 | 37.13% | 11.99% | 49.12% | 50.88% |
| Public | 22 | 52,214 | 42,905 | 210,568 | 24.80% | 20.38% | 45.17% | 54.83% |
| For-Profit | 86 | 246,440 | 67,109 | 606,864 | 40.61% | 11.06% | 51.67% | 48.33% |
| Total | 188 | 626,901 | 217,770 | 1,721,377 | 36.42% | 12.65% | 49.07% | 50.93% |
| Maryland | | | | | | | | |
| Religious | 5 | 21,410 | 7,715 | 67,186 | 31.87% | 11.48% | 43.35% | 56.65% |
| Nonsectarian Not-For-Profit | 29 | 96,677 | 22,288 | 294,212 | 32.86% | 7.58% | 40.44% | 59.56% |
| Public | 2 | 90 | 53 | 161 | 55.90% | 32.92% | 88.82% | 11.18% |
| For-Profit | 1 | 4,729 | 785 | 13,194 | 35.84% | 5.95% | 41.79% | 58.21% |
| Total | 37 | 122,906 | 30,841 | 374,753 | 32.80% | 8.23% | 41.03% | 58.97% |
| Minnesota | | | | | | | | |
| Religious | 5 | 11,400 | 3,464 | 24,250 | 47.01% | 14.28% | 61.29% | 38.71% |
| Nonsectarian Not-For-Profit | 28 | 41,498 | 12,048 | 125,433 | 33.08% | 9.61% | 42.69% | 57.31% |
| Public | 19 | 18,028 | 13,796 | 50,492 | 35.70% | 27.32% | 63.03% | 36.97% |
| For-Profit | 2 | 388 | 66 | 632 | 61.39% | 10.44% | 71.84% | 28.16% |
| Total | 54 | 71,313 | 29,374 | 200,808 | 35.51% | 14.63% | 50.14% | 49.86% |
| New Jersey | | | | | | | | |
| Religious | 17 | 70,943 | 13,873 | 190,588 | 37.22% | 7.28% | 44.50% | 55.50% |
| Nonsectarian Not-For-Profit | 61 | 268,703 | 36,378 | 754,184 | 35.63% | 4.82% | 40.45% | 59.55% |
| Public | 2 | 3,550 | 6,890 | 23,050 | 15.40% | 29.89% | 45.29% | 54.71% |
| For-Profit | 3 | 7,677 | 533 | 21,304 | 36.04% | 2.50% | 38.54% | 61.46% |
| Total | 83 | 350,873 | 57,674 | 989,126 | 35.47% | 5.83% | 41.30% | 58.70% |
| New York | | | | | | | | |
| Religious | 31 | 112,695 | 45,994 | 290,881 | 38.74% | 15.81% | 54.55% | 45.45% |
| Nonsectarian Not-For-Profit | 139 | 460,539 | 281,665 | 1,337,098 | 34.44% | 21.07% | 55.51% | 44.49% |
| Public | 11 | 19,560 | 12,129 | 67,117 | 29.14% | 18.07% | 47.21% | 52.79% |
| For-Profit | 6 | 11,925 | 6,856 | 30,899 | 38.59% | 22.19% | 60.78% | 39.22% |
| Total | 187 | 604,719 | 346,644 | 1,725,995 | 35.04% | 20.08% | 55.12% | 44.88% |
| Total for Six-State Sample | | | | | | | | |
| Religious | 139 | 441,359 | 191,438 | 1,317,329 | 33.50% | 14.53% | 48.04% | 51.96% |
| Nonsectarian Not-For-Profit | 481 | 1,430,298 | 624,847 | 4,647,835 | 30.77% | 13.44% | 44.22% | 55.78% |
| Public | 136 | 174,800 | 208,572 | 794,362 | 22.01% | 26.26% | 48.26% | 51.74% |
| For-Profit | 203 | 399,623 | 190,738 | 1,160,779 | 34.43% | 16.43% | 50.86% | 49.14% |
| Total | 959 | 2,446,081 | 1,215,596 | 7,920,305 | 30.88% | 15.35% | 46.23% | 53.77% |

* Medicare and Medicaid.

** Includes commercial insurance, private pay, and other third party payers.

Data Table 17

Charity Care Write-Offs, Other Indigent Care Write-Offs and Community Benefits Expenditures, and Hill-Burton Expenditures — Six-State Study 1998

| | <i>Number of Hospitals</i> | <i>Charity Care Write-Offs</i> | <i>Other Indigent Care Write-Offs and Community Benefits Expenditures</i> | <i>Hill-Burton Expenditures</i> | <i>Total Gross Patient Revenue</i> |
|-----------------------------------|----------------------------|--------------------------------|---|---------------------------------|------------------------------------|
| California | | | | | |
| Religious | 56 | \$125,735,708 | \$57,482,015 | \$10,098,569 | \$12,435,710,365 |
| Nonsectarian Not-For-Profit | 157 | \$313,623,872 | \$240,892,350 | \$10,797,445 | \$32,678,095,003 |
| Public | 67 | \$155,737,267 | \$1,516,037,605 | \$1,982,920 | \$9,331,768,084 |
| For-Profit | 102 | \$42,290,953 | \$279,021,276 | \$43,732 | \$13,724,879,439 |
| Total | 382 | \$637,387,801 | \$2,093,433,245 | \$22,922,666 | \$68,170,452,891 |
| Florida | | | | | |
| Religious | 16 | \$113,900,021 | \$0 | \$7,224,258 | \$5,254,698,189 |
| Nonsectarian Not-For-Profit | 55 | \$411,453,020 | \$0 | \$144,939 | \$13,096,898,057 |
| Public | 19 | \$587,530,519 | \$0 | \$3,355,128 | \$5,112,015,982 |
| For-Profit | 82 | \$190,503,057 | \$0 | \$0 | \$14,387,061,746 |
| Total | 172 | \$1,303,386,617 | \$0 | \$10,724,325 | \$37,850,673,974 |
| Maryland | | | | | |
| Religious | 5 | \$23,315,300 | \$0 | \$0 | \$626,425,943 |
| Nonsectarian Not-For-Profit | 26 | \$82,326,000 | \$0 | \$0 | \$3,162,832,703 |
| Public | 0 | \$0 | \$0 | \$0 | \$0 |
| For-Profit | 1 | \$422,700 | \$0 | \$0 | \$113,970,050 |
| Total | 32 | \$106,064,000 | \$0 | \$0 | \$3,903,228,696 |
| Minnesota | | | | | |
| Religious | 4 | \$2,027,619 | \$2,636,832 | \$0 | \$362,172,000 |
| Nonsectarian Not-For-Profit | 27 | \$9,495,838 | \$17,079,842 | \$0 | \$2,129,257,375 |
| Public | 19 | \$8,621,239 | \$13,178,761 | \$0 | \$821,937,465 |
| For-Profit | 2 | \$65,500 | \$0 | \$0 | \$47,813,574 |
| Total | 52 | \$20,210,196 | \$32,895,435 | \$0 | \$3,361,180,414 |
| New Jersey | | | | | |
| Religious | 16 | \$209,584,000 | \$0 | \$0 | \$4,078,174,119 |
| Nonsectarian Not-For-Profit | 60 | \$737,712,000 | \$0 | \$0 | \$16,468,196,248 |
| Public | 2 | \$112,707,000 | \$0 | \$0 | \$570,800,463 |
| For-Profit | 3 | \$9,243,000 | \$0 | \$0 | \$377,999,845 |
| Total | 81 | \$1,069,246,000 | \$0 | \$0 | \$21,495,170,675 |
| New York | | | | | |
| Religious | 29 | \$52,861,632 | \$0 | \$0 | \$5,088,820,427 |
| Nonsectarian Not-For-Profit | 134 | \$326,215,024 | \$0 | \$0 | \$26,185,781,308 |
| Public | 11 | \$16,082,163 | \$0 | \$0 | \$1,403,877,846 |
| For-Profit | 5 | \$209,920 | \$0 | \$0 | \$375,856,630 |
| Total | 179 | \$395,368,739 | \$0 | \$0 | \$33,054,336,211 |
| Total for Six-State Sample | | | | | |
| Religious | 126 | \$527,424,280 | \$60,118,847 | \$17,322,827 | \$27,846,001,043 |
| Nonsectarian Not-For-Profit | 459 | \$1,880,825,754 | \$257,972,192 | \$10,942,384 | \$93,721,060,694 |
| Public | 118 | \$880,678,188 | \$1,529,216,366 | \$5,338,048 | \$17,240,399,840 |
| For-Profit | 195 | \$242,735,130 | \$279,021,276 | \$43,732 | \$29,027,581,284 |
| Total | 898 | \$3,531,663,353 | \$2,126,328,680 | \$33,646,991 | \$167,835,042,861 |

Data Table 18

Charity Care Write-Offs, Other Indigent Care Write-Offs and Community Benefits Expenditures, and Hill-Burton Expenditures as Percent of Total Gross Patient Revenue — Six-State Study 1998

| | <i>Number of Hospitals</i> | <i>Charity Care Write-Offs as % of Total Gross Patient Revenue</i> | <i>Other Indigent Care Write-Offs and Community Benefits Expense as % of Total Gross Patient Revenue</i> | <i>Hill-Burton Expense as % of Total Gross Patient Revenue</i> | <i>Charity Care Write-Offs, Other Indigent Care Write-Offs and Community Benefits Expense, and Hill-Burton Expense as % of Total Gross Patient Revenue and Community Benefits Expense as % of Total Gross Patient Revenue</i> |
|-----------------------------------|----------------------------|--|--|--|---|
| California | | | | | |
| Religious | 56 | 1.01% | 0.46% | 0.08% | 1.55% |
| Nonsectarian Not-For-Profit | 157 | 0.96% | 0.74% | 0.03% | 1.73% |
| Public | 67 | 1.67% | 16.25% | 0.02% | 17.94% |
| For-Profit | 102 | 0.31% | 2.03% | 0.00% | 2.34% |
| Total | 382 | 0.93% | 3.07% | 0.03% | 4.04% |
| Florida | | | | | |
| Religious | 16 | 2.17% | 0.00% | 0.14% | 2.31% |
| Nonsectarian Not-For-Profit | 55 | 3.14% | 0.00% | 0.00% | 3.14% |
| Public | 19 | 11.49% | 0.00% | 0.07% | 11.56% |
| For-Profit | 82 | 1.32% | 0.00% | 0.00% | 1.32% |
| Total | 172 | 3.44% | 0.00% | 0.03% | 3.47% |
| Maryland | | | | | |
| Religious | 5 | 3.72% | 0.00% | 0.00% | 3.72% |
| Nonsectarian Not-For-Profit | 26 | 2.60% | 0.00% | 0.00% | 2.60% |
| Public | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| For-Profit | 1 | 0.37% | 0.00% | 0.00% | 0.37% |
| Total | 32 | 2.72% | 0.00% | 0.00% | 2.72% |
| Minnesota | | | | | |
| Religious | 4 | 0.56% | 0.73% | 0.00% | 1.29% |
| Nonsectarian Not-For-Profit | 27 | 0.45% | 0.80% | 0.00% | 1.25% |
| Public | 19 | 1.05% | 1.60% | 0.00% | 2.65% |
| For-Profit | 2 | 0.14% | 0.00% | 0.00% | 0.14% |
| Total | 52 | 0.60% | 0.98% | 0.00% | 1.58% |
| New Jersey | | | | | |
| Religious | 16 | 5.14% | 0.00% | 0.00% | 5.14% |
| Nonsectarian Not-For-Profit | 60 | 4.48% | 0.00% | 0.00% | 4.48% |
| Public | 2 | 19.75% | 0.00% | 0.00% | 19.75% |
| For-Profit | 3 | 2.45% | 0.00% | 0.00% | 2.45% |
| Total | 81 | 4.97% | 0.00% | 0.00% | 4.97% |
| New York | | | | | |
| Religious | 29 | 1.04% | 0.00% | 0.00% | 1.04% |
| Nonsectarian Not-For-Profit | 134 | 1.25% | 0.00% | 0.00% | 1.25% |
| Public | 11 | 1.15% | 0.00% | 0.00% | 1.15% |
| For-Profit | 5 | 0.06% | 0.00% | 0.00% | 0.06% |
| Total | 179 | 1.20% | 0.00% | 0.00% | 1.20% |
| Total for Six-State Sample | | | | | |
| Religious | 126 | 1.89% | 0.22% | 0.06% | 2.17% |
| Nonsectarian Not-For-Profit | 459 | 2.01% | 0.28% | 0.01% | 2.29% |
| Public | 118 | 5.11% | 8.87% | 0.03% | 14.01% |
| For-Profit | 195 | 0.84% | 0.96% | 0.00% | 1.80% |
| Total | 898 | 2.10% | 1.27% | 0.02% | 3.39% |

Data Table 19

California's County Indigent Care Program — 1998

| | Number of Hospitals | Gross Patient Revenue | | | County Indigent Program and Medicaid Gross Revenue as Percentage of Total Gross Patient Revenue | | |
|-----------------------------|---------------------|------------------------------|-------------------------|-----------------------------|---|---------------|---|
| | | County Indigent Care Program | Medicaid | Total Gross Patient Revenue | County Indigent Care Program | Medicaid | County Indigent Care Program and Medicaid |
| Hospital Type | | | | | | | |
| Religious | 56 | \$75,292,913 | \$1,821,729,232 | \$12,435,710,365 | 0.61% | 14.65% | 15.25% |
| Nonsectarian Not-For-Profit | 157 | \$370,789,022 | \$4,060,424,722 | \$32,678,095,003 | 1.13% | 12.43% | 13.56% |
| Public | 67 | \$1,789,570,555 | \$3,431,660,337 | \$9,331,768,084 | 19.18% | 36.77% | 55.95% |
| For-Profit | 102 | \$285,707,005 | \$2,592,953,029 | \$13,724,879,439 | 2.08% | 18.89% | 20.97% |
| Total | 382 | \$2,521,359,495 | \$11,906,767,320 | \$68,170,452,891 | 3.70% | 17.47% | 21.16% |

| | Number of Hospitals | Inpatient Days | | | County Indigent Program and Medicaid Inpatient Days as Percentage of Total Inpatient Days | | |
|-----------------------------|---------------------|------------------------------|------------------|----------------------|---|---------------|---|
| | | County Indigent Care Program | Medicaid | Total Inpatient Days | County Indigent Care Program | Medicaid | County Indigent Care Program and Medicaid |
| Hospital Type | | | | | | | |
| Religious | 56 | 14,949 | 447,403 | 2,253,847 | 0.66% | 19.85% | 20.51% |
| Nonsectarian Not-For-Profit | 157 | 66,318 | 972,313 | 6,758,111 | 0.98% | 14.39% | 15.37% |
| Public | 67 | 310,687 | 662,171 | 1,872,312 | 16.59% | 35.37% | 51.96% |
| For-Profit | 102 | 57,084 | 525,269 | 2,212,994 | 2.58% | 23.74% | 26.32% |
| Total | 382 | 449,038 | 2,607,156 | 13,097,264 | 3.43% | 19.91% | 23.33% |

| | Number of Hospitals | Inpatient Discharges | | | County Indigent Program and Medicaid Inpatient Discharges as Percentage of Total Inpatient Discharges | | |
|-----------------------------|---------------------|------------------------------|----------------|----------------------------|---|---------------|---|
| | | County Indigent Care Program | Medicaid | Total Inpatient Discharges | County Indigent Care Program | Medicaid | County Indigent Care Program and Medicaid |
| Hospital Type | | | | | | | |
| Religious | 56 | 3,161 | 93,244 | 504,750 | 0.63% | 18.47% | 19.10% |
| Nonsectarian Not-For-Profit | 157 | 13,900 | 189,316 | 1,489,584 | 0.93% | 12.71% | 13.64% |
| Public | 67 | 60,803 | 128,625 | 419,724 | 14.49% | 30.65% | 45.13% |
| For-Profit | 102 | 12,443 | 115,563 | 499,340 | 2.49% | 23.14% | 25.64% |
| Total | 382 | 90,307 | 526,747 | 2,913,398 | 3.10% | 18.08% | 21.18% |

Data Table 20

Top Twenty Current Hospital Systems* — 1999 Sorted by Number of Beds

| | | | | | | | | Gross Patient Revenue | |
|------|------------------------------|-----------------------------|------------|---------------------|------------------|-----------------------------------|--|-----------------------|------------------|
| Rank | System Name | System Sponsorship | Total Beds | Number of Hospitals | Number of States | Percentage of Hospitals Religious | Percentage of Public Hospitals Managed by System** | Medicare | Total |
| 1 | HCA | For-Profit | 34,312 | 165 | 22 | 0% | 1% | \$11,388,958,112 | \$33,390,473,036 |
| 2 | Quorum | Nonsectarian Not-for-Profit | 20,855 | 210 | 42 | 0% | 42% | \$3,828,761,391 | \$11,704,514,730 |
| 3 | Tenet | For-Profit | 10,300 | 52 | 17 | 2% | 0% | \$4,480,857,652 | \$13,179,917,107 |
| 4 | Ascension | Religious | 9,041 | 37 | 13 | 65% | 8% | \$2,836,534,480 | \$8,411,599,190 |
| 5 | Catholic Health Initiatives | Religious | 8,668 | 56 | 20 | 82% | 0% | \$2,750,339,425 | \$6,816,748,130 |
| 6 | Catholic Healthcare West | Religious | 7,584 | 41 | 3 | 61% | 5% | \$2,858,016,513 | \$9,788,107,523 |
| 7 | Trinity | Religious | 6,765 | 42 | 9 | 50% | 36% | \$2,058,954,925 | \$5,435,085,917 |
| 8 | Catholic Health East | Religious | 6,388 | 21 | 6 | 57% | 0% | \$2,005,634,274 | \$6,216,218,735 |
| 9 | Kaiser | Nonsectarian Not-for-Profit | 5,325 | 24 | 3 | 0% | 0% | not reported | not reported |
| 10 | Health Management Associates | For-Profit | 4,327 | 31 | 11 | 3% | 0% | \$1,406,781,706 | \$3,267,596,283 |
| 11 | Universal Health Services | For-Profit | 3,960 | 18 | 9 | 0% | 0% | \$1,096,566,178 | \$3,540,419,163 |
| 12 | Community Health Systems | For-Profit | 3,564 | 45 | 20 | 0% | 7% | \$834,699,418 | \$1,528,890,369 |
| 13 | Sutter | Nonsectarian Not-for-Profit | 3,159 | 19 | 1 | 5% | 0% | \$1,406,100,307 | \$5,621,549,230 |
| 14 | Baptist Health | Religious | 3,036 | 12 | 2 | 67% | 0% | \$870,343,587 | \$2,413,340,269 |
| 15 | SSM | Religious | 2,976 | 16 | 4 | 63% | 6% | \$883,701,637 | \$2,506,069,274 |
| 16 | Bon Secours | Religious | 2,897 | 14 | 6 | 93% | 0% | \$921,475,381 | \$2,282,381,352 |
| 17 | Adventist Health | Religious | 2,429 | 19 | 4 | 84% | 5% | \$588,230,373 | \$2,075,790,914 |
| 18 | Allina | Nonsectarian Not-for-Profit | 2,131 | 18 | 2 | 0% | 28% | \$654,168,865 | \$2,203,638,444 |
| 19 | Brim | Nonsectarian Not-for-Profit | 2,035 | 38 | 16 | 3% | 39% | \$336,620,841 | \$922,159,098 |
| 20 | Carondelet | Religious | 1,897 | 12 | 7 | 100% | 0% | \$544,678,517 | \$1,669,087,905 |
| 21 | Marian Health System | Religious | 1,287 | 8 | 4 | 88% | 0% | \$432,257,081 | \$879,222,651 |
| 22 | Intermountain | Nonsectarian Not-for-Profit | 1,257 | 16 | 2 | 0% | 0% | \$430,761,103 | \$828,578,954 |
| 23 | Sisters of Mercy | Religious | 206 | 18 | 0 | 78% | 0% | \$1,010,096,631 | \$2,875,271,759 |

* Non - Federal systems only

** Some private hospital systems, including religious ones, manage public hospitals under contract. This percentage reflects the portion of all hospitals in the system which are publicly owned.

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