SPECIAL REPORT

Hospital Mergers and Reproductive Health Care

By Patricia Donovan

Across the country, a growing trend of hospital mergers reflects an effort by health care facilities to consolidate in order to reduce costs, eliminate empty beds and compete successfully for managed care contracts. When hospitals merge or otherwise affiliate, there is always a possibility that the combined institution will decide not to continue certain services that had been offered by one of the hospitals prior to the consolidation. But when one of the hospitals is a Catholic institution, the continued provision of comprehensive reproductive health care becomes a major issue, because Church rules prohibit Catholic hospitals from providing and making direct referrals for a wide range of reproductive health services.* As a result, when a Catholic hospital consolidates with a nonsectarian institution—as more than 100 did in 1994[1]—it often insists that the new entity adhere to the Church's health care policies.

"This reorganization of health care constitutes one of the most serious and least visible threats to women's access to comprehensive reproductive health services in years," warns Janet Gallagher, director of the American Civil Liberties Union's (ACLU's) Reproductive Freedom Project.[2] These mergers "are a hidden crisis," agrees Lois Uttley, director of communications and development for Family Planning Advocates, a statewide advocacy group in New York.[3] Reproductive rights advocates say the impact of restrictions on these services is especially severe in small towns and rural areas, where a merger could result in a Catholic facility's becoming the only provider of hospital-based services in the community.

Two recent experiences illustrate the possible consequences of mergers involving Church-run institutions. In May 1996, a Catholic health care facility in Troy, New York, agreed, as part of an out-of-court settlement, to provide referrals and follow-up for family planning and contraceptive sterilization services. This settlement brought to a close the nation's first case to challenge the merger of a sectarian and a nonsectarian hospital that would have led to the combined institution's eliminating both reproductive health services and direct referrals for such care. In Great Falls, Montana, meanwhile, the August 1996 merger between a Catholic and a community hospital has resulted in the elimination of inpatient abortion services in the city.

The Troy Case

The events in Troy, New York, are an example of how a merger can adversely affect access to comprehensive reproductive health care when a community does not demand continuation of services and when the state fails to ensure their availability. The merger involved St. Mary's Hospital, a Catholic institution, and Leonard Hospital, a nonsectarian facility that also operated a network of primary care clinics; together, the hospitals served a financially and medically needy population in a three-county, largely rural area. Leonard's clinics provided reversible contraception, and the hospital provided vasectomies; staff referred women who requested abortions or tubal ligations directly to providers of those services, which included private doctors and a clinic in Albany. St. Mary's, on the other hand, offered no family planning services other than natural family planning, and provided no referrals for these services or for abortions.

In April 1994, Seton Health Systems applied to the Public Health Council, an arm of the state health department, for permission to operate a hospital formed by the merger of St. Mary's and Leonard. Seton, which is run by the same religious order that operated St. Mary's, made it clear from the outset that it would abide by Church policy on reproductive health care.

Although the Public Health Council has ultimate authority for approving the establishment of a new hospital, other agencies have advisory responsibilities. One of these bodies is the regional Health Systems Agency. In June 1994, that agency's executive committee reviewed Seton's application and recommended that approval be conditional on the development of "a formal plan regarding transition of those primary health care services currently offered by Leonard Hospital facilities (e.g., full range of reproductive health care services), which may be altered due to the philosophy of Seton Health Systems."[4] Despite that recommendation, the Public Health Council unanimously approved Seton's application by voice vote on July 29, 1994, without any discussion of Seton's responsibility to provide contraceptive or abortion services or referrals.

The council acted, moreover, before Seton's application had been considered by the State Hospital Review and Planning Council, which is charged with reviewing proposed hospital mergers and making recommendations on whether they should be approved. The planning council voted 17–5 on August 4, 1994, to approve Seton's application only on the condition that the agency agree to refer patients directly to reproductive health service providers.

In response to the planning council's vote, the Public Health Council reconsid-

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*These services are reversible contraception (other than counseling on natural family planning), male and female sterilization, abortion, infertility treatments such as artificial insemination and in vitro fertilization, condoms for human immunodeficiency virus (HIV) risk reduction and emergency contraception (even for women who have been raped). (See: National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Facilities*, Washington, D.C., 1971, rev. 1994.)

ered its initial approval of Seton's application. On September 23, 1994, it modified its earlier decision by giving Seton four options for handling a patient's request for contraceptive or voluntary sterilization services: Offer the services requested; refer patients to providers that offer the services; give patients a list compiled by the health department of providers offering the services; or refer patients requesting care to a state, county or local government agency that can supply a list of providers offering the services.

These options were to apply in situations where patients specifically requested a reversible contraceptive method or sterilization. The council imposed no obligation on Seton physicians to raise the issue of family planning with patients, even when pregnancy might be contraindicated. Nor were Seton physicians ever required to make referrals for abortion, even if continuing a pregnancy would threaten a woman's life.

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In a lawsuit filed shortly before Seton began operating the new hospital in January 1995, the plaintiffs—two young women who relied on Leonard's clinics for their health care, Family Planning Advocates and two local Planned Parenthood affiliates—sought to have the merger set aside. The plaintiffs charged that the state violated accepted standards of care by failing to require direct referrals for family planning. Seton's simply giving a patient a list of government agencies that "could then, theoretically, refer the patient to a provider…will force many patients to maneuver through a complex and burdensome process, often requiring two or more trips, in order to find a qualified health care practitioner to meet her reproductive health needs," the plaintiffs argued.[5]

The state's approval also violated informed consent laws, the plaintiffs contended, because it allowed Seton not to make any referrals whatsoever unless specifically asked to do so, even when it would be in a patient's best interest to know how to get contraceptive care or some other reproductive health service. Furthermore, the plaintiffs maintained, the state never adequately considered the "public need," as state law requires before approval of a new hospital. If the Public Health Council had investigated the consequences of the merger, the plaintiffs said in their brief, it "could not have found a 'public need' for a merger that would result in eliminating reproductive health services in Leonard's service area."[6] The merger, they pointed out, was particularly detrimental to poor, uninsured and underinsured women because few private doctors in the area treat Medicaid patients and none offer services on a sliding fee scale. If these women lost access to family planning services at Leonard's clinics, the plaintiffs added, some who did not own a car would have difficulty getting to another provider because public transportation is poor.

Initially, Seton was "adamantly opposed" to making any changes to its policy on reproductive health care in response to the lawsuit, reports Eve Gartner, an attorney at the Center for Reproductive Law and Policy, who represented the plaintiffs.[7] But at the strong urging of the trial judge (who threatened to rule against the hospital if it did not compromise) and after nearly a year of negotiations between Seton, the state and attorneys for the plaintiffs, a settlement was reached.

In a memorandum of understanding signed by Seton and the state health department in May 1996, Seton agreed to give patients requesting referrals for family planning and sterilization services a detailed list of qualified providers. It also agreed that if a Seton physician believes that it may be in a patient's best interest to avoid pregnancy, the physician will advise the woman of her situation, inform her that Seton provides natural family planning and offer to give her a list of practitioners and facilities that provide a broader range of contraceptive services.

Under the agreement, the state health department is to compile the referral list and update it every six months. The list must include the provider's name, telephone number, location and hours of operation. It also must indicate whether the provider accepts Medicaid or other third-party coverage for contraceptive and sterilization services, serves low-income patients on a sliding or reduced fee scale and is accessible by public transportation.

Seton further agreed that "an appropriately trained practitioner" will review the list with each patient requesting referral in light of the individual's needs, give the provider who is selected relevant medical records and "when medically indicated…follow up in a timely manner to confirm that the patient saw the provider and to obtain documentation regarding any medical care rendered for inclusion in the patient's medical record." The agreement states explicitly, however, that Seton staff are not required "to arrange for appointments, make phone calls or engage in any other direct contact with another provider."[8]

The agreement, says attorney Gartner, "is a crucial step toward guaranteeing that patients who rely on sectarian institutions for their health care obtain contraceptive and sterilization services they need and want."[9] Gartner acknowledges, however, that the agreement is "definitely a compromise,"[10] since it does not require Seton to provide such services itself, to make referrals directly to a provider or to make any referrals for abortion. But, she adds, it is probably the best that could be achieved, since the state had already approved the merger without any requirement of providing referrals for reproductive health care.

The Montana Merger

The experience in Great Falls, Montana, demonstrates that even when the state considers the impact of a merger, the continued availability of all reproductive health services is not guaranteed. The merger involved Church-run Columbus Hospital and nonsectarian Montana Deaconess Medical Center, the city's two acute care hospitals. Prior to the August 1996 merger, Deaconess was the only hospital in Montana that offered both prenatal genetic counseling and related abortions, probably because Great Falls is home to the state's only perinatologist. Approximately 12 abortions were performed annually at Deaconess, in virtually all cases because of fetal abnormalities. Nevertheless, after conducting an impact analysis, the attorney general approved the merger and allowed the new hospital, which was to be run by the religious order that had operated Columbus, to eliminate abortion services.

As a condition of approving the merger, the attorney general ordered Deaconess to give Intermountain Planned Parenthood the deed to an office condominium. Revenue from the sale or rental of the property could be used to cover the expenses of any woman who would have to travel to another city in Montana to obtain hospital abortion services that were no longer available in Great Falls or of any doctor who would have to travel to provide such services.[11] Ultimately, Deaconess gave Planned Parenthood a lump sum

payment of $250,000 in lieu of property, with the interest to be used to defray travel expenses (including expenses for a parent, spouse or partner who accompanies a woman).[12] As of November 4, 1996, Planned Parenthood had received one request for travel funds (from a physician).[13]

The attorney general directed the new hospital to "continue providing, without restrictions,…information and counseling on post-coital contraceptives for rape victims;…elective sterilization;…and [human immunodeficiency virus] risk-reduction counseling." With the exception of abortion, the attorney general required the hospital "to maintain the same level and type of services being provided by Columbus and [Deaconess] immediately prior to the consolidation."[14]

Shortly before August 1, 1996, when the merger was to become effective, the ACLU asked the Federal Trade Commission to investigate the merger's impact on reproductive health care. (The commission had the authority to look into the situation because the merger created a monopoly on acute care in the city.) The ACLU was especially concerned about the elimination of hospital abortions, noting that they tend to be more complicated procedures than outpatient abortions, either because the pregnancy is endangering the woman's life or health, or because they are performed late in pregnancy in response to the detection of a severe fetal anomaly.

In a letter to the agency, the ACLU wrote that "creation of a 'travel fund' for women requiring a hospital abortion does not solve the problem created by the merger's ban on abortion."[15] The ACLU argued that it is not realistic to expect that hospitals within a reasonable distance of Great Falls will make themselves available for abortion procedures formerly performed in Great Falls or that physicians in Great Falls will travel to another city to perform an abortion.

Additionally, the ACLU expressed concern that the state had not explicitly required the new hospital to provide infertility services or prescriptions for (as opposed to information and counseling about) emergency contraception or to distribute condoms in connection with human immunodeficiency virus risk reduction programs. Despite these concerns, the Federal Trade Commission took no action on the Montana merger.

Safeguarding Services

As the merger in Great Falls demonstrates, consolidations involving Catholic hospitals do not always result in the elimination of all reproductive health care to which the Church objects. There has, in fact, been a striking degree of inconsistency in the handling of these services in mergers involving Catholic and non-Catholic hospitals. According to a survey of institutions involved in 57 such mergers between 1990 and 1995, for example, 10 consolidations resulted in the complete elimination of Church-prohibited reproductive health services in the new entity, but 12 allowed the continuation of services other than abortions at the non-Catholic hospital. Six mergers resulted in moving reproductive health services to a legally autonomous, separately funded facility either on-site or nearby; and two established endowments to ensure that women would still have access to abortion services. In most of the remaining cases, the merged hospital did not report its policy on reproductive health care.[16]

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The type of association the institutions enter into and the local bishop's willingness to accept a "creative solution" to the provision of reproductive health services other than abortion are important factors. If, for example, the Catholic hospital buys or merges with a nonsectarian institution, the Church's ban on contraceptive and infertility services is generally applied to the new facility. Under other arrangements, such as affiliations or joint ventures, in which the two hospitals are connected in some way but retain separate identities, the nonsectarian hospital often continues to provide at least some of the reproductive health services it offered prior to the agreement.[17]

Whatever the arrangement, it must be reviewed and approved by the local bishop. As Dennis Brodeur, a former priest who has negotiated several hospital mergers, observes, "what is acceptable to a bishop in one diocese may not be acceptable to the bishop in the next."[18] The degree to which a state is willing to consider the implications of a merger and take steps to guarantee the continued availability of services is also a key factor in determining how the issue is resolved.

The ACLU and other national organizations concerned with reproductive rights have monitored the outcomes of mergers between Catholic and non-Catholic hospitals for several years, and in some cases have helped local activists intervene to protect reproductive health care. Now, state reproductive health care advocacy groups are launching efforts to increase public awareness of the risks these mergers pose and to help community residents ensure that reproductive health services remain available. (In many cases, mergers are conducted in secrecy, with little or no public knowledge, involvement or debate.)

In New York, for example, Family Planning Advocates launched MergerWatch in June 1996, shortly after the Seton case was settled. The project monitors proposed mergers in the state and trains community residents on how to intervene to preserve essential services. "The Seton case convinced me that…you can't affect a merger after the merger has happened," explained JoAnn Smith, executive director of Family Planning Advocates.[19]

The organization has published a guide, entitled *Hospital Mergers: The Hidden Crisis for Family Planning*, that describes steps reproductive rights supporters can take before and after merger plans involving Catholic and non-Catholic hospitals are announced, to reduce the likelihood that access to reproductive health care will be eliminated. These measures include learning which hospitals are financially vulnerable and thus potential merger participants; educating hospital board members about the issue; identifying community leaders who will speak out for maintaining comprehensive reproductive health care; and using the media to raise public awareness of the potential loss of services.

In Los Angeles, meanwhile, the California Women's Law Center and the National Health Law Program have formed the Initiative to Preserve Access to Reproductive Health Services, which will advise grass-roots organizations throughout the state on how to educate communities about the problem. The initiative also will keep reproductive rights in the forefront during merger negotiations through use of the media and community organizing.

"Unless we organize and educate communities, we won't be successful in preserving [these] services," says Susan Fogel, an attorney with the Women's Law Center. Furthermore, she points out that in several mergers, reproductive health services were eliminated on the grounds that the services were available from other local fa-

cilities, which subsequently closed. Consequently, she adds, "we need to talk about…long-term planning when we look at a merger agreement.…We can't assume that local community resources will still be there, especially in today's market when everything is changing. We have to be sure to guarantee these services continue."[20]

Fogel, like Smith at Family Planning Advocates, believes community action early in the merger process is generally a better strategy than legal action later. Attorney Gartner of the Center for Reproductive Law and Policy notes, however, that lawsuits may be effective in certain situations. Malpractice suits brought by women who did not receive services or referrals they needed and were entitled to and who suffered adverse health effects as a result are likely to be "an important tool in the future," Gartner says. "They go to the heart of what's wrong with the elimination of services."[21]

Some advocates think the wave of mergers between Catholic and non-Catholic hospitals will slow in the near future because some bishops are becoming less willing to agree to creative arrangements that permit reproductive health care to continue in Church-affiliated facilities. Even those who anticipate fewer mergers in the future, however, believe that pressures to reduce costs will continue to force Catholic hospitals to affiliate with nonsectarian institutions.

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