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The Coming Millennium: Enduring Issues Confronting Catholic Health Care

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INTRODUCTION

As the twenty-first century is about to dawn, it is natural to take stock of successes and failures, how far we've come, and how far we have to go. For Catholic health care, the twentieth century is closing with years of strong accomplishments and great challenges. The late 1990s saw the growth of multi-co-sponsored systems,[1] Catholic Health Association's ("CHA") "refounding,"[2] and the solidification, through Columbia/HCA's stumble, of non-profit, charitably driven health care. The "CH" moniker came more firmly in vogue, with Catholic Healthcare West ("CHW" the original "CH"), Catholic Healthcare Initiatives ("CHI"), and Catholic Healthcare East ("CHE) gaining strides. Significant reductions in Medicare reimbursement, with the Balanced Budget Act of 1997 ("BBA") projected to cut Medicare outlays by approximately $116 billion through the year 2002, confronted health care providers with issues of access and quality.[3]

High profile, often negative stories about Catholic health care led the evening news and front pages, with coverage by ABC and CBS News, the Wall Street Journal and the New York

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1. *See infra* Section 2, Issue 2 (discussing consolidations in Catholic health care).

2. Fr. Michael Place, S.T.D. became CHA's president on December 4, 1997. He immediately began a process of refocusing CHA to the needs and skill sets present in health care systems. *See Fr. Place Gains Input for Shared Ministry Vision,* CATH. HEALTH WORLD, June 1, 1998, at 1, 8.

3. *See* Deanna Bellandi, *The Quiet Restructuring: Blaming Feds, Hospitals Shed Workers, Facilities in Droves*, MOD. HEALTHCARE, Dec. 4, 1998, at 2.

Times,[4] among others, demonstrating continued confusion about the meaning—the essence—of "Catholic" health care. Merger Watch began tracking Catholic/other than Catholic partnerships on the internet.[5] Unions discovered that Catholic health care providers were attractive targets, forcing institutions to confront social justice teachings in an era of declining reimbursement and enhanced competition.[6] Father McCormick, of the University of Notre Dame, raised the very public question of whether Catholic health care would survive, in his article, "The End of Catholic Hospitals?," and answered in the negative.[7]

We are optimistic about the future of Catholic health care. Without minimizing the intensity of the challenges to be faced, Catholic health care is leaving the twentieth century tested, and in many ways stronger than it has ever been. Market position is generally stronger, partnerships more wide ranging, strategic options often more sophisticated, sponsoring religious congregations better focused. And yet, the sector's evolution toward new ways of connecting to the Church,[8] coupled with intensifying competitive pressures, demands that significant missteps be avoided.

What follows is a review of some of the key issues facing Catholic health care in 1999, with an eye toward their impact in 2000 and beyond. While the future will no doubt raise as yet unknown opportunities and challenges for the ministry, the bedrock nature of the issues discussed herein demands that they receive our continued attention. Three core issues are discussed: clarity in canonical and ethical interpretation, industry consolidation and "next generation" sponsorship. Each is presented in the context of significant events arising in 1998 and 1999, as a

4. *See, e.g.*, Susan K. Hume, *ABC News Report Angers Ministry Leaders*, CATH. HEALTH WORLD, Aug. 1, 1998, at 1; Lucette Lagnado, *Their Role Growing, Catholic Hospitals Juggle Doctrine and Medicine*, WALL ST. J., Feb. 4, 1999, at A1; Esther B. Fein, *Hospital Deals Raise Concern on Abortion*, N. Y. TIMES, Oct. 14, 1997, at B1; John Roberts, Anchor, Thalia Assuras, Reporter, *Merger of Catholic Hospital with Secular Hospital in New Hampshire Sparks Debate Over Abortion*, (CBS evening news, Dec. 7, 1997).

5. *See* Merger Watch, *Merger Status Report* (visited Feb. 5, 1999) <http://www/fpaofnsy.org/MergerWatch/status.html>.

6. *See* Ilana DeBare, *In the Name of the Father; Catholic Values Invoked by Both Sides in Hospitals' Battle with Union*, S. F. CHRON., Aug. 25, 1998, at D1 (discussing a union drive faced by CHW whose members claimed CHW violated its own religious principles by opposing their organizing).

7. *See* Richard A. McCormick, *The End of Catholic Hospitals?*, AMERICA, July 4-11, 1998, at 5, 12.

8. *See infra* Section 2, Issue 1.

way to illustrate the point and frame its importance for the coming millennium. In order to place the impact of the issues discussed into context, a brief background on the current state of Catholic health care will be provided.

I. Overview of Catholic Health Care in the United States

From the founding of the first Catholic hospital in the United States 150 years ago by the Sisters of Charity,[9] Catholic health care now enjoys a preeminent role in the nation's health care system. Today, there are 601 Catholic hospitals in forty-eight states that collectively admit sixty-five million patients per year.[10] In nineteen states, more than twenty percent of hospital admissions are to a Catholic facility, accounting for sixteen percent of community hospital admissions nation-wide.[11] In 1997, Catholic hospitals generated $35 billion in net patient revenues.[12] Seven hundred fourteen Catholic long-term care facilities in the United States provide respite, rehabilitation and skilled nursing care.[13] Collectively, Catholic facilities comprise the single largest provider of institutional care in the country. Four of the ten largest health care systems in the United States are Catholic.[14]

Though the sheer number of facilities is impressive, it is true that the century closes with Catholic hospitals facing a decline in numbers. Since 1984, sixty-seven Catholic hospitals have moved from "Catholic" to "no longer Catholic" status due to sales or mergers.[15] Many of these Catholic hospitals converted to ecu-

9. *See* Mary Kathryn Grant and Margaret Mary Modde, *The Evolution of Catholic Multi-Institutional Systems: Voluntary Multi-Hospital Systems*, 18 Topics Health Care Fin. 24 (1992).

10. *See* The Official Catholic Directory Anno Domini 1998 at 2111-48.

11. The latest statistics available date to 1996. *See New Covenant Unleashes the Potential*, Health Progress, July-Aug. 1996, at 20, 29.

12. *See* Deanna Bellandi & Bruce Japsen, *While You Weren't Sleeping: Not-for-Profit Growth Keeps Investor-Owned Systems Up at Night, According to 1998 Multi-Unit Providers Survey*, Mod. Healthcare, May 25, 1998, at 46 (indicating that Catholic health care systems generated $34.874 billion net patient revenues in 1997—up 7.3% from 1996).

13. *See* Kevin J. Sexton, *The Ministry Change Imperative: Catholic Healthcare Providers Must Translate Their Assets into Action*, Health Progress, Mar.-Apr. 1996, at 18, 19.

14. *See* Bellandi, *While You Weren't Sleeping*, *supra* note 12, at 36 (comparing the 10 largest providers on the basis of net patient revenues). Of the 10 largest not-for-profit health care systems, six are Catholic. *See id.*

15. *See 1998 Hospital Mergers, Acquisitions, Joint Ventures, Long-Term Leases and Other Partnerships*, Mod. Healthcare, Jan. 11, 1999, at 49 ("Hospital Merg-

menical status through merger or consolidation with other religiously based systems. Still others were sold to for-profit organizations.[16]

An even more important trend has been the decline in the number of Catholic health care systems.[17] Religious communities of sisters, brothers and priests have been reacting to calls for collaboration and demographic trends showing that fewer members desire to be involved in health care ministry. In response, efforts were begun to consolidate the ministry. These efforts, led by the "New Covenant Initiative,"[18] have borne fruit, breaking through the historical independence of religious communities and their institutional ministries. Co-sponsorships, through which multiple religious communities merge their ministries under a single governance and management structure, are common. Systems such as Catholic Health Initiatives with twelve separate religious community sponsors,[19] Catholic Health Care

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ers"). *See also Hospitals Enter Debate Over Catholic Identity*, NAT. CATH. REP., Nov. 7, 1997, at 20 (noting that often when a Catholic facility merges with a for-profit or other non-Catholic facility, it loses its Catholic status, and citing a report of the Catholic Health Association, that states 60 hospitals have moved from "Catholic" to "no longer Catholic" status due to sales or mergers since 1984). *But see* Deanna Bellandi, *Relax, Deal Pace Slowing*, MOD. HEALTHCARE, Jan 4. 1999, at 23 (discussing a trend of for-profits converting to non-profit status and indicating that 100 for-profit hospitals converted to non-profit status between 1988 and 1995).

16. The sheer magnitude of the for-profit health care market is one that Catholic health care leaders cannot ignore. For-profit health corporations, such as Columbia/HCA Healthcare Corporation, achieved a national presence through numerous acquisitions and mergers. Columbia/HCA tripled in size from 117 hospitals in 1993 to 343 in 1997, according to an annual hospital survey by Irving Levin Associates. *See* Michael Casey, *Hospital Mergers: Where Have They Gone?* MED. INDUSTRY TODAY, May 22, 1998. Tenet Healthcare Corporation is also a weighty for-profit competitor with 128 hospitals and net patient revenues of $7.7 billion. Columbia/HCA is larger than any other private health system in America, controlling over half of the for-profit beds with 336 hospitals and net patient revenues of $18.8 billion (second only to the U.S. Department of Veterans Affairs, which has $19.4 billion in net patient revenues). *See* Bellandi, *While You Weren't Sleeping, supra* note 12, at 48. Columbia/HCA's number one ranking will remain even after its planned divestiture and hospital spin-offs. For more discussion of Columbia's divestiture strategy, *see infra* note 72.

17. At least fifteen systems in the past three years have been eliminated. *See 1998 Hospital Mergers, supra* note 15 at 49. *See also* Bruce Japsen, *An Off Year for Consolidation: '97 Tally Shows Sharp Cutback in Big Corporate Deals*, MOD. HEALTHCARE, Jan. 14, 1998, at 44; *see also Review: 1996,* MOD. HEALTHCARE, Dec. 23, 1996, at 48.

18. The "New Covenant Initiative," co-sponsored by the National Coalition on Catholic Health Care Ministry, CHA and Consolidated Catholic Health Care, was launched at a national convocation of Catholic health care leaders in October 1995 in Chicago. It is intended to encourage collaboration, particularly mergers, among Catholic health care providers. *See New Covenant, supra* note 11, at 28.

19. "Sponsorship" is the term of art used to describe the canonical, legal, ethical and moral relationship that a religious community, diocese, or duly established lay

West with seven sponsors, Catholic Health Care East with twelve sponsors, and Catholic Health Care Partners with five sponsors have become market leaders.[20] Other sizable systems, such as the Daughters of Charity National Health System ("DCNHS"), are in merger discussions.[21]

In still other instances, Catholic health care systems initiated movement into direct relationship with the Church without a religious community sponsor serving as the interface. Two such organizations, Catholic Health Initiatives and Covenant Health Systems, are in the process of becoming completely lay-sponsored organizations.[22] No doubt others will follow.

As a result of the massive consolidation in the market, many Catholic health care providers find themselves part of larger, stronger, more sophisticated networks and systems than they belonged to in the past. Their ability to leverage human and financial resources is perhaps unparalleled in the history of Catholic health care. With the (at least temporary) slowdown in challenges to the non-profit model by Columbia/HCA,[23] in some markets, Catholic health care finds itself aggressively growing, and in many instances converting heretofore nonsectarian non-profit and investor-owned facilities to Catholic facilities.[24]

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body has with a Catholic ministry. *See generally* Lawrence E. Singer, *Realigning Catholic Health Care: Bridging Legal and Church Control in a Consolidating Market*, 72 TUL. L. REV. 159, 209-27 (1997) (discussing the sponsorship relationship and Church ownership of Catholic health care institutions).

20. CHE has 10 co-sponsors and two honorary sponsors. CHE will add a 13th sponsor when the Sisters of St. Joseph of St. Augustine, who operate Mercy Hospital of Miami, Florida, merge with CHE in 1999. *See News at Deadline*, MOD. HEALTHCARE, Feb. 1, 1999, at 4.

21. *See infra* Section 2, Issue 2, National Ministries, for a commentary of the June 1998 announcement of merger discussions between the Daughters of Charity National Health System ("DCNHS") and the Sisters of St. Joseph Health System. DCNHS is also in discussions with St. John's Health System of Detroit. *See News at Deadline*, MOD. HEALTHCARE, Feb. 8, 1999, at 4.

22. *See also infra* Section 2, Issue 2.

23. Despite Columbia's strong presence this decade, it is ending the century with a divestiture strategy and a public relations nightmare. Columbia/HCA faces both civil and criminal charges for Medicare and Medicaid fraud and abuse, when a former employee filed a whistle blower suit with the Department of Justice under the Federal False Claims Act. A second similar suit was filed in December 1998. *See* Sarah Huntley, *Columbia Faces 2nd Suit*, TAMPA TRIB., Dec. 31, 1998, Business & Finance at 1. In addition to fraud and abuse charges, Columbia/HCA also agreed to pay an antitrust fine of $2.5 million for failure to divest on time when acquiring hospitals in Utah and Florida. *See* Michael Casey, *Chicago Says Goodbye Columbia, Hello Tenet?* MED. INDUSTRY TODAY, Aug. 3, 1998.

24. *Modern Healthcare* reports non-profit health systems in 1997 grew faster than the for-profit systems (not-for-profit systems measured by total hospitals up 9% in 1997; for-profit systems' growth up 5.9%; overall growth of 7%). *See* Bellandi, *supra*

At the same time, however, the disparity between large, often multi-sponsored systems and smaller, generally single-sponsored institutions or systems continues to grow. Two-thirds of Catholic acute care health providers, measured by assets (and beds), are represented by the twenty-one Catholic systems.[25] Nevertheless, approximately 200 acute care institutions continue to be overseen by small systems or directly by a single sponsor.[26] These institutions or systems, for a variety of reasons, have eschewed the trend toward consolidation with other Catholic providers. The impact of all of these mergers has not been studied yet, either in financial terms, market terms or the relationship to the church.

In addition, the ministry remains challenged to reach out to other than acute care providers of health care. Long-term care providers, adult day care providers, AIDS hospices, rehabilitation specialty facilities, social service agencies and others provide essential health care services, and yet due to their disparity in asset and revenue base when compared to their acute care brethren, often find themselves a forgotten part of the ministry.[27] New models encompassing these types of providers in meaningful collaborations have yet to take hold, but have great promise, once developed, for ensuring the continued vitality of a holistic ministry.[28]

Finally, Catholic health care providers face the same competitive and reimbursement challenges confronting all providers. With Congress contemplating an additional $10 billion reduction in Medicare reimbursement beyond the $116 billion savings an-

note 12, at 35. For-profit acquisition pace slowed (for-profit systems added fewer hospitals in 1997 than in 1996), and their operating margins dropped as well (overall operating margins dropped from 20% in 1996 to 13.3% in 1997). *See* Bellandi, *id.* at 40. Non-profit health care organizations are increasingly found on the buyer-side of hospital transactions and are looking to the bond market to refinance existing debt and take on new health care projects such as acquisitions. Non-profits were the buyers in only 36% of transactions in 1994 but increased to 67% in 1996 and 75% in 1997, according to an annual hospital survey by Irving Levin Associates. *See* Casey, *Hospital Mergers*, *supra* note 16.

25. *See* Consolidated Catholic Health Care 1999 Governance Forum (materials on file with authors).

26. *See id.*

27. Systems concentrating on long-term care as a significant or primary focus include the Benedictine Health System of Duluth, the Carmelite Sisters for the Aged and Infirm, Franciscan Services of Chicago and Covenant Health Systems.

28. *See LTC Providers Find Strength in Networking*, CATH. HEALTH WORLD, Apr. 15, 1998, at 1.

ticipated through the Balanced Budget Act of 1997 ("BBA"),[29] the new millennium promises to be interesting, indeed.

II. Ministry Challenges

All three specific issues discussed below emanate from a common challenge—the question of self identity; namely, what it means to be a Catholic health care provider, and how that identity is explained to the public and to the successive generations of executives and board members who will be assuming system and institutional leadership positions. The core of Catholic identity throughout the history of Catholic health care largely has been tied to the leadership and presence of the founding religious community, typically sisters. As Catholic health care confronts the transitioning of this role from sisters to the laity, the need arises to wrestle with bedrock issues of mission and future—what are the core components of Catholic health care, and what are the key competencies that Catholic health care leaders need in order to assure continuation of the ministry?[30]

As discussed below, many of the issues confronted by Catholic health care have arisen in response to the lack of clear answers to these questions. It seems imperative that clear, easily understood answers to these questions are found and, indeed, much work is being done in this regard.[31] In the meantime, Catholic health care leaders and institutions can continue to expect enhanced scrutiny of the ministry and institutional decision-making as religious communities, health care systems and institutions continue to pursue consolidation and restructuring in their search for answers.

Issue 1: Clarity in Canonical and Ethical Interpretation

It is clear that clashes have occurred, and will continue to occur, between Catholic health care providers' need to respond to

29. *See infra* Issue 2: Consolidation.

30. See discussion regarding leadership development *infra* at note 141 and accompanying text.

31. Father Michael Place, President of the Catholic Health Association, commented on the choices being made today by different Catholic health care providers: "The situation in which health care is being conducted today is so fluid. . . [W]hat we're seeing is a ministry that is being extremely creative about how it can strengthen itself." *See* Deanna Bellandi, *Bon Secours Heads Home: Catholic System Forgoes National Consolidation to Focus on Assisted-Living, Non-Acute-Care*, Mod. Healthcare, July 8, 1998, at 30.

market-specific challenges and opportunities, and the Church's need to assure fidelity to doctrinal teachings. Church law vests significant authority in the local bishop for ministries serving in his diocese. As discussed below, bishops' approaches can vary widely. As health care systems have become larger, often operating in multiple dioceses, the question of whether the Church needs to develop a more consistent approach in interpreting issues involving canonical and ethical principles has moved to the forefront.

Certainly, a bedrock principle for canonical and ethical interpretation must be fidelity to the Church's mission and teaching, including respect for the bishops' role in overseeing that mission.[32] At the same time, however, perceived inconsistencies in approach can create confusion, opening Catholic institutions seeking to partner with other than Catholic providers, as well as dioceses and the Church itself, to charges of capriciousness. Lack of clarity may also inhibit the development of consistent corporate strategies and product lines as national or multi-regional systems strive to compete for managed care contracts on a larger scale. Co-sponsorship and lay sponsorship model formation[33] can be affected by diverse and sometimes conflicting canonical and ethical counsel.[34]

The issue of clarity and consistency assumes signal importance, given the movement toward lay-controlled organizations whose members may not be adequately schooled in Church law and theology,[35] as well as the prominent position that Catholic

32. The bishop's role over Catholic institutional activities occurring in his diocese flows both from canon law and the moral suasion attendant to the office. Bishops have the right to declare a ministry or institution "Catholic," to decide issues raising the possibility of scandal, and to intervene in sponsor actions in certain limited situations. For a thorough discussion of the bishop's role in Catholic health care, *see* Singer, *supra* note 19, at 210-15.

33. *See infra* Section 2, Issue 3.

34. For example, the formation of Provena Health, an Illinois multi-sponsored system, involved canonical and ethical input from five canonists and ethicists. *See* Presentation given by Sr. Kathleen Mulchay, SSCM, (then) Chairperson of the Board, Provena Health, and Gerald Pearson, President/CEO, Provena Health, Dec. 11, 1998, Loyola University Chicago School of Law's Center for Catholic Health Care and Sponsorship (materials on file with authors).

35. The *Ethical and Religious Directives for Catholic Health Care Services* (the "Directives"), foundational principles to which all Catholic health care providers must adhere, codified this new role for the bishops in the 1994 revision and cautioned that "serious consequences [to] the identity or reputation of Catholic health care services, or . . . the high risk of scandal" can arise if partnering arrangements are not carefully structured. *See* National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* 26, (1995). Accordingly, the Directives ad-

providers have assumed in many markets.[36] As health care institutions and systems move closer to lay sponsorship, bishops increasingly will find themselves interacting directly with executives and board members who may lack a common reference point with the bishop on issues of theology, ethics and canon law. Providing clear, consistent doctrinal interpretations will enhance the relationship between the Church and lay health care leadership. Further, the significant size of many of the leading Catholic health care systems has brought enhanced public scrutiny of actions taken by Catholic providers, particularly as these systems' connection to the "local level" becomes more remote. As a result, decisions that in the past might have been quietly negotiated at the community level instead become highly charged and publicized matters.

Anecdotal evidence suggests discomfort over perceived inconsistencies and misunderstandings regarding ethical and canonical guidance, particularly with respect to Catholic/non-Catholic partnering issues. Calls for consistency and direction were solicited at several public forums in 1998.[37] The Catholic Health Association is also pursuing the issue.[38] Several instances in 1998 serve to illustrate the concerns, as well as the public misperceptions that can result from conflict over issues of canonical authority and ethical perspective.[39]

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vise that the bishop is to be involved early in the decision making process, with such arrangements subject to his disapproval if they cause scandal or harm the Catholic ministry occurring in the diocese. *See id.* Difficulties arise, however, because there can be a wide divergence among bishops as to whether an activity is scandalous. *See* Singer, *supra* note 19, at 214.

36. Catholic health care has at least 20% market share in 19 states and greater than 25% market share in 10 states. *See New Covenant, supra* note 11. *See also* Sexton, *supra* note 13, at 19.

37. CHA Assembly, June 1998; The Kaleidoscope of Sponsorship, Apr. 21, 1998, at Loyola University Chicago School of Law's Center for Catholic Health Care and Sponsorship; Consolidated Catholic Health Care Governance Forum, Feb. 1998.

38. To avoid losing the generations of Catholic traditions ingrained in these facilities, the CHA recently voted to offer membership to select categories of for-profit health care providers. CHA members can recommend membership of non-Catholic and for-profit organizations that have either a direct or indirect relationship to a Catholic facility. *See Membership/Dues Proposal Reflects Changing Healthcare Ministry*, CATH. HEALTH WORLD, May 15, 1998, at S1.

39. Certainly one of the most publicized instances involved the partnership formed between the Sisters of Charity of St. Augustine ("CSA") and Columbia/HCA in 1996. After an extensive search for a partner for their health care system, the Sisters chose to create a for-profit joint venture with Columbia/HCA. Two bishops with CSA facilities in their dioceses approved the transaction; the third bishop did not. Ultimately, after widespread publicity of a rift in the Church, the Vatican resolved the controversy, allowing the transaction to go forward. Columbia/HCA paid

Certainly the signal conflict in 1998 was the sale of St. Louis University Hospital, a Jesuit institution, to Tenet, the nation's second largest proprietary hospital chain.[40] The sale raised at least three fundamental issues: (1) what is the mission of a Catholic health care institution; (2) can that mission continue under non-Catholic ownership; and (3) who is empowered under Church law to make that decision. St. Louis University, and its hospital, are Jesuit institutions. The University's desire to sell its hospital attracted national attention as the University trustees forged ahead after accepting Tenet's bid, which was $100 million more than a competing offer received from a consortium of Catholic health systems.[41] Archbishop Justin Rigali, bishop of the diocese in which the University and its hospital are located, publicly rebuked Tenet's offer, questioning the ability of a for-profit owner to assure the Hospital's continued fidelity to the Catholic mission and Catholic values.[42] Tenet had agreed to adopt the *Ethical and Religious Directives*, maintain current levels of charity care and pastoral care programs, appoint members of the Jesuit congregation to its governing board, and ensure that canon law is followed—conditions that satisfied the University trustees.[43]

The Catholic Health Association took a prominent stance against the sale, submitting written testimony to the Missouri Attorney General questioning Tenet's ability to continue the Hospital's historic mission to the poor and underserved.[44] Other ministry leaders, including Cardinals Mahoney (Los An-

over $200 million for the 50/50 joint venture, which had assets of $438 million and four acute care hospitals. A *Modern Healthcare* article in September 1998 hinted that Columbia/HCA may be looking to divest from the partnership in the near future. *See* Mary Chris Jaklevic, *Cleveland Pullout?: Columbia Seen as Seeking Buyers for Four Hospitals*, MOD. HEALTHCARE, Sept. 28, 1998, at 10. It was announced in March 1999 that Columbia/HCA would sell its 50% interest by July. *See* Mary Chris Jaklevic, *Goodbye Cleveland: Columbia to Sell Stake in Controversial Joint Venture*, MOD. HEALTHCARE, Mar. 8, 1999, at 2.

40. Tenet Healthcare Corporation has 128 hospitals and net patient revenues of $7.7 billion. *See* Bellandi, *While You Weren't Sleeping, supra* note 12, at 48.

41. *See SLU Finalizes Hospital Sale to Tenet Healthcare*, CATH. HEALTH WORLD, Mar. 15, 1998, at 1.

42. *See id.* at 4.

43. *See Directives, supra* note 35; *see also* J. Duncan Moore, Jr., *Going For-Profit: St. Louis Catholic Hospital Gets OK For Sale to Tenet*, MOD. HEALTHCARE, Mar. 2, 1998, at 35.

44. *See CHA Submits Testimony at SLU Hearing*, CATH. HEALTH WORLD, Jan. 15, 1998, at 1 (quoting Fr. Place, "The essential purpose [of health care] should be a cured patient, a comforted person, and a healthier community, not earning a profit or return on capital for shareholders.").

geles), O'Connor (New York) and Hickey (Washington, DC) also publicly urged Missouri and the Vatican to reject Tenet's bid.[45] Archbishop Rigali met with Vatican officials to argue his opposition to the sale. Ultimately, the Holy See approved the sale, avoiding the merits of the dispute and proclaiming instead that, under canon law, the Bishop lacked authority to disapprove of the transaction because the Board had become vested with full control of the institution more than thirty years prior to the proposed sale to Tenet.

Interestingly, the St. Louis sale was not the only acquisition in 1998 of a Catholic hospital by a for-profit entity. At least four other sale transactions occurred, although none of the other transactions attracted national attention, and presumably none of them were contested by the local bishop or other Catholic organizations.[46]

The sale of Queen of Angels-Hollywood Presbyterian Medical Center ("Queen"), coincidentally also to Tenet, also proved highly controversial in 1998.[47] Cardinal Mahoney, Archbishop of Los Angeles, rejected the proposed sale of the Hospital, ordering the Hospital's Board to cease and desist from continuing the transaction.[48] The Cardinal based his authority on canon law,[49] as well as provisions in Queen's bylaws stating that the institution must adhere to the *Directives* and that the Cardinal was the ultimate arbiter of that adherence.

Accordingly, argued the Cardinal, his decision that the sale would violate the *Directives* was binding upon Queen. Thus, the sale could not go forward under California law, which required

45. *See Bishops Denounce SLU Hospital Sale,* CATH. HEALTH WORLD, Nov. 15, 1997, at 1, 2 (quoting Cardinal Hickey, "In the highly competitive health market, for-profit corporations seldom provide extensive service to the poor. Instead, they often shunt such service to already struggling charitable health care institutions.").

46. *See 1998 Hospital Mergers, supra* note 15.

47. The Hospital, itself the merger of Catholic and secular institutions, was Catholic, although its canonical status was uncertain. *See Tenet Completes Acquisition of Queen of Angels-Hollywood Presbyterian Medical Center; Crucial Services, Charity Care Guaranteed,* (June 12, 1998), <http://www.tenethealth.com/corporate/about_tenet/at_news/june98_queen.html>.

48. *See* Ron Shinkman, *Another St. Louis?: Church Weighs in on Tenet Deal in L.A.*, MOD. HEALTHCARE, Mar. 2, 1998, at 20.

49. While canon law does not require the local bishop to approve facility sales, the Holy See has adopted a practice of requiring a bishop's "non-objection" before it will give its final approval to a sale of a Catholic institution. *See* Singer, *supra* note 19, at 211.

all institutional sales to be conducted in a manner that does not violate governing corporate documents.[50]

The Cardinal's ecclesiastical authority over Queen was never reported to be resolved. What is telling, however, is the step taken by Queen's Board to resolve the dispute. The Board amended the bylaws to remove the need for the Cardinal's approval, eliminating his civil law authority to stop the sale. From the California Attorney General's perspective, elimination of the bylaw provision removed the Cardinal's ability to influence the transaction under California law.[51] After requiring revisions to Tenet's offer so as to assure the continuance of the Hospital's historical level of charity care, the Attorney General allowed the sale to go forward.[52]

Actions by the Vatican negating a transaction in New Jersey, and by the Bishop of Providence, Rhode Island, reading the Vatican's New Jersey decision as binding precedent, have also created confusion and concern. In the New Jersey situation, St. Peter's Medical Center sought Vatican approval to merge with Robert Wood Johnson University Center, a non-Catholic institution.[53] Both hospitals are located in New Brunswick, New Jersey.[54] St. Peter's proposed to follow the *Directives* by carving out those services objectionable to Catholic doctrine and housing them in an independent entity outside of the joint system. No revenues generated by the prohibited procedures would flow back to St. Peter's.[55] Other Catholic providers seeking mergers with secular institutions had used this strategy.[56] In this instance, however, the Vatican's Congregation of the Clergy rejected the merger, ruling that corporately isolating the procedures failed to protect the Catholic institution and Church

50. *See generally* James R. Schwartz & H. Chester Horn, Jr., *Hollywood Squared; California's Hospital Conversion Law*, HOSPITALS & HEALTH NETWORKS, Aug. 5, 1998, at 62.

51. *See generally* Ron Shinkman, *Give-and-Take Closes Deal: Last Minute Changes Lead to Approval of L.A. Conversion*, MOD. HEALTHCARE, June 22, 1998, at 22.

52. *See id.*

53. *See* Bruce Japsen, *Vatican Taking Closer Look: Rejected N.J. Alliance Shows Deals Face Intensified Scrutiny*, MOD. HEALTHCARE, July 7, 1997, at 14. *See also* Bruce Japsen, *Vatican Ups Interest in Healthcare Issues*, MOD. HEALTHCARE, Dec. 8, 1997, at 25.

54. *See Japsen, Vatican Taking Closer Look*, *supra* note 53, at 14.

55. The agreement was anticipated to save the two hospitals over $75 million over five years. *See* Karen Pallarito, *Blessing Withheld: Vatican Rejects Deal Involving N.J. Catholic Hospital*, MOD. HEALTHCARE, June 23, 1997, at 4.

56. *See generally id.*

from scandal.[57] Importantly, the Congregation of the Clergy seldom becomes involves in merger and sale decisions, which are typically made by the Vatican's Congregation for Religious.

Months later, this directive was found to be precedential by the Bishop of Providence, who ultimately rejected a merger with a local health care provider that the bishop himself had helped to negotiate. The proposed merger between St. Joseph Health Services, a two-hospital system, and Lifespan had been the subject of approximately eighteen months of negotiation.[58] Significantly, St. Joseph is diocesan sponsored, so the bishop had been intimately involved in the discussions with Lifespan. The merger, according to a diocesan statement reported in *Modern Healthcare*, "was drawn from a careful review" of the *Ethical and Religious Directives* and "the diocese and St. Joseph Health Services conducted comprehensive negotiation with officials of Lifespan to ensure that the affiliation would ensure preservation of St. Joseph's Catholic identity and its ability to provide health care that is consistent with Catholic morality and ethics."[59]

Nevertheless, the Bishop rejected the merger after reading the Vatican's St. Peter's decision as binding precedent.[60] It remains to be seen whether other bishops will take a similar position or whether other Vatican curias reviewing health care transactions will adopt this approach.

An examination of reported transactions reveals that some bishops have felt more comfortable with partnerships.[61] One commonly used partnering model uses a joint operating company formed to jointly oversee and operate the partnering facilities.[62] The respective sponsors maintain asset ownership. This model typically is only approved when the secular hospital agrees to "spin-off" services deemed to violate the *Directives.* For example, before completing a merger with Mercy Health System of Ohio, the Community Hospital of Springfield, Ohio, built an independent clinic to provide sterilizations.[63] But the

57. *See id.*
58. *See* John Morrissey, *Catholics Call It Off: Bishop Scuttles R.I. Merger with Secular Network,* MOD. HEALTHCARE, Dec. 15, 1997, at 6.
59. *See id.*
60. *See id.*
61. *See* Mark Hayward, *Catholic Expert: Spinoff Clinic Could Ease Merger,* UNION LEADER, at A5 (detailing three models of secular partnerships: a loose alliance, a joint operating company, or a full consolidation that follows the *Directives*).
62. *See id.*
63. *See* Bruce Japsen, *Church Puts Faith in System Mergers in Light of Health Care Reforms,* MOD. HEALTHCARE, June 6, 1994, at 32, 34.

"spin-off" is not always physically separate. The Wall Street Journal indicated that in one instance, sterilizations are performed on the ground floor of a Catholic facility in Tennessee; the non-Catholic services "separated" only by a sign, logo, driveway and rent payment to the hospital.[64]

In joint operating agreements, unique arrangements can be structured.[65] One such arrangement is a church-managed city hospital in Texas, the Brackenridge Hospital.[66] The Seton Healthcare Network, sponsored by the Daughters of Charity, leases Brackenridge from the city of Austin and offers reproductive services under the bishop's approval.[67] The city insisted that the Hospital continue to offer contraception and sterilizations (not abortions) so the Daughters agreed to let the city pay for the fifth floor family planning office and the salaries of the related physicians and nurses.[68] In another reported instance, also sponsored by the Daughters of Charity, Niagara Falls Memorial Hospital was authorized by the Bishop of Buffalo to continue giving contraception and abortion referrals, on an interim basis.[69]

Certainly each of these episodes raises unique issues, many of the details of which were never publicly reported. What elevates the importance of these episodes is that they may well be harbingers of things to come. Both sales to Tenet raise the fundamental questions of what comprises the defining characteris-

64. *See* Lagnado, *supra* note 4, at A8 (discussing the Middle Tennessee Medical Center in Murfreesboro, Tenn., jointly owned by DCNHS and Baptist Hospital).

65. *See id.,* (noting that in structuring mergers and joint operating agreements, Catholic health systems may turn to an ethicist to reconcile Church doctrines with the transaction at hand).

66. *See Vatican Criticizes Hospital Deal,* TIMES-UNION (Albany, N.Y.), Aug. 1, 1998, at A2.

67. *See id.*

68. *See* Robert Siegel & Noah Adams, *Austin Catholic Hospital,* (NPR All Things Considered, Sept. 8, 1998), Transcript No. 98090811-212.

69. *See* Lagnado, *Role Growing,* WALL ST. J., *supra* note 4, at A8 (discussing women who want contraceptive injections go to a family practice center a block away). Still other times the hospitals will merge with the surviving Catholic hospital. For example, in 1997, Liberty Medical Center in Baltimore, Maryland, became a Catholic hospital when it merged with Bon Secours Health System. This type of model is commonly publicized in the news media, especially when the only hospital in the community is Catholic and patients have to travel for desired services that are not permitted under religious directives. Merger Watch in New York was formed to track Catholic acquisitions and increase public awareness when reproductive services are removed from a community due to merger activity; *see also supra* note 5; *see generally* Michael Casey, *Can Managed Care Incorporate Religious Beliefs?,* MEDICAL INDUSTRY TODAY, Apr. 16, 1998.

tics of Catholic health care, who makes this determination and whether these characteristics can be provided under alternative forms of ownership. The New Jersey, Rhode Island and other situations also raise the question of defining Catholic health care, but from the perspective of whether the moral and ethical grounding of this care is incompatible with certain relationships with secular partners.

Each of these instances illustrates the need to have both a clear understanding of the bedrock characteristics defining Catholic care,[70] as well as clearly understood canonical and ethical precepts in order to avoid public confusion and questionable press. As health care systems continue to develop across wider geographic and diocesan lines, ministry and economic strategies demand continued interrelationship between Catholic and secular providers. As institutions test alternative sponsorship models,[71] it is imperative that common understandings about ministry, and canonical and ethical precepts, continue to emerge.

ISSUE 2: CONSOLIDATION OF CATHOLIC HEALTH CARE

Consolidation continues to be a driving force in the Catholic health care landscape, although the consolidation pace has slowed significantly from that set during the period 1995 to 1997. Clearly affected by Columbia/HCA's divestiture strategy,[72] mergers and acquisitions declined twenty-seven percent overall

70. Much of this defining has revolved around the motivations underlying the presence of the Catholic health care ministry and its delivery of care. *See Making the Case for Not-For-Profit Healthcare,* Cardinal Joseph Bernadin, a speech at the Harvard Business School Club of Chicago, Jan. 12, 1995 (pamphlet on file with authors). While these motivations are an extremely important component of the defining characteristics, insurers, employers, patients, and regulators are increasingly asking whether care provided in a Catholic institution is experientially different. If it is not, sensitivity to religious issues arising in contracting and legislation will continue to wane. One of the most pointed examples occurred in New York, where proposed legislation would have required all health care providers to offer abortion and family planning services. *See NY Providers May Face Hobson's Choice*, CATH. HEALTH WORLD, June 15, 1998, at 6.

71. *See* discussion *infra* Section 2, Issue 3: Next Generation Sponsorship.

72. In April 1998, Columbia/HCA announced its regional restructuring plan, vowing to sell 22 hospitals in 1998 to the non-profit sector. The chairman and chief executive of Columbia/HCA, Thomas F. Frist, Jr., was quoted as saying that the decision to sell to non-profits was "the right thing to do for these communities." *See* Casey, *supra* note 16.

in health care, as compared to 1997 levels.[73] In 1998, 199 transactions involving 687 acute care hospitals or systems were announced.[74] Continued declines in overall merger and acquisition activity are predicted in 1999.[75]

Catholic health care likewise saw a moderation in merger and acquisition activity. In 1998, twenty-nine transactions were concluded, an increase of only three from 1997.[76] Three transactions involved system mergers;[77] several sizeable systems were created. In addition, some of the largest systems expanded or announced merger discussions. Several of these transactions are reviewed below.

Overall, 1998 saw the solidification of three models of Catholic health care delivery—national, regional and local. Significantly, most of the transactions to create these models have been driven by the New Covenant Initiative, a highly public movement to stimulate and facilitate health care system and facility mergers. By calling upon sponsoring religious congregations to work together in furtherance of the Church, the New Covenant Initiative resulted in the most radical reshaping of Catholic health care in the United States since the founding of the first Catholic hospital.[78] Importantly, most of the significant

73. *See* Deanna Bellandi, *Levin: Mergers Fell Sharply in '98*, MOD. HEALTHCARE, Jan. 25, 1999, at 8 (reporting a study done by Irving Levin Associates of New Canaan, Connecticut — 199 publicly announced deals in 1998, 217 in 1997).

74. *See id. See also* Deanna Bellandi, *A Year of More and Less: Number of Hospital Deals Drop, But More Facilities Change Hands*, MOD. HEALTHCARE, Jan. 11, 1999, at 48; Bruce Japsen, *An Off-Year for Consolidations: 1997 Tally Shows Sharp Cutback in Big Corporate Deals*, MOD. HEALTHCARE, Jan. 12, 1998, at 40 (explaining that the number of hospitals involved dropped 18%. There were only three system transactions, compared with 11 system mergers in 1996).

75. *See* Bellandi, *supra* note 15, at 23.

76. *See 1998 Hospital Mergers, supra* note 15, at 49. *See also 1997 Hospital Mergers, supra* note 18.

77. *See id.*

78. This spirit of cooperation has also flowed to "back office" functions. Prompted by the New Covenant Initiative and the desire to work together and foster lower costs, a group of 12 Catholic and other faith-based and non-profit health care systems formed a purchasing group, Consortia, on July 1, 1998. Consortia has an annual purchasing volume of approximately $2 billion and is an excellent example of achieving economies of scale by collaboration. *See Provena Joins Purchasing Group*, CATH. HEALTH WORLD, Nov. 15, 1998, at 3 (reporting a merger of Catholic Material Management Alliance from St. Louis and Sisters of the Sorrowful Mother-Diversified Health Services of Milwaukee, and that Consortia will purchase goods and services in over 35 states.). *See also Twelve Health Systems Form Consolidated Purchasing Company*, CATH. HEALTH WORLD, Mar. 1, 1998, at 3 (the original twelve member systems included: Ancilla Systems, Catholic Health Initiatives, Catholic Health Midwest, DCNHS, Franciscan Health Partnership, Holy Cross Health System, Hospital Sisters

mergers to date have been motivated primarily by ministry, not competitive or financial reasons. As such, the dominant transactional form has been merger (co-sponsorship), with each contributing religious community retaining an equal role in the new entity irrespective of assets contributed.[79]

It will be interesting to see if 1998 proves to have been a cusp year, with future merger activity having a decidedly financial motivation.[80] The entire health care industry has begun to downsize in anticipation of further Medicare cuts mandated by the BBA.[81] Though all health care providers face serious challenges from reimbursement cutbacks, hospitals will be hardest hit.[82] One expert has even predicted that an unpartnered Catholic hospital's ability to treat the indigent will completely disappear.[83]

Health System, Ministry Health Care, St. John Health System, Via Caritas Health System, Via Christi Health System and Wheaton Franciscan Services).

79. Under the typical co-sponsorship arrangement, assets are brought together by merger or creation of a joint holding company, with reserved powers maintained equally by the leadership of the respective religious communities whose ministries have been combined. *See infra* Section 2, Issue 3.

80. If so, for-profit systems may once again increase. Two relatively new organizations are seemingly well endowed. Vanguard Health Systems, of Nashville, Tennessee, was formed in January 1998 with the purpose of converting non-profit health care organizations to for-profit. Vanguard will offer capital to well-run facilities in need of debt financing and then build integrated networks in a regional area. Vanguard espouses that the regional boards will retain autonomy, continuing to make decisions and giving input on the local community's health care needs. Mission Health, also formed in 1998, will joint venture with non-profit facilities, provide equity, and convert facilities to for-profit apparently while allowing control at the local level — the majority of board seats remain with the original owner. *See* Anita Sharpe, *Entrepreneurs Look to Profit on Nonprofit Hospitals: Upstarts Target More Established Institutions and Offer Them Autonomy,* WALL ST. J., Feb. 2, 1998, at B6; *see also Money for Mission*, HOSPITALS AND HEALTH NETWORKS, Apr. 20, 1998, at 57.

81. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, 4304, 111 Stat. 251 (1997) (H.R. 2015). *See also*: <http://www.senate.gov/~finance/mcarecon.html> and <http://www.hcfa.gov/init/bba/bbaintro.html> (HCFA and Senate websites providing helpful summary projections).

82. Private "safety-net" hospitals rely on government reimbursement in their care of the poor. The BBA of 1997 cuts $650 million in Medicare disproportionate share hospital ("DSH") funding. *See Proposed DSH Cuts Jeopardize Private Hospitals that Care for the Poor,* CATH. HEALTH WORLD, Sept. 15, 1998, at 2. The number of inpatient days are also estimated to shrink, largely due to cutbacks in Medicare and Medicaid. In 1998, there were 744 inpatient days per 1,000 population. By 2000, inpatient days are estimated to be only 494 per 1,000 population. *See* John Sullivan, *Sponsorship School: Teaching Sponsorship As Ministry*, July 8, 1998, Loyola University Chicago School of Law's Center for Catholic Health Care and Sponsorship (Mr. Sullivan is Executive Vice President, Loyola University Chicago Medical Center) (on file with authors).

83. *See* McCormick, *supra* note 7, at 10. *See also* Sexton *supra* note 13, at 18 (reporting a 1996 study in *Health Progress* that predicted one-third of Catholic hospi-

The BBA is designed to reduce the government's Medicare spending by approximately $116 billion through 2002.[84] Significantly, the bulk of the cuts will occur in 2001 and 2002, although the impact is already starting to be felt. Fiscal year 1998 cuts are projected to total $6.7 billion,[85] and will reach, among other things, long term care, outpatient services and medical education. Reductions in 1999-2002 will total $16.3 billion, $29.8 billion, $20.8 billion and $41.5 billion, respectively.[86] Many pundits are predicting a strong wave of merger and closure activity should the BBA cuts be fully implemented.

If the predictions prove accurate, strong Catholic health care providers may find themselves challenged both to assure their own financial integrity, and to reach out to their weakened brethren. With finances driving transactions, the development of a co-sponsorship model with all sponsors having equal voice and vote could be called into question. If so, acquisitions may gain favor, with sponsoring congregations divesting themselves completely from health care, or receiving a minimal, unequal role in the acquiring entity because of the weakness of the institution brought into the acquiring system. One hospital, although not Catholic, has already cited the BBA as a reason behind its decision to sell itself to a larger system.[87]

It is important to note that not every health care system must merge to remain successful. There are numerous examples of well-positioned systems with strong revenue flows that should continue to thrive well into the next century.[88]

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tals could close in response to the combination of market-based reforms, such as managed care penetration and shrinking inpatient utilization, and government-sponsored health reforms such as cutbacks in Medicare and Medicaid).

84. *See* Bellandi, *supra* note 3, at 2. *See also* Sullivan, *supra* note 82 (total savings on Medicare Part A of $66.4 billion, including $17 billion on PPS, $16 billion on home health care, $9.5 billion on skilled nursing facilities; Medicare Part B savings of $33.6, including $15 billion on premiums, $17 billion outpatient services, $5.3 billion on physicians; Medicare+Choice savings of $21.8 billion).

85. *See* Sullivan, *supra* note 82.

86. *See id.*

87. Jewish Hospital in Lexington, Kentucky, announced its intent to sell to St. Joseph Hospital in September 1998. *See* Jim Warren, *Lexington, KY, Hospital to Keep New Acquisition Open,* LEXINGTON HERALD-LEADER, Sept. 15, 1998.

88. Hospital Sisters Health System, based in Springfield, Illinois, and sponsored by the Hospital Sisters of the Third Order of St. Francis, operates 13 hospitals and is ranked as one of the strongest systems in the Midwest due to its steady annual operating margins, strong market positions, and return on investment income. *See* Karen Pallarito, *The Strong, Silent Type: Low-Profile Midwest System Posts Impressive Numbers*, MOD. HEALTHCARE, Nov. 9, 1998, at 14. Further, the Sisters of Mercy systems of the St. Louis Province and Detroit Province, Resurrection Health Care (Chicago),

A. National Systems

Modern Healthcare reported in its 1998 Multi-Unit Providers Survey that, overall, four of the nation's ten largest health care systems in net patient revenues are Catholic: Catholic Health Initiatives ("CHI"), Daughters of Charity National Health System ("DCNHS"), Catholic Healthcare West ("CHW") and Catholic Health East ("CHE").[89] Of these four, DCNHS and CHI have a true national presence, operating institutions across the United States.

St. Louis-based DCNHS is the oldest of two national systems, formed twelve years ago by the Daughters of Charity. The Daughters still remain the sole national sponsor of DCNHS.[90] DCNHS reported operating forty-seven acute care hospitals in 1998, with 11,409 beds.[91] The system generated $3.6 billion net patient revenue.[92]

DCNHS and the Sisters of St. Joseph Health System announced in June 1998 their discussion of a possible merger or co-sponsorship.[93] If the transaction closes, the total system would generate $8 billion in annual revenue, making it the fourth largest system in the country and the largest Catholic health system in terms of revenue.[94]

Relatively new to the national scene, Denver-based Catholic Health Initiatives was formed in 1996 by the merger of the Franciscan Health System, the Sisters of Charity Health Care System

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Sisters of St. Joseph of Orange (California), Sisters of Providence (Seattle), and Sisters of Providence (Spokane) are just some of the many examples of dominant single sponsor health care systems. Interestingly, the two Sisters of Providence recently announced a merger of their religious communities, but not their health care systems. *See Two Provinces Agree to Combine*, CATH. HEALTH WORLD, Nov. 1, 1998, at C3.

89. *See* Bellandi, *supra* note 12, at 36, 48 (CHI $3.7 billion; DCHNS $3.6 billion; CHW $2.7 billion; CHE $2.0 billion). Note that CHE revenues may be understated in the *Modern* Survey as some revenues were not reported by co-sponsoring systems. *See also St. Mary's*, *infra* note 113, at 4.

90. The Daughters currently co-sponsor with other systems only on the local level. *See* Deanna Bellandi, *Catholic Merger Envy: Daughter of Charity Wants a Big Deal of its Own*, MOD. HEALTHCARE, Mar. 23, 1998, at 4.

91. *See* Bellandi, *supra* note 12, at 48.

92. *See id.* at 36, 48.

93. *See* Michael Casey, *Daughters of Charity Stays the Course*, MED. INDUS. TODAY, June 30, 1998.

94. *See id.* (combined system would have 64 hospitals in 15 states.). *See also* Bellandi, *supra* note 12, at 36 (with revenues of $8 billion, DCNHS would follow the top three systems in net patient revenues: the U.S. Department of Veterans Affairs ($19.4 billion), Columbia/HCA Health Care Corp. ($18.8 billion), Kaiser Permanente ($14.4 billion).

and the Catholic Health Corporation.[95] CHI sponsorship is structured under canon law as a public juridic person, enabling it to be a lay-sponsored organization.[96] Due to an aggressive growth strategy, CHI now spans twenty-two states and, in 1997, surpassed DCNHS as the largest Catholic health system in the country.[97]

The significance of CHI, and perhaps DCNHS, assuming that it is opening itself up to co-sponsorship,[98] cannot be overstated. By offering a national presence, significant financial strength and a willingness to work with religious congregations seeking to partner or reduce their role in health care, national organizations offer a compelling incentive for Catholic collaboration where little or none may have existed before. The significant growth of CHI in just three years attests to the strength and allure of a national presence. While most of the consolidation activity today is occurring on a regional basis, there is little doubt that national organizations, skilled in working with multiple religious communities, will continue to grow. Indeed, if national or multi-regional managed care contracting comes to the foreground, or other operating or ministry benefits are discovered, additional national organizations might be created through mergers of large, regional systems.

B. Regional Strategies

The majority of consolidations occurring in the Catholic acute care sector involve regional strategies. As sponsors and systems

95. *See* Deanna Bellandi, *Designed for Growth: Catholic Megasystem CHI Ready to Take Off*, MOD. HEALTHCARE, Apr. 13, 1998, at 35.

96. *See id.* (CHI has a 14-member governing board with seven lay members and seven religious members.). For a detailed review of CHI's structure, *see id. See also* discussion *infra* at Section 2, Issue 3.

97. *See id.* Just in the last year, CHI has merged with a North Dakota hospital and eight clinics in the upper Midwest, consolidated operations with an Iowa Catholic system under a joint operating company, formed a joint venture with a for-profit system in Nebraska, and acquired a Columbia/HCA hospital in Little Rock, Arkansas, and another hospital in Chattanooga, Tennessee.

98. Effective September 1997, the Daughters modified their governance structure by eliminating their regional boards in preparation for expansion to a national level. Donald Brennan, President and CEO, commented: "Going from three layers [of governance] to just local and national, we can be much more able to respond in a timely way to challenges we face. We don't want our structure to be an impediment to timely decision making. . . . Our new model will accommodate system-level co-sponsorship with other religious congregations, when there is clear evidence that joining together would significantly advance a strong, vibrant Catholic health ministry." *See* Bruce Japsen, *Daughters Loosen Reins: Catholic Giant Takes Steps to Make Partnerships Easier*, MOD. HEALTHCARE, Oct. 6, 1997, at 114.

have sought partnerships, many have turned toward their neighbors in order to address local or regional needs.

Regional systems vary considerably in asset size and geographic coverage. Examples of large regional co-sponsorships include CHW and newly formed CHE.[99] Three sponsoring congregations established CHW in 1986, the Burlingame Regional Community of the Sisters of Mercy, the Auburn Regional Community of the Sisters of Mercy, and the Sisters of St. Dominic of the Congregation of the Most Holy Rosary of Adrian, Michigan.[100] Since its founding, CHW has tripled its size to include seven sponsors. CHW is comprised of thirty-six hospitals,[101] and its assets total $4.78 billion, with annual revenue in 1997 of $2.7 billion.[102] *Modern Healthcare* placed it among the country's most aggressive acquirers in 1997.[103]

CHE was formed in early 1998 by three co-sponsors: Eastern Mercy Health System of Radnor, Pennsylvania; the Sisters of Providence Health System of Holyoke, Massachusetts; and the Allegheny Health System of Tampa, Florida.[104] CHE includes thirty-three hospitals, thirty-one long term care facilities, twenty residential facilities, five mental health facilities, 16,667 beds and almost 32,000 employees; CHE facilities are geographically scattered over seventeen communities in ten states from Maine to

99. Certainly there are many other health care systems that have adopted a regional strategy. The Sisters of Mercy of St. Louis, Bon Secours Health System and the Sisters of Providence (Seattle) are but three of several other systems with a regional focus.

100. *See* Rhonda L. Rundle, *Catholic Hospitals Aggressively Fight for Mergers; Balancing Charity, Big Business Isn't Easy*, ARIZ. REPUBLIC, Mar. 16, 1997, at D1.

101. *See* Bellandi, *supra* note 12, at 48.

102. *See id.*

103. *See* Bruce Japsen and Lisa Scott, *System Growth a Close Race, 1997 Multiunit Providers Survey Finds Not-for-Profits Ahead by a Nose*, MOD. HEALTHCARE, May 26, 1997, at 51 (In 1997, CHW acquired eight hospitals, or a 33% growth in one year.). *See also* Ron Shinkman, *Tenet-Catholic Venture: For-Profit Religious Systems Link in Central California*, MOD. HEALTHCARE, Jan. 15, 1998, at 18 (CHW formed a successful 50/50 partnership with Tenet whereby seven hospitals from each organization in the northern San Joaquin Valley pool their resources to jointly negotiate for managed care contracts. To manage the partnership, a new company was formed, Central Valley Health Care System, and three members from each hospital were named for its board. No assets were exchanged; each organization retains full ownership of its respective holdings.).

104. *See* Michael Casey, *Catholics Unite on the East Coast*, MED. INDUS. TODAY, Feb. 5, 1998.

Florida.[105] Combined annual revenues are currently $2.8 billion.[106]

Promising regional negotiations are expected to conclude in 1999 that will result in the creation of systems rivaling the size and coverage of CHW and CHE. A new system, Christus Health, created by the February 1, 1999, merger between the Incarnate Word Health System of San Antonio and the Sisters of Charity Health Care System of Houston, spans five states and is the sixth largest Catholic system in the United States.[107] Additionally, the system may become the dominant player in the southeast Texas market if the negotiations with Columbia/HCA to purchase two of its hospitals in Houston are successful.[108]

Metropolitan alliances are a common regional strategy. In New York City, three systems from Manhattan, Brooklyn and Rockville Centre began discussions in 1998 to create one large regional network in the metropolitan area, with over $1 billion in combined annual revenues.[109] Discussions began at the request of New York's Archbishop, Cardinal John O'Connor, who encouraged sponsors to come together and provide integrated managed health services and preserve the Catholic health care ministry. The network is envisioned to "develop and expand current joint managed care products, coordinate health care and social services in the region, reduce administrative overhead, consolidate existing services, introduce wellness programs and provide for group purchasing of supplies and pharmaceutical products."[110]

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105. *See Catholic Health East Becomes Fully Operational*, CATH. HEALTH WORLD, Feb. 1, 1998, at 4.

106. *See id.*

107. *See Texas Sisters of Charity Agree to Consolidate Their Systems,* CATH. HEALTH WORLD, Aug. 1, 1998, at 1, 4 (Both ministries originally were founded by the same community of sisters over 130 years ago but separated because of the distance between them when part of the group established Santa Rosa Hospital in San Antonio. The two religious orders will remain separate and govern equally.). *See also Christus Health Begins Operations*, CATH. HEALTH WORLD, Feb. 15, 1999, at 3.

108. *See generally Sisters of Charity Negotiate Purchase of Two Hospitals*, CATH. HEALTH WORLD, Nov. 15, 1998, at 3.

109. *See* Michael Casey, *Catholic Providers Look At Merger Alternatives: NY Catholic Healthcare Providers Expected to Unite*, MED. INDUS. TODAY, Jan. 15, 1998 (discussing Catholic Health Care Network and a 15-hospital managed care organization from New York City, Catholic Health Services of Long Island, Catholic Medical Center of Brooklyn and Queens). *See also Texas Sisters of Charity*, *supra* note 107, at 4.

110. *See* Casey, *supra* note 109.

A slowdown in regional formations is likely to occur in 1999 and beyond, as many of the largest Catholic health care systems have gone through mergers and acquisitions toward creation of a large regional model. Acquisitions in the future are likely to involve single facilities or smaller systems that either lacked the financial strength to serve as the base of a regional system, or chose not to join existing or new co-sponsorships. This is not to say, of course, that every institution or system should or must attach itself to a large local or regional system. Nevertheless, while the pace of consolidation across Catholic health care is likely to slow, consolidation itself is certain to continue.

C. Local Strategies

Partnerships at a local level most often stem from two or more institutions concluding that collaboration expands quality health care services and lowers costs. Examples range from programmatic or service sharing through affiliation, joint ventures and merger. It is typically at the local level where collaborations with non-Catholic partners occur. The range and quantity of these "partnerships," some formal and many not, are too varied and numerous to track. A few illustrations are useful, however, to illustrate activities at the local level.[111]

For example, during the discussions to form the Catholic Health Services of Long Island in late 1997, a major concern was to "be able to speak with a single voice" in a competitive marketplace.[112] Similarly, in East St. Louis, Illinois, where the poor

111. Two situations in 1998 impressed upon the Catholic health community that higher rate increases can be negotiated with large systems and multi-year contracts. First, Bishop Mansell, the Bishop of Buffalo, insisted that the Catholic hospitals in his diocese would not accept a lower rate for Medicare services from the Buffalo-based HMO, Independent Health. The HMO dramatically cut the rate of reimbursement and the independent Catholic providers in the area would have been forced to reduce care for the elderly. Bishop Mansell publicly vowed that any community member who wanted service from a local Catholic hospital would be able to receive it. He created a consortium of Catholic hospitals to negotiate together for a new contract at better rates. *See* Jerry Zremski, *Bishop Fights Insurer's Cutoff of Catholic Hospitals,* BUFFALO NEWS, Sept. 3, 1998, at 1B. Second, similar rate disputes occurred in California between CHW and Blue Cross of California. CHW ran advertisements stating that Blue Cross's 4.4 million members could no longer be served at any of the 30 CHW hospitals the next Tuesday, which was the expiration of their contract with Blue Cross. Blue Cross quickly signed a multi-year contract with more acceptable reimbursements. *See* Bloomberg News, *Wellpoint, Catholic Healthcare Settle Dispute,* L.A. TIMES, July 9, 1998, at D2.

112. *See* Stuart Vincent, *Single Agency to Run Catholic Hospitals; Diocese Cites Need for Unified Voice*, NEWSDAY (Naussau and Suffolk Edition) Oct. 26, 1997, at A33 (quoting Msgr. Alan Placa, the bishop's secretary for health affairs). The Long

and indigent patient base is fifty percent, a strong need to cut costs is unmistakable.[113] To do so, St. Mary's Hospital of East St. Louis contracts with other nearby Catholic health care facilities and has built a comprehensive network of services; St. Mary's operates its own capitated Medicaid managed care plan, now with over 4,000 members.[114]

National ministries consolidate and affiliate on multiple levels. For example, CHI announced in September 1998 its plan to adopt local strategies in its Pennsylvania and New Jersey markets. Five CHI hospitals are affiliating with the University of Pennsylvania Health System to "develop joint programs in behavioral health, geriatrics, home care, cancer care, and disease management [as well as other] . . . clinical services."[115] The two systems remain independently owned but through affiliation will be able to expand their coverage and services. The affiliation gives the network a twenty percent market share in the region, allowing for more negotiating clout with managed care insurers.[116]

Within a local area it may be beneficial for Catholic sponsors to focus on one area of expertise, thereby capitalizing on the strengths and traditions of the religious community. The Sisters of St. Francis of Mishawaka, Indiana, and the Franciscan Sisters of Chicago "swapped" health care facilities in early 1999 for this very reason.[117] Prior to the swap, the Franciscan Sisters spon-

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Island, NY, diocese sponsored four independent hospitals. They were merged into a single corporate entity, the Catholic Health Services of Long Island in October of 1997. The Interim President and CEO of Catholic Health Services, Ronald Aldrich, observed: "Health care providers need to position themselves to be regionally integrated delivery networks providing a full spectrum of services and to be a provider of choice for managed care organizations that are looking at a particular geographic area. . . . [You need] the right services for the right price with the right scope." *See id. See also* Daniel Kruger, *New York City Catholic Hospital Systems Discuss Possible Consolidation*, THE BOND BUYER, Aug. 28, 1998, at 7. Interestingly, New York state law prohibits the flow of revenues from a New York hospital to an out-of-state facility. Therefore, regional systems with facilities outside of New York often do not want to partner with New York institutions or systems. *See id.*

113. *See St. Mary's Aids Poor Through Medicaid Managed Care Plan*, CATH. HEALTH WORLD, Sept. 1, 1998, at 4.

114. *See id.* at 1.

115. *See Five CHI Hospitals Affiliate with University of Pennsylvania Health System*, CATH. HEALTH WORLD, Oct. 1, 1998, at 3 (quoting William T. Foley, CHI's group president).

116. *See* Josh Goldstein, *University of Pennsylvania Health System to Add Five Hospitals*, PHILADELPHIA INQUIRER, Sept. 10, 1998 (Penn. and CHI signed a 10-year affiliation agreement without transferring assets).

117. *See* Bruce Japsen, *Nuns Groups Swap Hospital, Care Facilities*, CHI. TRIB., Nov. 30, 1998.

sored only one hospital, St. Anthony's Medical Center in Crown Point, Indiana. They now operate eleven long-term care facilities, while the Sisters of St. Francis sponsor nine acute care hospitals.[118]

Collaboration is not limited to acute care—long term care and assisted living industries also find strength in collaboration. Alliances among Catholic long-term care providers in Pennsylvania and Ohio were formed recently to share resources and to position for future managed care contracting.[119] Bon Secours Health System based in Marriottsville, Maryland, for example, announced a corporate focus on assisted-living.[120] Bon Secours joint ventured with Manorhouse Retirement Centers of Richmond, Virginia, and Life Care Services of Des Moines, Iowa, to open additional assisted living facilities.[121] The Sisters of Bon Secours were influenced by the needs of the local communities for services in assisted living. Bon Secours plans to open new assisted-living facilities to "round out the post-acute care services it already offers," including long-term and home health care.[122]

Certainly the need to respond to market dynamics and community needs will draw Catholic providers into new and varied ways to collaborate with area institutions and service providers.

ISSUE 3: NEXT GENERATION SPONSORSHIP

Though much of the consolidation activity can be explained, at least in part, as a response to competitive market pressures, clearly an overarching purpose behind consolidation is the attempt to create what might be termed a "permanent" or "next generation" sponsorship vehicle. This model of sponsorship—of

118. *See id.*

119. *See LTC Providers Find Strength in Networking*, *supra* note 28, at 1, 3.

120. *See* Bellandi, *supra* note 12, at 66, 70 (The number of assisted living facilities grew 11% in 1997. The increasing elderly population is a favorable demographic to this industry; census predictions of the year 2010 expect over 80 million people over age 65, compared to 34 million today. The assisted living industry is profitable because most of the residents are private payers and thus the industry is not dependent on Medicaid/Medicare for funding, as are long-term care facilities.). *See also* Christine Ngeo, *Growing Like Wild: Hospitals Enter Booming Assisted-Living Business*, MOD. HEALTHCARE, Aug. 3, 1998, at 26. "By the year 2030, the demand for assisted-living beds will more than double to 903,000 from 427,000 in 1996, according to a 1997 study by Price Waterhouse. Assisted living accounts for about 75% of the 50,667 senior housing units currently under construction, according to a survey released in June 1998 by the American Seniors Housing Association." *Id.*

121. *See id.*

122. *See id.*

legal and canonical connectedness to the Church—will transcend the Church's current reliance, on (primarily) women religious to assure structural fidelity to Church and mission.[123] Demographic trends among both women and men religious make it apparent that the vast majority of Catholic health care's assets will one day be either diocesan sponsored or under sole lay control. This is a tremendous change from the predominant model of sponsorship that generally vests ultimate control in a religious congregation, or occasionally in a diocese, through retention of reserved member powers in the controlling civil law documents.[124]

The significance of this change can best be explained by reference to the Influence Continuum represented in Figure A. From left to right, the diagram represents theoretical changes in influence[125] that the religious institute sponsor has over its ministry.[126] Three points of explanation are in order. First, the diagram should not be read as demonstrating inevitable movement toward lesser degrees of influence—it is possible for a religious sponsor to maintain its influence at any point in the continuum.[127] Nevertheless, it is highly probable that the vast majority of sponsors and institutions will find themselves drawn further to the right of the continuum, toward lay-sponsorship models.

123. The term "sponsorship" is not defined in Church law or civil law. Originally intended to define the relationship between a religious community and its incorporated ministry, the term is challenged as some institutions have moved into a direct relationship with the Church without a religious community intermediary, in effect becoming "self sponsored." Sponsorship typically involves a legal oversight function, through the reservation of certain key authorities in the corporation's articles of incorporation and/or bylaws. *See* Singer, *supra* note 19, at 217 *et. seq.* One religious community, the Wheaton Franciscans, has defined sponsorship as "an ongoing public relationship that the Wheaton Franciscans have with a corporate entity for the purpose of fulfilling the mission of the Church. Sponsorship is exercised through responsibility and authority to determine or influence governance structures, education, resources, operating policies, strategic planning, resource allocation, and leadership selection." *See Sponsorship School: Teaching Sponsorship As Ministry*, Loyola University Chicago School of Law's Center for Catholic Health Care and Sponsorship, July 1997 (materials on file with authors).

124. *See* Singer, *supra* note 19, at 217.

125. Influence consists of more than legal control. It encompasses the sponsor's ability to exert both formal and informal pressure on the institution to assure its fidelity to the congregation's mission and to the Church.

126. The model focuses on religious congregations because they sponsor approximately 90% of Catholic health care institutions.

127. It is, however, largely inconceivable that a sponsor will be able to return to a prior position on the continuum.

FIGURE A:

The Influence Continuum

Presence	Direct Sponsorship	System	Co-Sponsorship (asset merger)	Public/Private Juridic Person

Second, the model only reflects theoretical influence. It is certainly the case that sponsors seemingly with a strong model of influence may, in fact, have little actual influence.[128] Finally, the model should not be read as reflecting a loss of fidelity to mission or Church—rather it merely represents pictorially the religious sponsor's direct relationship to its ministry. Moving to the right of the continuum, therefore, is neutral—neither good nor bad.

At the left-most point of the continuum is presence. Under the presence model, now seldom seem in health care ministry, the institution's legal and canonical connection to the Church was assured because the institution was wholly subsumed by the religious institute. Here, for example, the hospital was Catholic because it was (literally) built by the sisters, operated by the sisters, administered by the sisters, and staffed (often wholly) by the sisters. There was no need to question linkages to the Church or fidelity to mission because the institution often lacked a legal or operational existence separate from its founders.

During and after the onset of the Second Vatican Council,[129] religious communities often lost members as new avenues for service in the Church were opened. Members who did remain often chose to avoid service in large institutions, while others sought to move away from the traditional ministries of health care and education. The result was that at a time when health care institutions were facing tremendous growth and needed

128. For example, even though reserved powers over a system or institution may enable a sponsor to act, the potential detrimental effects of acting may make it problematic to do so. When the Eastern Mercy Health System (now merged into CHE) and the Sisters of Charity of St. Augustine removed institutional boards who sought to thwart system plans, tremendous negative publicity resulted. *See* Jay Greene, *Power Struggle with System Leads to Hospital Board's Ouster*, MOD. HEALTHCARE, Aug. 12, 1996, at 8.

129. By encouraging lay participation in Church ministry, "Vatican II" opened opportunities for lay people who previously might have considered joining religious life. *See* Timothy G. McCarthy, THE CATHOLIC TRADITION: BEFORE AND AFTER VATICAN II 1878-1993, 74 (1994).

greater presence by religious communities, religious communities were unable to continue missioning large cadres of sisters, brothers or priests to the ministry.

The development of the concept of "sponsorship" then moved to the forefront, as a way to assure fidelity to mission and ministry at a time when influence by presence could no longer be provided. Under what can be termed "direct" sponsorship, movement away from day-to-day involvement and presence in the ministry began. Under this model, which prevails today,[130] sisters moved away from the bedside, into first executive, and now more typically governance or oversight (corporate member) positions. From a legal perspective, fidelity to mission and Church is most commonly assured through retention of reserved powers by the leadership team of the religious community (the Superior and Council).[131]

Usually, health care systems are created in the form of parent organizations, further distancing the religious from institutional involvement.[132] Most institutions that began with mandates that institutional or system boards be comprised of a majority of sisters have been pared down to requirements of one-third or less. Often, no minimum is stated. Energy is now strongly focused at the system level, with many religious institutes recognizing that they will no longer be able to spread a shrinking pool of qualified members into institutional board positions.

By sheer size of assets controlled, the co-sponsorship model seems to have quickly gained dominance. Under this model, religious institutes typically cause a merger of their ministries, agreeing to share reserved powers over the joint enterprise. The

130. By number of sponsors, but not necessarily by size of assets controlled.

131. Some congregations have delegated these reserved powers to another body, typically composed of members of the religious community, so as to eliminate the tie between congregational leadership and institutional leadership. These Sponsorship Board structures enable members of the congregation who have special expertise to assist in overseeing the ministry even though they may not be elected leaders of the religious community. Still other communities, particularly in education, are experimenting with written agreements between the institution and the sponsors under which the institution agrees to adhere to certain ministry objectives determined by the religious institute. For more information on these alternative models, *see Sponsorship School*, Loyola University Chicago School of Law's Center for Catholic Health Care and Sponsorship (materials on file with authors).

132. Catholic health care was the first to develop systems in a meaningful, large scale way. *See* Grant, *supra* note 9, at 24.

reservation of powers can be divided equally or premised upon an agreed formula,[133] such as assets contributed to the merger.

Co-sponsorship formation will often cause the religious institute to move away from the congregational leadership team (Superior and Council) as the locus of reserved power decision making—there are simply too many decision makers involved if the membership body of the shared enterprise is comprised of the entire leadership teams of each contributing religious institute. Co-sponsorships also are often formed with an eye toward moving into lay sponsorship models, as discussed below. At their best, co-sponsorships can enable individual religious institutes both to develop the shared intellectual and financial capital necessary to effectively transition the ministry to lay control, should this become necessary or desirable, as well as to gain the perspective necessary to accomplish this task.[134]

Co-sponsorship represents a step further down the influence continuum by dint of its further distancing the religious community from its "original" ministry. While typically the traditions reflected in the sole sponsored institution continue, they are overlaid with the development of a new culture of the shared whole. Further, should the co-sponsorship accept more partnering religious communities, the size of the joint enterprise and the lessening of each individual community voice over the whole further decreases each sponsor's individual influence over the ministry. Importantly, however, while each sponsor's individual influence declines, the collective influence typically grows by virtue of the increased size, and presumably strength, of the joint ministry.

Finally, at the right of the continuum is the creation of a juridic person to house the health care ministry. Juridic persons can be thought of as artificial entities, analogous to corporations under state law, which are vested with certain rights and

133. For example, Covenant Health, based in Milwaukee, Wisconsin, was created by the Felician Sisters and the Wheaton Franciscans. Control over the joint entity was determined by the amount of assets brought into the transaction. *See* Clarette Stryzewski, CSSF, President/CEO of Felician Health Care, Inc. and Sr. Rose Mary Pint, OSF, (then) Chairperson of the Board, Wheaton Franciscan Services, Inc., *Fourth Generation Sponsorship: Moving To Influence*, Mar. 26, 1996, Loyola University Chicago School of Law's Center for Catholic Health Care and Sponsorship (conference materials on file with authors).

134. The inherent distancing that occurs through co-sponsoring a ministry larger than a traditional one, as well as sharing responsibility, necessarily enables a detachment to occur that may make transition to lay sponsorship more comfortable.

responsibilities under Church law.[135] Under a juridic person model, the health care system or institution is recognized as Catholic in its own right, separate and apart from its connection to the religious sponsor. The relationship of these entities can be directly to the local bishop, or to Rome.[136] Canonically, the organization becomes a self-sponsored ministry, with the governing board able to assume the reserved powers now typically maintained by the religious institute. To date, only a handful of health care systems have obtained juridic person status,[137] although significantly, Catholic Health Initiatives, one of the largest systems in the country, is in this category.

Though the Influence Continuum is useful if used to explain the religious community's relationship to its sponsored institutions, it begs the question of how these models can assure institutional fidelity to the Church. An important element of what religious communities have brought to health care sponsorship is a life-long corporate commitment, as a self-perpetuating group, to oversight of the ministry. Now that the ability to provide this commitment is being called into question for many congregations, there is the realization that transitioning this responsibility to the laity will call for radically new approaches, as the ability to create such a long-term, corporate commitment within the laity is improbable. The result is that board and executive leadership education in areas such as sponsorship, mission, canon law, ethical principles and board/leadership selection and retention, on an ongoing basis, is vital if system and institutional Catholic identity are to continue.

This is not to say that Catholic health care has been blind to this challenge—far from it. Organizations such as CHI were formed with the premise that they would be established as models capable of lay sponsorship.[138] Other systems, such as Covenant Health Systems, have altered their form to take this

135. For a thorough discussion of juridic persons, *see* Singer, *supra* note 19, at 219 *et. seq.*

136. *See Codex Iuris Canonici* (1983) c. 116-117.

137. There are two types of juridic persons, public juridic persons and private juridic persons. Private juridic persons are typically created by the local bishops, and their assets are not considered Church property. Public juridic persons commonly are created by the Vatican; their assets are considered Church property. *See* Singer, *supra* note 19, at 219.

138. Indeed, the religious community sponsors of CHI are in the process of transferring their Church law ownership of institutional properties to CHI, in a process known as alienation.

step.[139] Still other, different canonical models are in use.[140] Many of the largest Catholic health systems in the country have come together to form the Partnership for Ministry Leadership Development, an organization whose charge is to develop training programs for health care executives.[141] National organizations, such as the Catholic Health Association, Consolidated Catholic Health Care and Loyola University Chicago School of Law's Center for Catholic Health Care and Sponsorship have taken up the challenge as well.

No doubt, individual approaches will be developed; some of which will succeed wonderfully, while others may fail. Building upon the successes will be crucial; in this regard, the sharing contemplated by the Partnership is to be applauded. On the other hand, it seems likely that failure can only be minimized through efforts to develop explicit, broadly accepted, testable criteria by which fidelity to mission and Catholic heritage can be evaluated. Institutional representatives, such as executives and Board members, as well as sponsors and bishops must jointly develop such criteria, if they are to be accepted. Already, many systems and sponsoring congregations have laid the groundwork for such an initiative by developing policies and measuring tools for their own use.

Beyond comfort in developing accepted criteria, thought must be given to who will hold the ministry accountable. In direct sponsorship and co-sponsorship models, direct accountability to the sponsoring community and the bishop is appropriate. In lay sponsorship models the accountability link becomes more tenuous, however, particularly as models may have ultimate responsibility to a Vatican curia, with individual institutional accountability vested in multiple bishops by virtue of the fact that an institution is in a particular diocese. Widespread acceptance of accountability criteria and an evaluation mechanism would seem to be crucial to assure a successful

139. *See* Nancy Mulvihill, *Public Juridic Person Ensures Catholic Presence*, HEALTH PROGRESS, Jan.-Feb. 1996, at 25-27.

140. Primary Health System, for example, placed its for-profit, Catholic, Cleveland facilities into a private juridic person. *See* Steven L. Volla, Chairman of the Board, Primary Health Systems, L.P., *Fourth Generation Sponsorship: Moving To Influence*, Mar. 26, 1996, Loyola University Chicago School of Law's Center for Catholic Health Care and Sponsorship (conference materials on file with authors).

141. Funded by 16 systems, the Partnership will develop leadership training programs using the internal resources of its members, as well as outside technical support. *See Leadership Partnership Names Executive Director*, CATH. HEALTH WORLD, Nov. 1, 1998, at 1.

transition to lay sponsorship models. The work to develop an accountability mechanism is certain to be a primary focus of Catholic health care providers, sponsors and bishops well into the new millennium.

CONCLUSION

As the millennium draws to a close, Catholic health care providers find themselves challenged both by the health care competitive, reimbursement and legal environment, as well as by internal, ministry-driven forces. Questions of mission and focus are certain to become more pointed than ever before, as tactical and ministry-oriented strategies are conducted in an atmosphere of heightened public and regulatory attention. Clearly, successful Catholic organizations must maintain strong mission and business fundamentals. We are confident that the next generation of Catholic health care institutions, executives and sponsors will find a way to do so.