3. Hospitals Sponsored by the Roman Catholic Church: Separate, Equal, and Distinct?

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THE HOSPITAL OF THE TWENTY-FIRST CENTURY IS evolving at the interface of shifting government policy, highly specialized professions, cutting-edge technology, and intense market competition. Hospitals sponsored by the Roman Catholic Church constitute a special case of the modern hospital sector. As religious organizations, they have an obligation to the Church and their congregational sponsors to preserve the social role and Catholic identity of their health care ministry by acting according to Roman Catholic social justice beliefs and doctrine. Although the ministry is extended to communities in many ways, hospitals continue to be the center of Catholic health care delivery.

Since its charitable and humble inception, Catholic health care has undergone many changes (Farren 1996). Catholic hospitals have changed from being "ecclesiastical" institutions in the early part of the century to representing a substantial portion of nongovernmental hospitals (Stevens 1989; 1991). Over time, this ecclesiastical context has been eroded as environmental changes have transformed the original, predominantly Catholic, composition of the workforce to one that is more secular. Concomitantly, Catholic health care organizations have responded to environmental pressures by changing their scope of services, organizational arrangements, and financing mechanisms. Nonetheless, they have

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remained faithful to their religious values with a strategy to retain their core identity, which is defined by the provision of comprehensive health care to vulnerable and underserved populations.

According to many observers, this metamorphosis of the Catholic health care tradition has yielded organizations that more closely resemble other nonprofit and/or for-profit health care providers. All Catholic health care organizations are struggling to keep pace with economic, political, and legal pressures in order to survive as fiscally sound organizations while continuing to hold on to a distinctive Catholic identity (Stepsis and Liptak 1989; Sullivan 1993; Prince 1994; Hehir 1995; Kauffman 1995; Catholic Health Association 1998; Cochran 2000).

Although a great deal is known about health care organizational characteristics, less is known about how Catholic health care organizations differ empirically from other organizational ownership forms in the present environment. The Catholic Health Association of the United States (CHA) has published numerous reports describing its member hospitals (1991a; 1992a); the dynamics of Catholic identity in health care (1987; 1992b); the impact of Catholic health care on communities (1991b); and issues and directions for the future (1991c; 1993; 1998). This information, however, is directed to CHA member organizations, which represent more than 94 percent of hospitals sponsored by the Catholic Church (Mark Unger, Catholic Health Association, May 28, 1999: personal communication), and thus may be biased in favor of member organizations.

Why Does This Matter?

Catholic health care in the United States, when viewed from the national perspective as a collective of institutions with a common mission, represents the largest private-sector effort to deliver medical care, long-term care, and related health services to persons in need. The extant literature contains anecdotal, philosophical, and theological discussions of how Catholic health care may be described as different. To date, organizational research has concentrated on ownership and performance in terms of financial outcomes, efficiency, and returns to the community. It has been difficult to define Catholic identity and to translate it into quantifiable, measurable terms. Consequently, few studies have quantified and empirically examined Catholic health care and its contribution to our health care delivery system.

In examining Catholic hospitals as a subject of organizational study, it is important to consider historical change and past research in the evolution of Catholic health care and the meaning of Catholic identity. My purpose in writing this paper is to answer the following questions:

1. What are the arguments for assigning a separate identity to Catholic health care?
2. Is Catholic health care actually different from what it claims to be?
3. What are the challenges to any distinctions that do exist?

The Case for a Separate Identity: What Are the Arguments?

Throughout its history, Catholic health care has been challenged to redefine its identity continually within the broader context of society, religion, and health care sponsorship (Farren 1996). What began nearly 200 years ago primarily as a social welfare ministry in response to urban need and inspired by Christian charity has been defined increasingly by its technical capacity. To maintain its connection to the Church, it created a *separate*, and special, identity composed of private, nonprofit health care providers. Catholic hospitals have chosen methods of differentiating themselves from other, changing forms of hospital ownership. Arguments for separateness in the literature juxtapose ideas about the sponsored health care ministry of the Catholic Church and the uncoupling of society from religious sponsoring institutions.

The Theological Argument

Catholic health care differs in a few notable ways from the care controlled by other religious health care delivery systems (Vowell 1992; Sullivan 1993; Cassidy 1994). The Code of Canon Law for the Roman Catholic Church permits the diocesan bishop to determine the qualities necessary to identify an institution as Catholic, and thus as sharing in the mission of the Church. Morrisey (1987) suggests three major qualities for determining Catholic identity:

1. a relationship between an institution and ecclesiastical authorities, which provides for accountability

2. the legal establishment of the entity
3. the Church's possession of a degree of control over the institution

Vowell (1992) believes that environmental changes resulted in these three qualities being modified from the original six qualities of Catholic health care, which were described by Ashley and O'Rourke (1978) as follows:

1. guidance and direction supplied by the diocesan bishop, who applies and interprets the Ethical and Religious Directives for Catholic Health Care Services
2. religious institute sponsorship
3. charitable funding solicitation
4. provision of the sacramental and pastoral needs of patients and staff by priest chaplains
5. Catholic identity of, or acceptance of Catholic ethical norms by, physicians, nurses, and administrators
6. use of symbols, like crucifixes and chapels, that are expressions of the Catholic faith

The moral responsibility of Catholic health care is outlined in the Ethical and Religious Directives for Catholic Health Care Services. The directives describe procedures that are judged morally wrong by the National Conference of Catholic Bishops and the United States Catholic Conference. New insights in theological and medical research and new requirements of public policy led to the addition in 1994 of a section on partnerships between Catholic and non-Catholic organizations and providers. The specific goals of the directives are "preserving the identity and reputation of Catholic health care [and] avoiding the possibility of scandal" (*Origins* 1994, 460). In this context, "scandal" is a term describing the appearance of anything that would discredit the moral principles of Catholic theology.

From a theological perspective, Catholic health care is differentiated by sponsorship and ministry values, preferential service to the poor, and its identity as an extension of the Church. As the health care environment becomes increasingly regulated and competitive, the Catholic identity grows more difficult to maintain. The emergence of for-profit corporations in the 1970s has meant that nonprofit organizations have had to assume an additional burden of providing uncompensated, unpopular,

or stigmatized, care (LeBlanc 1991). Increased regulation and competition have forced hospital closures and mergers, reducing the number of Catholic hospitals from 640 in 1990 to 601 in 1999 (Place 1999a).

The Historical Evolution Argument

Hospitals in the United States historically have had a strong charitable orientation; most provided free care, room, and board to any that needed it. In the absence of social welfare structures, religious communities were founded on the premise that social needs had to be met. In the late eighteenth and early nineteenth centuries, the poor of the Western world were kept impoverished, Catholics were oppressed (especially in England), and poor Irish Catholics were relegated to the most abject conditions (Regan 1978). Some historians contend that this discrimination was the reason for the formation of separate religious hospitals (Starr 1982; Stepsis and Liptak 1989; Rosenberg 1989), especially in urban areas with high concentrations of poor immigrants (Farren 1996).

In mid-nineteenth century Europe, Catholic religious orders were among the first to open their "houses of charity and mercy." These were refuges for the poor and the sick, who had been chosen to suffer as a redemptive quality in the eyes of God. Health care was viewed as a "calling" and an extension of the ministry of the Church. An early religious leader, Catherine McAuley, the founder of the Religious Sisters of Mercy in Ireland, summarized her motivation as "finding a need and filling it" (Regan 1978).

In the mid- to late nineteenth century, religious orders were invited by diocesan bishops to expand their communities to the United States. The lack of government response to public health and social problems created a vacuum that was filled by 254 religious communities, many of which are still active today (Sullivan 1993). Most religious orders of sisters accepted vows of poverty, chastity, and obedience and service to the poor, the sick, and the ignorant. Schools and hospitals were generally the social institutions through which they carried out this commitment. Many of the first hospitals, such as Mercy Hospital in Pittsburgh and Charity Hospital in New Orleans, were sponsored by Catholic religious orders.

Catholic hospitals spread exponentially across the United States. By 1996, there were 622 hospitals in 48 states and 714 long-term-care

facilities in 47 states (Sexton 1996). States with the largest numbers of Catholic hospitals are California, Illinois, New York, and Wisconsin. Sexton (1996) reports that these states (along with Texas, New Jersey, and Pennsylvania) represent market shares of less than, or equal to, 25 percent, whereas some states, like Alaska, Montana, and Oregon, with only a few Catholic hospitals, nevertheless have very high market shares. White (1996) reported that, in 1993, 143 (26.8 percent) Catholic Health Association member hospitals were located in the 100 largest cities, 242 (45.4 percent) hospitals were located in other, smaller urban areas, and another 148 (27.8 percent) hospitals were located in rural areas.

As the twentieth century progressed, society came to view the hospital less as a place where poor people go to die and more as one where persons of all financial levels might improve their health (Starr 1982; Stevens 1989; Kauffman 1995). Many hospitals moved away from providing indigent care as the supply of hospital beds exceeded the demand for inpatient services and as health care costs rose dramatically (Lynn 1988). The demand for indigent and charity care diminished with the implementation of Medicare and Medicaid programs in the 1960s (Zeckhauser, Patel, and Needleman 1995). However, increased regulation in the 1970s and the introduction of prospective payment in the 1980s renewed the challenges to caring for the indigent and uninsured. Some Catholic Church leaders (Sullivan 1993; Bernardin 1995; McCormick 1995) contend that the government's creation of a marketplace environment in the 1990s has had disastrous consequences from a Catholic perspective of social justice. Measuring the effectiveness of health care delivery solely in terms of profitability has necessitated the corporate restructuring of Catholic hospitals, thereby threatening the mission of providing services to the poor and medically indigent.

No study of the history of Catholic health care would be complete without mentioning the dramatic effect of the Second Vatican Council (1962–65) on the way the Catholic Church understands itself and interacts with the world. Before the Second Vatican Council, the Church was identified as a world apart from the secular world. Clergy possessed the ultimate responsibility for church leadership. A paradigmatic shift occurred with Vatican II, when the onus of responsibility for church leadership moved from the clergy to the laity. Social justice issues, such as meeting the basic health care needs of all members of society and providing health care for the indigent and uninsured, continue to be

emphasized. Human rights, such as the right to employment, to have a collective voice at work (Steinfels 1999), and to receive health care (Cochran 1999), also remain central concerns.

The Legal Argument

Catholic hospitals hold dual citizenship with their tax-exempt status. As an extension of the Roman Catholic Church *and* as nonprofit health care providers, Catholic hospitals have enjoyed tax-exempt status, which is defined by section 501(c)(3) of the Internal Revenue Service Code. This tax-exempt status is a major characteristic distinguishing nonprofit from investor ownership. There are, however, other legal differences, such as laws requiring more public accountability from nonprofit hospitals and certain federal regulations of exempt, nonprofit hospitals (Horty and Mulholland 1983). The word "nonprofit" has been associated with charity: provision of charity medical care and dependence on charitable contributions to sustain financial obligations. The differentiation has less to do with profits than with the mission of an organization: charitable organizations reinvest excess revenues in the organization, whereas investor-owned hospitals share the excess revenues with their investors. Ironically, despite their designation as charitable organizations, nonprofit hospitals are *not* required by law to provide a minimum level of charity care. A 1969 Treasury Department ruling lifted the requirement tying charity care levels to tax-exempt status, replacing it with "the community benefit standard" (Tokarski 1994).

Under that standard, hospitals qualify for nonprofit status if they operate a full-time emergency department open to all people, regardless of their ability to pay; accept Medicare and Medicaid patients; and funnel surplus revenue into improving facilities and patient care. Despite legal challenges by groups claiming that the community benefit standard does not exact enough charity care from tax-exempt hospitals, the 1969 provision remains on the books (Tokarski 1994).

Changing regulation and increasing competition have led to scrutiny of this nonprofit status as nonprofits come increasingly to resemble investor-owned (IO) hospitals. Numerous empirical studies have attempted to describe these similarities (Herzlinger and Krasker 1987; Hultman 1991; LeBlanc 1991). As reimbursement patterns have changed with the advent of Medicare and Medicaid, and as tax laws have been amended in ways that make philanthropy less desirable, charitable

contributions have decreased from 13 percent of hospital revenues half a century ago to less than 0.5 percent of average revenues in the 1980s (Gray 1991). Charity or indigent care also has decreased as hospitals struggle to avoid closure (Lynn 1988) or reduce their free care as part of general cost-cutting measures (Feder, Hadley, and Mullner 1984).

The Mission Argument

Tightened budgets and narrow or negative financial margins have made it harder for Catholic hospitals to compete while continuing to fulfill their social justice mission of providing undercompensated, unpopular (LeBlanc 1991), stigmatized, and compassionate care (White 1996) services. At the same time, it is increasingly important to measure Catholic identity in terms that health policy makers, managed-care payers, employers, and consumers can evaluate (Dranove 1995). Fonner and Tang (1995) point out that when the distinctiveness of Catholic identity is measured, it becomes easier to market to consumers and purchasers of health care services.

Specifically, in the landscape of providers, do certain services, not offered by other ownership types, epitomize Catholic identity? Are there certain services that Catholic hospitals do not provide, thereby denying communities access to these services? Two empirical studies have attempted to answer both of these questions.

White and Begun (1998–99) examined the factors associated with the provision of certain services that are representative of Catholic health care mission statements. Namely, services that enhance access, are stigmatized, and are considered compassionate were first identified. This national study, limited to private, urban hospitals for the year 1993, revealed that Catholic hospitals offered more compassionate care services than other private, nonprofit hospitals, and more compassionate care and stigmatized services than IO hospitals. This study focused on services that Catholic hospitals offer as extensions of their mission and values.

On the other hand, there are certain services that a Catholic hospital would not provide. On the basis of the moral teaching of the Catholic Church, health care is seen as a basic human right and universal health care coverage is supported. At the same time, the Church considers abortion morally wrong and opposes coverage of abortion as a health service in a national health plan (McHugh 1994). The provision of abortion and

other reproductive-altering services prohibited by the religious directives would violate its moral commitments and thus would not be offered by Catholic hospitals.

When community hospitals have merged with Catholic hospitals or networks, reproductive health services often are phased out (Bellandi 1998a). Weisman, Khoury, Cassirer, et al. (1999), in a study of Catholic hospitals that merged with other ownership types between 1990 and 1996, analyzed the provision of reproductive health services following the mergers. They found that in successfully negotiated affiliations between Catholic and non-Catholic partners, explicit strategies are devised for reproductive health services, resulting in the curtailment of specific services (i.e., surgical abortion) and the enhancement of others (i.e., obstetrics).

Clearly, Catholic hospitals are largely differentiated by the services they offer. In this way, the values of the Catholic faith are being expressed and Catholic health care remains true to its mission.

The Case for Isomorphism: What Is the Evidence?

Catholic health care must be able to compete with "like" organizations, so they need to be *equal* in the marketplace. Isomorphism is the idea that organizations will imitate other organizations in their environment when they face the same set of environmental pressures. The evolutionary pattern of hospitals confirms that organizations compete not only for market position and niche but also for political power, institutional legitimacy, and social and economic fitness. Whereas hospitals once were charitable organizations for the sick and injured, they have gradually adopted characteristics of businesses. For-profit and nonprofit hospitals exhibit similar attributes and espouse similar missions and goals (Meyer and Rowan 1977; Starr 1982; Griffith 1999) in the course of adopting adopt corporate management structures (DeWitt 1981).

An examination of isomorphism must include a comparison of Catholic hospitals and other ownership types. In this section, I will review the literature pertaining to ownership and performance indicators of Catholic hospitals in order to illustrate their similarities to other hospital ownership types.

Financial Performance

A study by Kwon, Safranski, Martin, et al. (1988), analyzing only Catholic hospitals, indicated that financial distress was associated with the following characteristics:

1. urban-area location (i.e., location in a metropolitan statistical area)
2. not being part of a multi-institutional system
3. affiliation with a medical school
4. lower than average occupancy rates
5. inclusion of several complex medical services (e.g., organ transplants, open-heart surgery, organ banks, and others)
6. Medicare reimbursement constituting a large proportion of total revenues
7. Medicaid reimbursement constituting a large proportion of total revenues
8. hospital-based outpatient services constituting a large proportion of total revenues
9. extended lengths of stay

These characteristics were associated, directly and indirectly, with the amount of indigent care and management style of the hospital. Kwon and colleagues (1988) concluded that management style has more responsibility for the financial condition of hospitals than any other group of variables.

A later study by Williams, Hadley, and Pettengill (1992) added that a hospital's financial status and mission or community standing determined hospital closure to a highly significant degree. Consistent with the results of other studies (Kwon et al. 1988; Lillie-Blanton, Felt, Redmon, et al. 1992; Bray, Carter, Dobson, et al. 1994), urban hospitals that provided few services and hospitals located in areas of intense competition were more likely to close. New study variables used by Williams, Hadley, and Petengill (1992), representing commitment to mission, are particularly germane to the study of hospital ownership and risk of closure. The specific variables used to characterize the degree of mission include the following dichotomous variables (indicating high or low volumes or proportions of services): long term care, inpatient surgery, outpatient surgery, outpatient visits, care of Medicare and Medicaid patients, and the range of services offered. Hospitals that closed had a lower community standing or commitment to mission.

Tang (1995) analyzed a national sample of Catholic hospitals to identify the significant determinants of financial performance for the year 1992. After controlling for the urban–rural location, teaching status, and geographic regions, the most important variables explaining financial performance were the ratio of long-term debt to total assets, occupancy rates, length of stay, bed size, and percent of nonwhites in the area. A negative relation between the Herfindahl index and the expense per discharge suggests that hospitals located in less concentrated areas with lower market power were more expensive than those in more highly concentrated areas, leading to the conclusion that competition increases Catholic hospital costs.

In a nationwide study analyzing urban hospital performance of stewardship, defined by prudent use of fiscal resources, Catholic hospitals were compared with secular nonprofit and IO hospitals for the year 1993 (White 1996). The variables used in this study were return on assets, margin, and operating expense per discharge. The results showed that, after adjusting for organizational and market factors, Catholic hospitals are more likely to resemble secular nonprofits and differ from IO hospitals on these measures of stewardship.

Throughout the history of the Catholic Church, care of the poor has been a driving source of mission. Hospitals cannot always adhere to this mission to serve the poor when they are not financially viable institutions. This is the crux of the problem in Catholic health care today: how can the Catholic Church continue to sponsor health care when charity and mercy must be replaced with bottom-line profits? This question has been hotly debated by Catholic health care leaders (Curley 1995; *Health Systems REVIEW* 1995; Tokarski 1995).

Other Operating Performance Indicators

There are conflicting findings regarding hospital ownership and performance. Efficiency has been evaluated as a measure of performance. Some studies based on traditional ratio analysis have shown that IO hospitals are more efficient than nonprofit hospitals (Kwon et al. 1988; Gray 1991). In a study of the performance of hospitals under Medicare's prospective payment system (PPS), Bray and colleagues (1994) found that the production efficiency achieved by the more profitable, or "winning," hospitals exceeded that of the less profitable, or "losing," group. Despite the number of winning hospitals that have remained

open under PPS, the overall margin of Catholic institutions has steadily declined since 1984.

In examining 235 Catholic community hospitals with data from 1986 to 1989, Prince and Ramanan (1994) described associations between three levels of operating performance and a variety of hospital-specific characteristics. Their results showed that the panel of 78 Catholic hospitals with low returns lagged significantly behind the two other panels with higher returns because the financial conditions of the former made it difficult to raise new capital to invest in medical technology, equipment, and facilities to support changes in medical practice. Assuming that these hospitals are essential for maintaining access to health care in their communities, more disclosure of the uncompensated care and community services they provide is warranted in order to reveal the full impact of a closure (Prince and Ramanan 1994). To that end, some states (e.g., a California law passed in 1994) have mandated that nonprofit hospitals identify and report the level of community benefits they provide (Mann, Melnick, Bamezai, et al. 1995).

Researchers have used data envelopment analysis (DEA), a nonparametric technique, to conduct studies of ownership and organizational efficiency (Valdmanis 1990; Ozcan, Luke, and Haksever 1992; Ozcan and Luke 1993). In general, they have found that nonprofit and public hospitals tend to be more efficient than IO hospitals. For the year 1992, DEA was applied to study the technical efficiency of church-owned and other nonprofit hospitals in California (White and Ozcan 1996). When compared with their peers on the basis of bed size, Catholic hospitals tended to use production inputs to create more efficient outputs.

Catholic-Sponsored Managed Care

Increasingly, Catholic systems are participating in the managed-care marketplace by sponsoring health maintenance organizations (HMOs), entering into joint ventures with managed care organizations (MCOs), or developing provider-sponsored organizations (PSOs) (Unland 1998; Haughney 1998). Kelly (1996) has raised the issue that combining health care delivery and financing within single entities or in mutually dependent entities raises a serious question of conflict of interest. If this is the case, it had not deterred some 50 Catholic systems from entering into a range of financial partnerships by 1998 (Hurley, White, and Draper 1999).

There is no empirical research on Catholic MCOs to describe either the services they offer and deliver or whether they reflect the Catholic mission in detectable and measurable ways. On the one hand, they may have distinctive managed-care features or approaches that express mission-driven values. However, these would perhaps make it difficult to sustain a profit. Schlesinger and Gray (1998, 159) point out: "Community benefit is frequently seen as antithetical to appropriate 'businesslike' practices."

On the other hand, isomorphic pressures may be compelling mission-driven MCOs to conform closely to commercially sponsored managed care. Moreover, it is possible that these enterprises have little to do with the Catholic mission but are merely an auxiliary activity designed to produce profits or, at a minimum, to reduce potential losses. Many of these MCO purchases and joint ventures have reported huge losses (Japsen 1998; Bellandi 1999b) and others have been sold (Bellandi 1998b). These may be indicators of the rigidity of isomorphic pressures.

What Are the Challenges to Distinctiveness?

The survival of Catholic health care depends on its ability to maintain fidelity to a different master while delivering a distinctive, values-based ministry. This is perhaps the most understudied area of organizational research. It is far easier to describe how Catholic hospitals represent a separate case of private, nonprofit institutions. It is also easier to show that Catholic hospitals perform like secular hospitals when dimensions of economic and medical outcomes are measured. It is far more difficult to quantify the distinctiveness of Catholic identity and its effect on organizational and patient outcomes. This section describes the challenges to a distinct identity for Catholic health care.

System Membership

The majority of Catholic hospitals, by the very nature of their religious-order sponsorship, are members of multihospital systems. What began as federations of hospitals of similar heritage and tradition (D'Aunno and Zuckerman 1987) has evolved into fewer systems, sometimes comprising multiple sponsors and ownership arrangements (Coyle 1999). What

impact does this affiliation have on Catholic identity, survival issues, or nonprofit status?

Shortell (1988) states that the search for security and protection has driven most system affiliation, constituting a defensive retreat from a highly uncertain and complex hospital environment. This conclusion was reached after careful evaluation of study outcomes, which showed no evidence to suggest that system hospitals provide more charity care than nonsystem hospitals (Gray 1986; Schlesinger, Bentkover, and Blumenthal 1987; Shortell 1988; Shortell, Morrison, and Friedman 1990). Grant and Modde (1992) identified three trends among developing Catholic health systems in the early 1980s:

1. religious institutes, composed of two or three hospitals, forming systems that imitated the larger units
2. the beginning of diversification by the more established systems
3. the beginning of alignments by smaller existing systems with other systems for geographic reasons or because they shared spiritual or corporate cultures

Shortell, Morrison, and Friedman (1990) contend that, in the 1990s, systems must behave like true systems rather than like loose collections of hospitals organized under a corporate umbrella. Others believe that religious sponsors must make fundamental decisions about the terms and conditions they find acceptable for continued involvement in collaboration and consolidation (Pettinati 1988; Grant and Modde 1992). Innovative diffusion networks have been studied in order to discover strategies for integrating multihospital systems and alliances (McKinney et al.1991). Researchers holding this supply-side point of view contend that more integrated multihospital systems, which share missions and behavioral norms, will be better able to diffuse innovative management strategies. This is one way to enhance the "systemness" that Shortell (1988) described as lacking in multihospital systems of the 1980s.

Catholic Hospital Partnerships

The end of the twentieth century witnessed a redefining of the beliefs and values surrounding the traditional hospital. Hospitals had changed from freestanding organizations that were locally controlled to components of large, multi-institutional systems with a variety of structural and

ownership arrangements. Why was this necessary? From the perspective of economic viability, most urban Catholic hospitals in 1992 were less profitable, had older equipment, and treated more Medicare patients than the average matched nonprofit community hospital (Prince 1994). This situation, coupled with increased managed care penetration and the growth of capitated delivery systems in the 1990s, compelled Catholic health care leaders to consider partnerships in order to ensure that their institutions would survive.

Catholic hospital partnerships faced challenges to their identity. While they were consolidating, merging, and negotiating joint ventures and acquisitions, or what Connors (1995) calls "arranged marriages," new ownership forms were being created. In 1994 alone, there were more than 100 new partnerships in the form of mergers, affiliations, or joint ventures between Catholic and non-Catholic hospitals (Burda 1995), HMOs, and managed-care networks (Anderson 1990; Lewin 1995). One study reported that, between 1990 and 1995, 39 Catholic hospitals were sold, and no longer retain their religious identity; five merged with other institutions and are no longer Catholic; three merged with other Catholic hospitals; and four merged with non-Catholic hospitals to become institutions that remain Catholic. A dozen Catholic hospitals have shut their doors altogether since 1990 (Tokarski 1995). Although the CHA is currently conducting a national study on partnerships of the legal and moral ownership changes involving Catholic hospitals, there is no definitive information to update these statistics (Mark Unger, Catholic Health Association, May 28, 1999: personal communication).

As these new organizational forms emerge, Catholic health care leaders will try to ensure that their religious mission and values permeate the new, hybrid organization. They must reach agreements with their secular partners on how the hospital will handle procedures, such as abortion, sterilization, in vitro fertilization, and artificial insemination, that are forbidden by the Ethical and Religious Directives for Catholic Health Care Services (*Origins* 1994). Because many of the new organizational forms do not offer the prohibited services, some people believe that their health care services are being restricted unfairly by the Catholic Church (Lewin 1995; Bellandi 1999a). Still others believe that the moral authority of the Catholic Church in the public forum may restrict the allocation of resources among individuals (Cahill 1988).

One hybrid organizational form, the merger, represents agreement on the new organization's legal and moral definition. Mergers between

Catholic and non-Catholic hospitals present challenges for a "new" identity. Do the new organizational forms represented by the 127 Catholic and non-Catholic hospital mergers that have taken place between 1990 and 1998 (Bellandi 1999a) continue to uphold Catholic values, or have they taken on a secular identity? These issues concern health care leaders, governing boards, and their communities.

When two or more Catholic sponsors merge their health care services, these issues may become even more salient because of the deeply entrenched histories representing the values of their religious founders. In May, 1995, two Catholic-sponsored health care systems (Catholic Healthcare West and Daughters of Charity National Health System–West) consolidated. Still called Catholic Healthcare West, this new system comprises hospitals sponsored by five religious congregations (Japsen 1995b). Also in 1995, a multisystem collaboration was strengthened by a legal commitment to merge three Roman Catholic health care systems—Sisters of Charity Health Care Systems of Cincinnati, Ohio; Franciscan Health Systems of Aston, Pennsylvania; and Catholic Health Corporation of Omaha, Nebraska—to become Catholic Health Initiatives (CHI), the largest U.S. Catholic provider at the time (MacPherson 1996). In 1997, the Sisters of Mercy (Eastern System), the Franciscans, and the Daughters of Charity merged to form Catholic Healthcare East. Catholic sponsors continue to announce plans to merge with other Catholic systems. Even with a commonality of religious beliefs, the various congregations of the Catholic Church bring to the table their own missions and values, adding to the challenge of achieving successful mergers (MacPherson 1996).

Rather than church mission, organizational culture and values may be used as indicators of organizational fit between Catholic and other hospital ownership types. Connors (1995) believes that a "marriage" between Catholic providers and IO providers is unlikely because their motives and incentives are radically different. Leaders of religious institutions believe that it is important to infuse the values and beliefs of the Church into the new organizational partnerships (Connors 1995; Leonard and Morrison 1995).

Despite Connors' predictions, mergers and alliances of Catholic and IO systems have been structured. One example is the partnership that was formed between Columbia/HCA and Sisters of Charity of St. Augustine Health System (Japsen 1995a). However, this partnership was dissolved within a few years (Zuckerman 1999). The CHA vehemently opposes

such Catholic–IO mergers and has prohibited IO hospitals from joining CHA (Japsen 1995d).

Collaboration, without mention of ownership type, is one of the ten key themes of Catholic health care identity, according to the CHA president, Reverend Michael D. Place (1999b). In this way, Catholic hospitals will seek partners who share their values and, by forging these new relationships, will be able to accomplish more in pursuit of their mission. These trends in partnership point to a constantly changing "Catholic" hospital in response to environmental pressures.

Secularization of the Nonprofit Sector

The link between churches and the nonprofit social services they support has been the subject of a long-standing debate between proponents of minimal church involvement in social services and those who view such involvement as an indispensable part of religious faith and practice (Freeland 1992; Cochran 1999). Although this controversy has been eclipsed in recent years by the relationship between government and the entire nonprofit sector, it is nonetheless worth examining in the context of discussing the distinctiveness of Catholic health care.

Some have found that, over time, church membership had become less relevant to the growth of nonprofit health care organizations in the United States (Freeland 1992; Martin 1993). Catholic hospitals were founded in order to fulfill a societal need. That is, members of the Roman Catholic Church were closely linked to Church-sponsored social institutions. The strength and significance of religion, then, may depend critically on the "external forms" that churches adopt. This view supports the argument that Catholic health care and educational institutions that were once tightly coupled to the social service orientation of the Catholic Church have assumed a different shape in order to survive. This is consistent with the position of Drucker (1994), who believes that a pluralist society of yesterday has been replaced with individual organizations created for only one task. No longer are single organizations concerned with controlling everything that goes on in their communities.

Implications

Although there is no dearth of research on organizational ownership and hospital performance indicators, the literature that examines, quantifies,

and empirically tests Catholic hospital ownership remains small. However, it has produced work with some important implications for the organizational expression of Catholic health care.

Empirical studies evaluating performance of Catholic hospitals have shown that market forces and regulatory requirements are associated with isomorphic behaviors on certain dimensions. Catholic hospitals have been shown to behave *like* or *equal to* their private, secular, nonprofit counterparts on measures of financial performance and the provision of certain services. In terms of stewardship and the careful, prudent deployment of resources, Catholic hospitals have been scrutinized to ascertain that the community services they provide equal or exceed their tax liability.

Beliefs and values are so institutionalized that the Catholic Church, and by extension its sponsored health care ministry, has continued to redefine itself in response to environmental pressures. For centuries, the Catholic Church has been a prominent social actor in the realm of social justice. Not only must Catholic hospitals respond to the complex bureaucracy of their Church and religious institute sponsors; they must also respond to the deeply institutionalized beliefs and values associated with the modern hospital (Somers 1969).

Thus, the contemporary Catholic hospital can be described as holding dual citizenship. One passport is issued for the Catholic Church as religious sponsor, with all the expectations of mission effectiveness that this implies. The other passport is issued for the community in which the hospitals serve. This dual citizenship often results in "duel competition." In other words, the two institutions of religion and health care converge on the Catholic hospital to create a hybrid organization, with each faction holding such deeply entrenched values and beliefs that either one may opt to redefine itself in order to survive. What we may have, then, are organizations that no longer reflect the original intent of the Catholic Church and its sponsored health care ministry. Conversely, Catholic hospitals may have been so successful at promoting their principles—protection of life, commitment to health care as a common good, service to the poor—that other hospitals may choose to imitate them by adopting their social justice mission. Nonetheless, it appears that the Catholic health care ministry is in the process of redefining itself once again with new organizational partnerships and forms. If these organizational forms are unable to promote a clearly sacramental mission of the Catholic Church, perhaps it is time to transfer their resources to new types of institutions that will establish a distinctively Catholic identity (Cochran 2000).

If Catholic health care is to survive the uncertainty and radical changes that are occurring in the architecture of health care delivery, more resources must be invested in the services they deliver in order to clarify the ways in which they are distinctive. How can Catholic identity be quantified, measured, and distinguished from other ownership types? Does the presence or absence of certain services make an organization Catholic? Is there something distinctive about Catholic health care that results in perceptibly different patient outcomes? These and other questions must be addressed in order for Catholic hospitals to remain a major segment of the health care delivery system.

What Do We Need to Know?

On the basis of the published works on Catholic health care, it is clear that most of the contributions are descriptive and qualitative. Few studies have defined and measured the relevance of this large sector of nonprofit health care. In order to know more about the strength of the contribution of this sector, I have identified the following areas for future research and evaluation:

1. *Assess the impact of Catholic health care on the health status of their targeted populations, compared with other provider ownership types.* The literature is devoid of studies that evaluate performance indicators for improving community health status by hospital ownership type. Although we know that Catholic hospitals tend to provide more community benefit services, little evidence has emerged to translate this investment into measurable improvements in the health status of the communities they serve.
2. *Assess the impact of intersectoral competition on access, services provided, and community benefits.* One intensively studied area is the association of ownership type and market competition. Although this continues to be an important phenomenon for study, the effect of intersectoral competition in areas other than price between mixed ownership types within the same market deserves scrutiny as well. For example, in a mixed ownership market, does the presence of a Catholic hospital have a "spillover" effect on other ownership types? If Catholic hospitals were removed from the market, what would change?

3. *Assess organizational and financial challenges to Catholic health care providers and their impact on the ability to differentiate a religious mission.* As described earlier, strong environmental forces are affecting all segments of health care delivery, and Catholic health care in particular has the added institutionalized bureaucracies of the Church and its religious sponsors. As Catholic providers merge with Catholic and secular organizations in vertical and horizontal arrangements, their operating strategies change. How will they continue to differentiate themselves in a secularized society? Will mission-driven MCOs survive? The small amount of research that has been carried out on financial and other operating indicators is now outdated. More research is needed on financial and organizational operating indicators and how these changes are affecting the "legitimacy" of Catholic identity.
4. *Assess and evaluate the effect of mission-driven health care from the perspective of the various religious sponsors. Is there intrasector variation?* The CHA has published numerous reports and descriptive studies on its member institutions. A few studies have analyzed differences between Catholic hospitals and other ownership types. However, no studies have described operational and outcome variations of Catholic systems with different sponsors. These may be important evaluation criteria when religious sponsorship groups are considering affiliations and partnerships.
5. *Evaluate the impact of Catholic health care on individual patient responses.* An area ripe for research is the impact of Catholic ownership on the individual patient. Areas for study would be patient satisfaction, the healing response, and the effect of caregivers. Do Catholic hospitals have a different way of selecting, educating, and retaining employees that makes a measurable difference? Do patients have better outcomes?
6. *Assess and evaluate organizational innovativeness, particularly as it relates to the adoption of alternative and complementary services.* As they become more involved in managed competition and focus on decreasing costs, health care organizations are turning to alternative and complementary medicine. With their roots already established in the religious context, would Catholic hospitals be expected to be early adopters of these services? Would they tend to spend more on spirituality and "mind-body" effects on healing? Is this one way to enhance the legitimacy of Catholic hospitals? We need studies

that give us more information about the relation of religion and spirituality to healing and the role for the Catholic hospital.

Conclusion

This article has presented an overview of the literature on the health care ministry sponsored by the Roman Catholic Church, particularly health care delivered in hospitals. A confluence of powerful environmental forces at the beginning of the twenty-first century is threatening the future of Catholic health care. A review of the research that defines, differentiates, and describes the performance and identity measures of Catholic hospitals reveals them to be a *separate* case of private, nonprofit hospital. They have experienced environmental pressures to become isomorphic with other hospital ownership types and are *equal* on some dimensions. To keep pace with the changing demands of religious sponsorship and the social role of the hospital, Catholic hospitals continue to redefine themselves. To justify a *distinct* and legitimate social role, they must begin to emphasize organizational commitments to a "Catholic" way of doing things. Without a palpable and routinely noticeable distinctiveness, the institutions fail the "identity challenge" of what makes them Catholic, even when they meet their medical and economic challenges successfully (Cochran 2000). In this article I have identified studies that would be helpful in understanding the future of Catholic health care, and Catholic hospitals in particular.

Challenges to maintaining the identity of this special case of private, nonprofit hospitals are often the result of competing, countervailing forces that exert pressure on them to be simultaneously equal, separate, and distinct. In the twenty-first century, Catholic health care leaders will likely develop broader definitions of Catholic identity. A united effort will be required to create health networks that are directed and staffed by values-based providers who offer a continuum of accessible services to diverse populations in a cost-efficient manner.

References

Anderson, H.J. 1990. Catholic Hospitals Join Forces with Non-Catholic Competitors. *Hospitals* 64(20):44, 46, 48.

Ashley, B.M., and K.D. O'Rourke. 1978. *Healthcare Ethics: A Theological Analysis.* St. Louis: Catholic Health Association.

Bellandi, D. 1998a. What Hospitals Won't Do for a Merger. *Modern Healthcare* 28:28–30, 32.

Bellandi, D. 1998b. Tapped in Wisconsin: Three Wisconsin Provider-Owned Health Plans in the Red. *Modern Healthcare* 28(April 20): 2–3.

Bellandi, D. 1999a. Catholic Deals with Non-Catholics Grow. *Modern Healthcare* 29(11):24.

Bellandi, D. 1999b. Sisters of Mercy Chief to Step Down. *Modern Healthcare* 29(14):3.

Bernardin, J. 1995. The Catholic Moment. *Health Progress* 76(1):25, 28.

Bray, N., C. Carter, A. Dobson, J.M. Watt, and S. Shortell. 1994. An Examination of Winners and Losers under Medicare's Prospective Payment System. *Health Care Management Review* 19(1):44–55.

Burda, D. 1995. Catholic, Public Systems in Charlotte, N.C., Turn Partnership into Merger. *Modern Healthcare* 25(6):17.

Cahill, L.S. 1988. Catholicism, Ethics and Health Care Policy. *Catholic Lawyer* 32(1):38–54.

Cassidy, J. 1994. Catholic Identity is Based on Flexible, Reasonable Tradition. *Health Progress* 75(1):16–17, 25.

Catholic Health Association. 1987. *The Dynamics of Catholic Identity in Healthcare: A Working Document.* St. Louis.

Catholic Health Association. 1991a. *Issues and Directions for the 1990s: Responses from the Ministry Leadership.* St. Louis.

Catholic Health Association. 1991b. *A Community Benefits Report on Catholic Healthcare Providers.* St. Louis.

Catholic Health Association. 1991c. *The 1991 Assessment of the Catholic Institutional Healthcare Ministry, Its Community Context, and Sponsorship Structures.* St. Louis.

Catholic Health Association. 1992a. *A Profile of the Catholic Healthcare Ministry, 1992.* St. Louis.

Catholic Health Association. 1992b. *The Call to Collaborate: Responses from the Ministry Leadership.* St. Louis.

Catholic Health Association. 1993. *The Catholic Healthcare Ministry's Transition to a New Century.* St. Louis. (Draft.)

Catholic Health Association. 1998. Mission-Driven Market Strategies: Lessons from the Field. *Health Progress* 79(4):50–53.

Cochran, C.E. 1999. The Common Good and Healthcare Policy. *Health Progress* 80(3):41–44, 47.

Cochran, C.E. 2000. Keeping Hospitals Catholic. *Commonweal* (February 25):12–16.

Connors, E.J. 1995. Arranged Marriages, Unlikely Partners. *Health Progress* 76(4):18–21, 58.

Coyle, S.M. 1999. When Sponsors Become Partners. *Health Progress* 80(6):34–7.

Curley, J.E. 1995. Letter to the editor. *Hospitals & Health Networks* 69(24):8.

D'Aunno, T.A., and H.S. Zuckerman. 1987. The Emergence of Hospital Federations: An Integration of Perspectives from Organizational Theory. *Medical Care Review* 44:323–43.

DeWitt, C. 1981. Getting Down to Business. *Hospitals* 55(19):76–8.

Dranove, D. 1995. "Marketplace." New York and Washington, D.C.: National Public Radio (August 28).

Drucker, P.F. 1994. The Age of Social Transformation. *Atlantic Monthly* 274:53–80.

Farren, S. 1996. *A Call to Care: The Women Who Built Catholic Healthcare in America.* St. Louis: Catholic Health Association of the United States.

Feder, J., J. Hadley, and R. Mullner. 1984. Falling through the Cracks: Poverty, Insurance Coverage, and Hospital Care for the Poor, 1980 and 1982. *Milbank Memorial Fund Quarterly/Health and Society* 62:544–66.

Fonner, Jr., E., and B. Tang. 1995. Six Challenges Facing Catholic Health Care Marketing. *Journal of Health Care Marketing* 15(1):13–20.

Freeland, E.P. 1992. The Dynamics of Nonprofit and Public Organizational Growth in Health Care and Higher Education: A Study of U.S. States, 1910–1980 (doctoral dissertation, Princeton University). *Dissertation Abstracts International.*

Grant, M.K., and M.M. Modde. 1992. The Evolution of Catholic Multiinstitutional Systems. *Topics in Health Care Financing* 18(4):24–31.

Gray, B.H. Ed. 1986. For Profit Enterprise in Health Care. Washington, D.C.: National Academy Press.

Gray, B.H. 1991. *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals.* Cambridge: Harvard University Press.

Griffith, J.R. 1999. *The Well-Managed Healthcare Organization*, 4th ed. Ann Arbor, Mich.: Health Administration Press.

Haughney, C. 1998. Providence Provides: Catholic Hospital Enjoys Financial Health. *Washington Business Journal* (April 20).

Health Systems REVIEW. 1995. No Margin, No Mission:25–9.

Hehir, J.B. 1995. Identity and Institutions. *Health Progress* 76:17–23.

Herzlinger, R.E., and W.S. Krasker. 1987. Who Profits from Nonprofits. *Harvard Business Review* 65(1):93–106.

Horty, J.F., and D.M. Mulholland, III. 1983. Legal Differences between Investor-Owned and Nonprofit Health Care Institutions. In *The New Health Care for Profit: Doctors and Hospitals in a Competitive Environment*, ed. B.H. Gray, 17–34. Washington, D.C.: National Academy Press.

Hultman, C.I. 1991. Uncompensated Care before and after Prospective Payment: The Role of Hospital Location and Ownership. *Health Services Research* 26:613–22.

Hurley, R.E., K.R. White, and D.L. Draper. 1999. An Analysis of Catholic-Sponsored Managed Care Organizations. Richmond: Virginia Commonwealth University (unpublished study).

Japsen, B. 1995a. Catholic Systems Eye $4 Billion Merger. *Modern Healthcare* 25(7):2.

Japsen, B. 1995b. Columbia's Big Catholic Deal Faces Scrutiny. *Modern Healthcare* 25(21):2–4, 10.

Japsen, B. 1995c. Western Catholic Systems Merge into 24-Hospital, 8,000-Physician Network. *Modern Healthcare* 25(22):16.

Japsen, B. 1995d. Catholic Group Bans For-Profits. *Modern Healthcare* 25(24):2–3.

Japsen, B. 1998. Oklahoma Hospital-Owned HMOs in Red. *Modern Healthcare* (April 3):28.

Kauffman, C.J. 1995. *Ministry & Meaning.* New York: Crossroad.

Kelly, M.J. 1996, February. What Catholics Should Bring to the Health-Care Debate. *U.S. Catholic*:15–23.

Kwon, I.W., S.R. Safranski, D. Martin, and W.R. Walker. 1988. Causes of Financial Difficulty in Catholic Hospitals. *Health Care Management Review* 13(1):29–37.

LeBlanc, A.J. 1991. Undercompensated, Unpopular Services in Hospitals: The Case of HIV/AIDS (doctoral dissertation, Pennsylvania State University). *Dissertation Abstracts International.*

Leonard, D.A., and G.B. Morrison. 1995. The Influence Model of Sponsorship. *Health Progress* 76(5):14–17, 22.

Lewin, T. 1995. Some Fear Catholic Hospital Mergers May Affect Care. *Richmond Times-Dispatch.* (March 12):A12.

Lillie-Blanton, M., S. Felt, P. Redmon, S. Renn, S. Machlin, and E. Wennar. 1992. Rural and Urban Hospitals Closures, 1985–1988: Operating and Environmental Characteristics that Affect Risk. *Inquiry* 29, 332–44.

Lynn, M.L. 1988. Case 8: Mercy Health Services. In *Strategic Management of Health Care Organizations,* eds. W.J. Duncan, P.M. Ginter, and L.E. Swayne, 653–68. Boston: PWS-Kent.

MacPherson, P. 1996. Church and Fate. *Hospitals & Health Networks* 70(6):33–4, 36.

Mann, J., G. Melnick, A. Bamezai, and J. Zwanziger. 1995. Managing the Safety Net: Hospital Provision of Uncompensated Care in Response to Managed Care. In *Advances in Health Economics and Health Services Research,* eds. R.M. Scheffler and L.F. Rossiter, 49–77. Greenwich, Conn.: JAI Press.

Martin, M. 1993. Catholic Hospitals Strive to Retain Religious Focus in an Increasingly Secular Country. *Canadian Medical Association Journal* 148(1):64–6.

McCormick, R. 1995. The Catholic Hospital Today: Mission Impossible? *Origins* 24:648–53.

McHugh, J.T. 1994. Health Care Reform and Abortion: A Catholic Moral Perspective. *Journal of Medicine and Philosophy* 19:491–500.

McKinney, M.M., A.D. Kaluzny, and H.S. Zuckerman. 1991. Paths and Pacemakers: Innovation Diffusion Networks in Multihospital Systems and Alliances. *Health Care Management Review* 16(1):17–23.

Meyer, J.W., and B. Rowan. 1977. Institutional Organizations: Formal Structure as Myth and Ceremony. *American Journal of Sociology* 83:340–63.

Morrisey, F.G. 1987. What Makes an Institution "Catholic"? *Jurist* 47:531–44.

Origins. 1994. Ethical and Religious Directives for Catholic Health Care Services (revised). Vol. 24:449–62.

Ozcan, Y.A., and R.D. Luke. 1993. A National Study of the Efficiency of Hospitals in Urban Markets. *Health Services Research* 27:719–39.

Ozcan, Y.A., R.A. Luke, and G.H. Haksever. 1992. Ownership and Organizational Performance: A Comparison of Technical Efficiency Across Hospital Types. *Medical Care* 30:781–94.

Pettinati, P.M. 1988. The Hospitals of the Sisters of Mercy: Can They Survive and Maintain Their Mission? (doctoral dissertation, Boston University). *Dissertation Abstracts International.*

Place, M.D. 1999a. The Catholic Health Association of the United States. President's Page. Letter to the Editor of the Wall Street Journal (February 10) Web site:. www.chausa.org/WSJLTR.ASP.

Place, M.D. 1999b. Catholic Identity: A Unifying Force. *Health Progress* 80(2):10, 14.

Prince, T.R. 1994. Assessing Catholic Community Hospitals Versus Nonprofit Community Hospitals, 1989–1992. *Health Care Management Review* 19(4):25–37.

Prince, T.R., and R. Ramanan. 1994. Operating Performance and Financial Constraints of Catholic Community Hospitals, 1986–1989. *Health Care Management Review* 19(4):38–48.

Regan, M.J. 1978. *Tender Courage: A Brief Sketch of the First Sister of Mercy.* Gwynedd Valley, Penn.: Gwynedd-Mercy College (brochure).

Rosenberg, C.E. 1989. Institutionalized Ambiguity: Conflict and Continuity in the American Hospital. *Second Opinion* 12:63–73.

Schlesinger, M., J. Bentkover, and D. Blumenthal. 1987. Multi-Hospital Systems and Access to Health Care. In *Advances in Health Economics and Health Services Research,* eds. R. Scheffler and L. Rossiter, vol. 7, 121–40. San Francisco: CAI Press.

Schlesinger, M., and B. Gray. 1998. A Broader Vision for Managed Care, Part 1: Measuring the Benefit to Communities. *Health Affairs* 17:152–68.

Sexton, K.J. 1996. The Ministry Change Imperative. *Health Progress* 77(2):18–22.

Shortell, S.M. 1988. The Evolution of Hospital Systems: Unfulfilled Promises and Self-Fulfilling Prophesies. *Medical Care Review* 45:177–214.

Shortell, S.M., E.M. Morrison, and B. Friedman. 1990. *Strategic Choices for America's Hospitals: Managing Change in Turbulent Times.* San Francisco: Jossey-Bass.

Somers, A. 1969. *Hospital Regulation: The Dilemma of Public Policy.* Princeton, N.J.: Princeton University Press.

Starr, P. 1982. *The Social Transformation of American Medicine.* New York: Basic Books.

Steinfels, P. 1999. Seeking to Bridge the Gap between Catholic Health Institutions and Labor Organizers. *New York Times* (September 4):A10.

Stepsis, U., and D. Liptak. Eds. 1989. *Pioneer Healers: The History of Women Religious in American Health Care.* New York: Crossroad.

Stevens, R.A. 1989. *In Sickness and in Wealth: American Hospitals in the Twentieth Century.* New York: Basic Books.

Stevens, R.A. 1991. The Hospital as a Social Institution, New-Fashioned for the 1990s. *Hospital & Health Services Administration* 36(2):163–73.

Sullivan, J.M. 1993. An Opportunity for Positive Change: We Have the History, Experience, and Will to Preserve a Catholic Presence in Healthcare. *Health Progress* 74(7):56–65.

Tang, B. 1995. The Impact of Competition on the Financial Performance of Catholic Hospitals (unpublished doctoral dissertation, Saint Louis University). *Dissertation Abstracts International.*

Tokarski, C. 1994. A Nonprofit or For-Profit Health System: Does It Matter? *Medicine and Health Perspectives* 48(6):1–4.

Tokarski, C. 1995. For Whom the Church Bell Tolls. *Hospitals & Health Networks* 69(20):41–3.

Unland, J. 1998. New Opportunities for Providers/Insurers. *Health Progress* 79(3):54–9.

Valdmanis, V.G. 1990. Ownership and Technical Efficiency of Hospitals. *Medical Care* 28:552–61.

Vowell, T.H. 1992. Preserving Catholic Identity In Mergers: An Ethical and Canon Law Perspective. *Health Progress* 73(2):28–33.

Weisman, C.S., A.J. Khoury, C. Cassirer, V.A. Sharpe, and L.L. Morlock. 1999. The Implications of Affiliations between Catholic and Non-Catholic Health Care Organizations for Availability of Reproductive Health Services. *Women's Health Issues* 9(3):121–34.

White, K.R. 1996. Catholic Healthcare: Isomorphism or Differentiation? (doctoral dissertation, Virginia Commonwealth University). *Dissertation Abstracts International.*

White, K.R., and J.W. Begun. 1998/99. How Does Catholic Hospital Sponsorship Affect Services Provided? *Inquiry* 35:398–407.

White, K.R., and Y.A. Ozcan. 1996. Church Ownership and Hospital Efficiency. *Hospital & Health Services Administration* 41:297–310.

Williams, D., J. Hadley, and J. Pettengill. 1992. Profits, Community Role, and Hospital Closure: An Urban and Rural Analysis. *Medical Care* 30:174–87.

Zeckhauser, R., J. Patel, and J. Needleman. 1995. *The Economic Behavior of For-Profit and Nonprofit Hospitals: The Impact of Ownership on Responses to Changing Reimbursement and Market Environments.* Cambridge: Harvard University Press.

Zuckerman, A. 1999. *The Future of Health Care: 2000 and Beyond.* Bon Secours Hampton Roads Health System Planning Conference, Williamsburg, Va., April 10.

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