

Setting the Record Straight: Catholic Hospitals and Access to Reproductive Health Services

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*Representing California's Catholic
Health Systems and Hospitals*

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Recent reports have suggested that mergers between Catholic and non-religious hospitals have contributed to a scarcity of reproductive services in California. This claim is not supported by one credible study or analysis and is completely erroneous.

Catholic hospitals have been serving California communities and patients for nearly 150 years. During that time, Catholic hospitals have been at the forefront of women's services, especially for poor women. Catholic hospitals have been leaders in their

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communities providing a range of women's health services, such as improving access to prenatal care and breast cancer

screening, reducing rates of domestic violence, helping women out of poverty and educating women on nutrition.

This document refutes several inaccurate and misleading charges that have been leveled against Catholic hospitals by examining the facts with respect to the following issues:

- Catholic Hospital Affiliations
- Treatment of Victims of Sexual Assault
- Access to Reproductive Services
- Standards of Care for Post Partum Tubal Ligations
- Revisions to the *Ethical and Religious Directives for Catholic Health Care Services*

Catholic Hospital Affiliations

The claim that Catholic hospital systems are rapidly gobbling up secular hospitals, converting them to Catholic and, thereby, making reproductive health services scarce is not supported by the facts. Since 1993, a mere 1.2 percent (or 5) California acute care hospitals changed their identities from "secular community-based" to Catholic. Another 19 California hospitals have affiliated with a Catholic health care system, but have not changed their identities to Catholic. These hospitals continue to provide most reproductive health services, with two exceptions: abortion and in-vitro fertilization.

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California has the highest per capita abortion rate of any state – a rate that is double the national average.¹ The existence of Catholic and Catholic-affiliated hospitals in California has apparently not, therefore, made abortions inaccessible. Further, the vast majority of abortions are performed in outpatient clinics – very few are performed in hospitals.

Treatment of Victims of Sexual Assault

Sixteen (16) California Catholic or affiliated hospitals are considered rape trauma centers and 18 are considered sexual assault response team (SART) sites. Such sites provide emergency contraception when treating the victims of rape.

Police officers know to take rape victims to hospitals that are equipped to provide treatment and gather forensic evidence.

Many counties contract or designate a hospital as the most appropriate site for exam of rape victims or work with a SART pursuant to guidelines set by the state. Most California hospitals, Catholic or otherwise, are not comprehensive rape treatment sites.

Simply stated: Catholic hospitals provide emergency contraception when treating rape victims. Further, the *Ethical and Religious Directives for Catholic Health Care Services (Directives)* do not preclude Catholic hospitals from providing emergency contraception

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as part of appropriate rape treatment. As a matter of fact, the *Directives* allow for the provision

of emergency contraception when treating rape victims.

Access to Reproductive Health Services

Only one independent study has been done in the area of access to reproductive health services. In January 2000, at the request of reproductive rights advocates, the California Medical Assistance Commission (CMAC) conducted an inquiry into access to certain reproductive health services by Medi-Cal beneficiaries in areas served by a Catholic or Catholic-affiliated hospital. In addition, CMAC produced two staff reports on access to sterilization services by Medi-Cal beneficiaries and found no evidence that an access problem exists.

In its first report,ⁱⁱ CMAC staff addressed concerns

“regarding the acquisition of community hospitals by Catholic Healthcare West (CHW) and the potential corresponding impact this may have on access to reproductive health services.” CMAC’s analysis led to the following three conclusions:

1) “Because there are multiple contracting hospitals in all program areas which contain CHW Catholic hospitals, and because these

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other hospitals are available to provide PPTL [post partum tubal ligation] services, there should be no access problems for beneficiaries who wish to obtain PPTL services.”

2) “Neither CMAC nor DHS [Department of Health Services] have ever been informed of any access problems involving PPTL services. This is true even within the past several months when this subject has been discussed widely.”

3) “If an access problem should be discovered, it is likely the result of misinformation or a lack of information relating to services available within the areas of operation of the SPCP [Selective Provider Contracting Program].”ⁱⁱⁱ

In its subsequent report,^{iv} CMAC staff concluded that Medi-Cal beneficiaries have at least the same access to voluntary tubal ligations at the time of delivery as does the general population. CMAC reported that “a lack of Medi-Cal beneficiary access to hospital inpatient services to obtain postpartum tubal ligation does not appear to be indicated by this OSHPD data.”^v

CMAC staff analyzed total deliveries, total voluntary tubal ligations and tubal ligations performed at time of delivery for CMAC contract hospitals and concluded:

1. “The ratio of tubal ligations performed at the time of delivery to total deliveries performed for Medi-Cal patients is 1 tubal ligation for every 13.3 deliveries. The ratio for all other patients is 1 tubal ligation performed at the time of delivery to every 15.4 deliveries. This would indicate that Medi-Cal patients have at least the same access to voluntary tubal ligations at the time of delivery as does the general population.”

2. “The percent of “Total” tubal ligations performed at the time of delivery is 54.4% and the percent of total tubal ligations *not* performed at the time of delivery is 45.6%. This would indicate that there is no established medical standard regarding when a tubal ligation should be performed.”^{vi}

Standard of Care for Post-Partum Tubal Ligations

Statements have been made – as fact – that the standard of care is to perform a tubal ligation at the time of delivery. Again, we have searched the literature for definitive conclusions on this issue. And, again, there are none. There are a host of medical and social reasons why a physician and patient may choose to have a tubal at a later date.

In the same report referenced above, CMAC noted that the reproductive rights proponents who earlier made claims as to the “standards of care” issue failed to provide any written documentation.^{vii}

CMAC staff independently obtained several documents from the American College of Obstetrics and Gynecologists (ACOG, which is the recognized, leading medical specialty organization on reproductive issues) and noted

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that none of the documents “makes a definitive statement that postpartum tubal ligation is the standard of practice. Rather, all the documents

state that there are a variety of factors to be considered in determining the timing of this elective procedure.”^{viii} And the various ACOG documents fall short of establishing a “standard of care.”

Also important to this discussion is that “sterilization services for Medi-Cal beneficiaries are the subject of fairly comprehensive regulations within Title 22 of the California Code of Regulations. They involve a number of criteria including a general 30-day waiting period between the date of written informed consent and the date of sterilization. Because of the regulatory requirements, PPTL requires thought and preparation on the part of the beneficiary and her physician.”^{ix}

Revisions to the Ethical and Religious Directives

The *Ethical and Religious Directives for Catholic Health Care Services (Directives)* provide guidance on certain moral issues that face Catholic health care today. Recently, the United States Catholic Bishops revised the *Directives*, as they have on other occasions over the last 20 years.

It has been reported that the revisions are a “first time” event – they are not. The revisions offer clarifying language and are to guide bishops and Catholic health care organizations when they are considering partnerships with non-Catholic hospitals in order to preserve the delivery of health care in communities.

The revisions do not prohibit arrangements between Catholic and non-Catholic entities; they clarify the kinds of arrangements that can be structured in the future. No changes are expected in current partnerships or services provided by Catholic or community-based affiliated facilities in California as a result of the revisions.

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Conclusion

Catholic health care leaders are prepared to debate and discuss these issues in good faith. But to be useful, any such debate must be anchored in fact, not on anecdotes and sound bites based on innuendo. Health care is too fundamental a human need, and too difficult to provide on a financially viable basis, to have health care providers and the public constantly distracted by factually flawed rhetoric.

Endnotes

ⁱ *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, as reported in California Healthline July 30, 1999, AP/Nando Times, July 29, 1999, and AP/Baltimore Sun, July 30, 1999.

ⁱⁱ *Staff Report on Availability of Selected Reproductive Services in SPCP Contracting Hospitals*, February 24, 2000, California Medical Assistance Commission.

ⁱⁱⁱ *Ibid.*, p. 2.

^{iv} *Access to Reproductive Services – Additional Staff Report*, May 8, 2000, California Medical Assistance Commission.

^v *Ibid.*, p. 6.

^{vi} *Ibid.*, p. 6.

^{vii} *Ibid.*, p. 1.

^{viii} *Ibid.*, p. 2.

^{ix} *Staff Report on Availability of Selected Reproductive Services in SPCP Contracting Hospitals*, February 24, 2000, p. 1.

